

Trust Board Paper W1

To:	PUBLIC Trust Board						
From:	John Adler						
Date:	27 June 2013						
CQC regulation:	All applicable						
Title:	Emergency Floor Development - Approval of the Strategic Outline Case						
Author/Responsible Director: Nicky Topham – Project Director / John Adler – Executive Sponsor							
Purpose of the Report:							
<ol style="list-style-type: none"> Asks that the Trust Board approve the Strategic Outline Case (SOC) for the development of a new Emergency Floor at the LRI site which will be submitted next week to the NTDA to approve the SOC and request support for funding the scheme. Requests that the Trust Board support the resolution to commit to the expenditure entailed in developing the full business case. 							
The Report is provided to the Board for:							
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Assurance							
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Summary / Key Points:							
<ol style="list-style-type: none"> In line with the National concern about the ability of emergency services to cope with demand; UHL has experienced a rise in attendances to its Emergency Department (ED). This has resulted in many patients waiting for excessive periods, our performance being well below the standard 95%. The increased pressure is related to demographics – an ageing population and growth in dementia. UHL’s ED serves a population of circa 1m, with a travel distance of 30 miles to the nearest ED. This makes it one of largest services in the country. Our trajectory for improvement has been submitted to the NTDA and was agreed by the Trust Board as part of our Annual Operating plan, and supported by the Emergency Care Improvement Support Team (ECIST). UHL has instigated a number of short term measures to improve performance. Over the past few months a number of different external bodies have reviewed the ED and its performance. The Emergency Care Intensive Support Team (ECIST) reviewed the emergency care improvement programme in March 2013. They reported that they believed the Trust is heading in the right direction and that as initiatives become embedded, operational performance, patient experience and patient outcomes will improve. However, they felt that the physical environment is acting as a ‘brake’ on performance with an inadequate number of adult and paediatric resuscitation bays and majors cubicles. Privacy, dignity and patient safety is also adversely affected by the poor environment. 							

5. The current department was built for attendances of 100,000 patients per year. Our current attendances are 155,000 per year. There is inadequate capacity resulting in constant overcrowding and inefficiencies, which exacerbate the performance issues.
6. Whilst process redesign is being undertaken within the existing footprint, there is still an issue with the size of the department. There is therefore a need for change to the physical estate to improve patient flows, staff efficiencies, capacity issues and adjacencies.
7. Discussion between UHL and the NTDA have strongly suggested that the Department of Health would be sympathetic to supporting UHL with some capital to develop an emergency floor, and have requested a SOC as soon as possible. This has resulted in an accelerated programme and hence the circulation of the SOC to the Trust Board with 24 hours notice. This was presented at the Trust Board Development Session on Monday 24th June and to the Executive Team on the 25th June.
8. Interserve and Capita have been appointed through the Leicester, Leicestershire and Rutland Facilities collaborative (LLRFMC) to develop the SOC.
9. The vision for this scheme is that there will be a single front door for any 'emergency' patient – whether they will be treated within the urgent care facility or in the ED. Surgical and medical admission units and designated acute and emergency elderly frailty units will be adjacent.
10. This Case describes options for the delivery of this facility. It is likely that it will be a refurbishment of the current emergency department and the adjacent space in the Balmoral Building where out-patients is currently situated. It will be in two phases – phase 1 will be the refurbishment of the Outpatient area to house the new ED. Phase 2 will be to convert the existing ED into the assessment area.
11. This will require the current Outpatient department to be re-located. The majority of clinics are proposed to locate in the interim to the Brandon Unit at the Leicester General Hospital, which will require refurbishment to ensure it is fit for purpose. Engagement has commenced with staff and patients examining key aspects of the proposed relocation including patient opinion, travel and car parking, due regard assessment. We shall be engaging with the Health Overview and Scrutiny Committees (OSC's) on this proposal. There is provision within the existing capital programme to fund this.
12. The space required will be between 6,000 and 7,200m². This has been calculated using projected activity to 2017/18, and recognises that the resuscitation and majors areas will need expansion in line with the increasing elderly population. Within this it is recognised that the whole health economy are progressing projects to reduce the number of patients attending the LRI, but these will be the lower acuity patients who can otherwise be seen in urgent care centres or by their GP.
13. The refurbishment has a potential capital expenditure of between £38 and £43m.
14. The revenue assumptions in the case at this stage are that the case will be revenue neutral – and reflect the capital charges and a reduction in agency staff since it will be easier to recruit to vacant posts. This represents a worst case scenario since cash releasing benefits are expected from increased efficiencies. This will be articulated in the FBC.
15. If approval to proceed is granted, the FBC will need to be developed between now and November with a view to commencing construction in the New Year. It is proposed that the first phase will be complete later in the year – the exact timescale will be dependent on the design solution.
16. Engagement is occurring externally with the CCGs and will continue as the project progresses.
17. The full business case will reflect:
 - Agreed schedules of accommodation to support future activity and increasing

morbidity of the population

- Detailed design which reflects the clinical adjacencies required to deliver the service
- Process redesign to ensure flows are optimised
- Staffing models to reflect the accommodation and new patient flows
- Full financial model to reflect the savings identified through the process redesign and improvements in staff recruitment

18. It is proposed that Interserve / Capita will develop the FBC for this project in order to meet the timescales for such a complex scheme. Once the SOC is approved by the Trust Board, the Trust Board are asked to support the Chief Executive agreeing a contract of works to develop the FBC. This can be funded from the capital programme this year, and can be stopped at any point should the project not proceed. A separate report has been submitted to the private trust Board on this owing to the commercial in confidence nature of this paper

Recommendations:

The Trust Board is asked to:

1. Approve the SOC for its submission to the NTDA, and in doing so support the continued progress of the project through the development of the Full Business Case
2. Approve that the Chief Executive incurs expenditure for the development of the Full Business Case, that authority be granted to the Chairman and/or Chief Executive to sign the necessary contract documentation.

Previously considered at another corporate UHL Committee?

Trust Board Development session – 26th June, 2013

Executive Team meeting on 25th June, 2013

Board Assurance Framework:

N/A

Performance KPIs year to date:

N/A

Resource Implications (eg Financial, HR):

As stated in the SOC

Assurance Implications:

N/A

Patient and Public Involvement (PPI) Implications:

Engagement will be undertaken as part of the design process

Stakeholder Engagement Implications:

Engagement will be undertaken as part of the design process

Equality Impact:

Due regard will be considered in full at design development stage

Information exempt from Disclosure:

Requirement for further review?

The Trust Board are asked to review progress at key project milestones.

Health

Strategic Outline Case

FINAL

Emergency Floor

June 2013



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Contents

1.	Executive Summary	3
1.1	Introduction	3
1.2	Strategic Case	3
1.3	Economic Case	4
1.4	Commercial Case	6
1.5	Financial Case	6
1.6	Management Case	6
2.	Introduction	8
3.	Purpose of the Strategic Outline Case	9
4.	Strategic Case	10
4.1	Organisation Overview	10
4.2	Business Strategy	12
4.3	Trust Estate	13
4.4	Strategic Context – National	15
4.5	Strategic Context – Local	17
4.6	The Case for Change – Emergency Services	19
4.7	Investment Objectives	20
4.8	Benefits Criteria	21
4.9	Risks	24
4.10	Constraints	25
4.11	Dependencies	25
5.	Economic Case	27
5.1	Development of Options	27
5.2	Long List of Options	29
5.3	Options Appraisal: Financial	30
5.4	Options Appraisal: Non-Financial	31
5.5	Short Listed Options	32
6.	Commercial Case	34
6.1	Commercial Strategy	34
6.2	Procurement Strategy	34

7. Financial Case	35
7.1 Introduction	35
7.2 Impact on the Trust's Income & Expenditure Account	35
7.3 Savings	36
7.4 Capital Cash Flows	37
7.5 Summary of Capital Cash Flows – Sources & Applications	38
7.6 Impact on the Balance Sheet	38
7.7 Sensitivity	39
7.8 Affordability	39
8. Management Case	40
8.1 Programme Management Arrangements	40
8.2 Project Board Role & Responsibilities	40
8.3 Membership of the Project Board	41
8.4 Programme Milestones	42
8.5 Programme Quality & Assurance Management	42
9. Appendices	43
Appendix A Emergency Floor Patient Flows & Adjacencies	44
Appendix B Financial Analysis	45

1. Executive Summary

1.1 Introduction

This document sets out University Hospitals Leicester NHS Trusts (hereafter referred to as ‘the Trust’ or ‘UHL’) proposals to invest in a fit for purpose, modern emergency floor for the provision of emergency services at its Leicester Royal Infirmary (LRI) site.

It should be noted that although this document has been produced within a challenging timeframe, so that critical deadlines for the approval of capital funds can be met, it still meets the guidance set down by HM Treasury. The Strategic Outline Case (SOC) provides an early indication and high level option appraisal of the proposed way forward (not necessarily the preferred option), having identified and undertaken analysis of available options, together with indicative costs and based on available data at the time of writing.

It is for subsequent business case stages to revisit the outcome of this SOC in more detail and to identify a preferred option which demonstrably optimises value for money. Such documents will also define the likely deal, demonstrate its affordability and details the supporting procurement strategy, together with management arrangements for the successful rollout of the scheme.

1.2 Strategic Case

In order to provide the level of high quality emergency care and assessment services to comply with regulatory standards that is expected of the Trust, it is essential that the Trust ensures that its patients and staff can work and receive treatment in a safe environment and that patient treatment is efficient and timely in its delivery. In doing so provision of adequate majors cubicles, mental health, minors, imaging, resus, paediatrics, medical assessment beds and supporting infrastructure accommodation/ environment will need to be able to support the specific service delivery requirements relating to the associated emergency and assessment care.

In line with the national concern about the ability of emergency services to cope with demand, UHL has experienced an rise in attendances to its emergency department. This has resulted in many patients waiting for excessive periods and performance being well below the standard 95% (week ending 8th June it was 86%). This reflects poor quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment and increased clinical risk and compromised patient safety. Recruitment and retention has also been adversely affected.

Whilst process redesign is being undertaken within the existing footprint and built environment, there is still an issue with the size of the emergency floor in its entirety and is deemed totally inadequate to cope with the demand by the Emergency Care Intensive Support Team (ECIST).

The investment objectives for this SOC are described as follows:

Investment objective 1: Increased Capacity

- To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.

Investment objective 2: Improved Clinical Adjacencies

- To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.

Investment objective 3: Improved Efficiency

- To improve service efficiency through:
 - The elimination of service duplication caused by service separation
 - Improved clinical adjacencies
 - Improved service throughput
 - Improved emergency service targets

Investment objective 4: Improved Working Environment

- To provide a modern, safe and fit for purpose working environment for staff.
- To provide facilities that are fully compliant with NHS and other regulations.
- To provide facilities that minimise clinical risks.
- To improve staff recruitment and retention.

Investment objective 5: Service Modernisation

- To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices.

Investment objective 6: Improved Environment for Patients and their Families

- To provide modern, safe, fit for purpose facilities for patients and their families to use the Trust's services, and provide high quality, comfortable accommodation that protects privacy and dignity.

Investment objective 7: Developing a Centre of Excellence

- To enhance the Trust's reputation as a centre of excellence for training, through the provision of a centralised services in modern accommodation.

1.3 Economic Case

1.3.1 Development of Options

As a result of undertaking high level demand and capacity modelling of the emergency department and assessment areas, the outputs of the schedules of accommodation have determined a space requirement of approximately 8,000m², using Health Building Note (HBN) ideals based on a new build solution.

It should also be noted that the schedule of accommodation was produced with a view to understand the maximum space envelope required and is still to be fully developed by implementing the use of 'flexible space' within each department as well as across the emergency floor as a whole. This level of detail will be understood as part of the detailed design process undertaken during the Full Business Case (FBC), and is fully expected to rationalise the proposed requirement.

1.3.2 Long List of Options

This high level option development exercise suggests it prudent to financially appraise a long list of options that allows for between 6,000m² and 7,200m² sized scheme alongside other suitable comparators; in this instance suitable comparators will be options appraising a 'do nothing', 'a do minimum' as well as undertaking a 'new build' approach.

The long list of options is listed in the following table:

Long List of Options	Description	Cost	Short Listed Options
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Do Nothing	No investment at all	Nil	X
Do Minimum	Bring facilities up to Category B standard in current locations	£317,000	X
Refurbishment of existing areas to accommodate emergency department and associated assessment areas (approximately 6,000m ²).	Option 1	£38,071,264	√
Refurbishment of existing areas and part new build to accommodate emergency department and associated assessment areas (approximately 7,200m ²).	Option 2	£43,120,000	√
New Build (approximately 8,000m ²).	Option 3	£50,192,727	X

Option 3 clearly meets expectation from a standard demand and capacity modelling perspective that has been developed in parallel with both clinical aspiration and ‘new build’ HBN guidance, though indicative analysis deems it unaffordable from a capital and revenue perspective. There is also issue with the lack of suitable sites available on the LRI site to undertaken the development whilst maintaining critical service adjacencies and patient flows.

Although option 1 fully demonstrates the ethos behind the ‘left shift’ in emergency department attendance and reduced area requirement as a consequence, it has been deemed too much of a risk by both clinicians and the Trust executive team to potentially size the proposed development too small against that demonstrated by other organisations that provide what is considered exemplar emergency department and associated service provision.

Option 2 therefore demonstrates a space allocation that will potentially meet the increase in activity currently modelled for the emergency department in terms of majors and resus, which is expected to grow with an aging population. However, further detailed demand and capacity modelling is required to confirm this anticipated trend, which will then confirm the actual size of environment required to deliver an optimum emergency service, which is currently 20% greater in terms of both space and capital funding requirements.

1.3.3 Short List of Options

The ‘do nothing’, ‘do minimum’ and ‘new build’ options have therefore been discounted from the long list of options to determine a proposed short list of options for appraisal at FBC.

Option 1 will see the refurbishment of existing areas to accommodate the emergency floor and assessment areas; requiring approximately 6,000m² as defined by earlier Trust modelling incorporating a ‘left shift’ approach (McKinsey’s).

Option 2 will see the refurbishment of existing areas and part new build to accommodate the emergency department and assessment areas; requiring approximately 7,200m² as defined by more recent demand and capacity modelling in line with both service aspirations and HBN guidance.

These cost estimates have been produced by the project team and will require further development and validation as part of the FBC process.

Costs exclude optimism bias as would be expected at this stage; but include nominal amounts for new equipment purchases, consultant fees, contingencies and value added tax (VAT).

- The Trust has excluded optimism bias at this stage but will carry out a full assessment for the subsequent business case stages.
- A nominal amount has been included for new equipment, this amount does not include for replacement of major pieces of equipment such as x-ray machines and/ or CT scanners as these (it is assumed) will be transferred from existing locations or funded separately by the Trust through a combination of block capital funds and/ or charitable donations.
- Enabling costs are currently excluded as the relevant schemes are to be separately funded.

1.4 Commercial Case

Interserve/ Capita Symonds Limited (CSL) Health have been commissioned through the Lot 2 agreement, and will work with the Trust to develop this SOC, detailed design and Full Business Case in order to achieve a robust Guaranteed Maximum Price (GMP) for the construction phase of the project that provides a quality build as well as proves to be value for money. It is then anticipated the scheme will be delivered on the same basis as a P21 plus programme using the NEC form of contract.

1.5 Financial Case

As is described in the SOC, proposed emergency department activity is anticipated to increase and as a consequence the impact of a 20% increase in required space and capital funding needs to be financially appraised. The key impact would be to increase the space required by 20% from approximately 6,000m² to 7,200 m², subsequently increasing construction costs to from approximately £38m to £43m.

Assuming the same level of impairment (at 30%) the capital charges would rise to £2.7m from the current £2.4m.

The financial case deems option 1, at 6,000m² is affordable, and analysis suggests that the 20% uplift in capital funding required to develop option 2 with space requirement of approximately 7,200m², is also affordable.

Further financial analysis is required and will be undertaken as part of the development of the FBC:

- Selection of an affordable preferred option; this should include more detailed capital costings including optimism bias, equipment and any enabling works not identified under separate schemes, development/ review of revenue models for emergency services and economic appraisal of the options.
- Review of Trust financial plans for funding capital investment.
- Sensitivity testing.

1.6 Management Case

The project will be managed by the University Hospitals Leicester NHS Trust. The Project Board has the responsibility to drive forward and deliver the outcomes and benefits of the project, being the reconfiguration of Level 1 Balmoral Building into an emergency floor.

Roles and responsibilities are as follows:

- Senior RO/Project Owner – John Adler, Chief Executive, UHL
- Project Director – Nicky Topham, Programme Director of Reconfiguration, UHL
- Project Manager – Chris Turner, Associate Director, Capita Symonds
- Senior Supplier – Stephen Samuals, Director of Interserve

In order to ensure successful delivery of the development, the Project Board is made up of Healthcare and Capital Investment specialists, as follows:

Member	Title
Dr Kevin Harris	Chair/ Medical Director
Nicky Topham	Project Director/ Programme Director of Reconfiguration, UHL
Chris Turner	Project Manager/ Associate Director, Capita Symonds
Stephen Samuals	Senior Supplier/ Director of Interserve, UHL Facilities Management
Victoria Powell	Senior Consultant, Capita Symonds
Andrew Seddon	Director of Finance
Phil Walmsley	Head of Operations
TBC	Senior User/ Acute Divisional Director or Representative
TBC	Senior User/ Planned Care Divisional Director or Representative
TBC	Senior User/ Woman's & Childrens Divisional Director or Representative
Kim Wilding	Senior User/ UCC Divisional Manager or Representative
Nigel Bond	LLR Facilities Management Company

The detailed Programme for the development is dependent on the preferred option and dates may change as a result, however indicative milestones for delivery are as follows:

Milestone	Date
Preparation of Strategic Outline Case	10 th Jun 2013
Strategic Outline Case Trust Board Approval	27 th Jun 2013
Strategic Outline Case to NTDA	5 th Jul 2013
Detailed Design complete	30 th Sept 2013
Financial Plan complete	31 st Oct 2013
Full Business Case submission to UHL	8 th Nov 2013
Full Business Case completion	28 th Nov 2013
Full Business Case Approval (internal & external)	31 st Dec 2013
Phase 1 Construction commences	Jan 2014
Handover	Oct 2014
Trust Commissioning Period	Oct 2014
Trust Operational	Nov 2014

2. Introduction

This document sets out University Hospitals Leicester NHS Trusts (hereafter referred to as 'the Trust' or 'UHL') proposals to invest in a fit for purpose, modern emergency floor for the provision of emergency services at its Leicester Royal Infirmary (LRI) site.

In line with the national concern about the ability of emergency services to cope with demand, UHL has experienced an rise in attendances to its emergency department. This has resulted in many patients waiting for excessive periods and performance being well below the standard 95% (week ending 8th June it was 86%). This reflects poor quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment and increased clinical risk and compromised patient safety.

UHL has instigated a number of short term measures to improve performance. Whilst process redesign is being undertaken within the existing footprint and built environment, there is still an issue with the size of the emergency floor in its entirety and is deemed totally inadequate to cope with the demand by the Emergency Care Intensive Support Team (ECIST).

Their findings identified that 12,600 patients are seen annually in a 6 bedded resuscitation area and 52,000 ambulance patients through a 16 cubicled majors area. Inadequate space results in patients being lined up in trolleys in the open floor space in majors. Size and poor adjacencies therefore inhibit the Trust's ability to smoothly move patients through the department and associated floors. In addition to the aforementioned, the Medical Assessment Unit (MAU) is currently on the 5th floor of the Balmoral building which further hinders efficiency.

As a consequence, there is an urgent need for change to the physical estate currently supporting the emergency floor in order to improve patient flows, staff efficiencies, capacity issues and adjacencies.

3. Purpose of the Strategic Outline Case

This Strategic Outline Case (SOC) sets out proposals for investment in the provision of new facilities for emergency services at the University Hospitals of Leicester NHS Trust. It summarises key decisions and activities undertaken to develop these proposals and to provide a robust basis for investment and associated decision making.

The SOC has been produced in accordance with the principles of the Five Case Model recommended by the NHS. This SOC and the subsequent business case process combine to fulfil the five case model, which is defined as follows:

- **Strategic Case**; this describes the strategic context and the case for change, together with the supporting investment objectives for the project.
- **Economic Case**: this demonstrates that the organisation has selected a preferred way forward, which best meets the existing and future needs of the service and is likely to optimise value for money (VFM).
- **Commercial Case**: this describes the planned procurement methodology.
- **Financial Case**: this assesses the funding arrangements and affordability and the impact on the Trust's balance sheet.
- **Management Case**: this demonstrates that the project is achievable and can be delivered successfully in accordance with accepted best practice.

This document represents the first step in any proposal that involves major capital investment and aims to set the strategic need, the context of the case for change and to elicit the support of all associated stakeholders.

It should be noted that although this document has been produced within a challenging timeframe, so that critical deadlines for the approval of capital funds can be met, it still meets the guidance set down by HM Treasury. The SOC provides an early indication of the proposed way forward (not necessarily the preferred option), having identified and undertaken analysis of available options, together with indicative costs; based on available data at the time of writing.

It is for subsequent business case stages to revisit the outcome of this SOC in more detail and to identify a preferred option which demonstrably optimises value for money. Such documents will also define the likely deal; demonstrate its affordability; and details the supporting procurement strategy, together with management arrangements for the successful rollout of the scheme.

The following is the proposed route for document review, challenge and approval.

SOC Programme for Approval	Date
Circulate document	Monday 24 th Jun 2013
Present document to the Trust Development Board	Monday 24 th Jun 2013
Present document to the Trust Executive Team	Tuesday 25 th Jun 2013
Trust Board to delegate authority to the CEO & Chair to approve outside of the Trust Board forum	Thursday 27 th Jun 2013
SOC approved by the CEO & Chair via delegated Trust Board authority	Friday 28 th Jun 2013

4. Strategic Case

The purpose of this section is to explain how the scope of the proposed project fits within the existing business strategies of the organisation and provides a compelling case for change, in terms of the existing and future operational needs of the organisation.

4.1 Organisation Overview

4.1.1 Locations & Services

UHL is one of the largest teaching hospitals in the country and operates across three main sites; the Glenfield Hospital, Leicester General Hospital and the Leicester Royal Infirmary, and is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); equating to approximately 1 million residents. The majority of the population is split as follows:

- Leicester City – population 304,722
- Leicestershire County and Rutland – population 685,100



The Trust provides a wide range of services across its three main sites; these are summarised in the following table:

Services available at University Hospitals of Leicester main sites		
Leicester Royal Infirmary	Leicester Gen. Hospital	Glenfield Hospital
General surgery	Elective orthopaedics	Paediatric cardiology
Gastroenterology	Urology	Cardiothoracic surgery
Trauma	Nephrology	Respiratory medicine
Obstetrics & Gynaecology	Renal transplantation	Breast surgery
Well babies	End stage renal failure	Breast screening
Emergency gynaecology	Sports medicine	Orthodontics
Rheumatology	Neurology	Restorative dentistry
Diabetes & endocrinology	Obstetrics & gynaecology	Adult cardiology
Adult & paediatric A&E	Elective gynaecology	Clinical support services
Acute medicine	Clinical support services	
Paediatric medicine & surgery	Emergency Surgery	
Oncology & radiotherapy	Hepatobiliary	
Ear, nose & throat (ENT)	Diabetes Centre of Excellence	
Ophthalmology		
Maxillofacial surgery		
Vascular surgery		
Plastic surgery		
Clinical haematology		
Dermatology		
Infectious diseases		
Genetics		
Genito-urinary medicine		
Immunology		
Stroke medicine		
Elderly medicine		
Clinical support services		
Central pathology		
Emergency Surgery		

4.1.2 Activity & Finance

During 2012/ 13 UHL delivered 10,841 babies, and treated 102,800 inpatients, 80,900 day cases and 763,427 outpatients. In June 2013 the Trust has 1,780 beds open, 30 of which are additional capacity beds.

Currently the Trust has approximately 10,000 staff based in substantive whole time equivalent (WTE) posts. In addition there are 1,075 active volunteers, volunteering across a range of services including the Women's Royal Voluntary Service (WRVS), Chaplaincy and other groups such as the Radio Fox team.

UHL financial results for 2011/ 12 and 2012/ 13 show that the Trust made a surplus of £88k and £91k respectively. Details for future years are set out in the financial case section of this document.

4.1.3 Clinical Management

The clinical management is structured into three divisions, with each division led by a senior consultant called the divisional director. The three divisions are as follows:

- Acute Care
- Planned Care
- Women's and Children's

Each divisional director has a medical background and works in a clinical environment as well as providing overall leadership for the division. Alongside the director the divisions each have a head of nursing and a divisional manager. Across the three divisions there are fifteen CBUs based on core service lines. Each of these is led by a clinician, senior nurse and manager.

The clinical management of the organisation is supported by the following corporate directorates:

- Communications and External Relations
- Corporate Medical
- Finance and Procurement
- Human Resources
- Operations
- Nursing
- Research and Development
- Strategy including Facilities and Information Technology
- Corporate and Legal Affairs

4.1.4 Clinical Strategy

UHL's purpose is to provide '*Caring at its Best*' and their staff have helped to create a set of values that embody who they are and what UHL is here to ensure. These are:

- *We focus on what matters most*
- *We treat others how we would like to be treated*
- *We are passionate and creative in our work*
- *We do what we say we are going to do*

- *We are one team and we are best when we work together*

‘Our patients are at the heart of all we do and we believe that ‘Caring at its Best’ is not just about the treatments and services we

provide, but about giving our patients the best possible experience. That’s why we’re proud to be part of the NHS and we’re proud to be Leicester’s Hospitals.’

... *Caring at its best*

A relentless focus on safety/ quality/ patient experience and outcomes, underpinned by the effective use of data and robust performance management will help to ensure the Trust delivers on its overarching strategic objective of providing ‘safe, high quality patient-centred care’. This theme runs throughout UHL’s strategic objectives and those of its division’s and CBU’s.

The national population aged over 75 is increasing dramatically leading to an increase in demand. Building on the success of the hospital based Emergency Frailty Unit (EFU) the Trust will work with its partners to develop enhanced support for older people in the community setting and/ or community hospitals. This will be complemented across the organisations hospitals by extending the coverage of the Frail Older People Advice and Liaison Service (FOPAL) through the development of dedicated clinical teams. In addition an Acute Frailty unit will be introduced which will be staffed by multidisciplinary teams, led by geriatricians.

4.1.5 Emergency Services Commitment

The Trust is also focused to develop joined up emergency care by improving models of care both outside and within the hospital setting. For those who have to attend hospital, care will be provided in an environment designed to deliver a better patient experience and better quality outcomes.

The current growth in emergency admissions is not sustainable, therefore in partnership with CCG’s, Leicester Partnership Trust and Local Authority Partners and through the pro-active management of long term conditions, UHL intend to intervene to make as much care as possible ‘planned’, thereby reducing emergency admissions to hospitals.

For those patients who require acute hospital care, the Trust is developing a new emergency care model which will bring senior clinical decision makers closer to the front door of the hospital; ensuring these teams have rapid access to tests and diagnostic imaging, transforming the speed, quality and experience of our emergency care pathway. This accompanied by the proposed investment to the emergency floor built environment will enable the Trust to develop its emergency services as not only the largest in the country but also the best.

4.2 Business Strategy

UHL is focused on becoming a successful Foundation Trust (FT) that is internationally recognised for placing quality, safety and innovation at the centre of its service provision. The organisation intends to build on its strengths in specialised services, research and teaching, and offer faster access to high quality care, whilst developing staff and improving the patient experience.

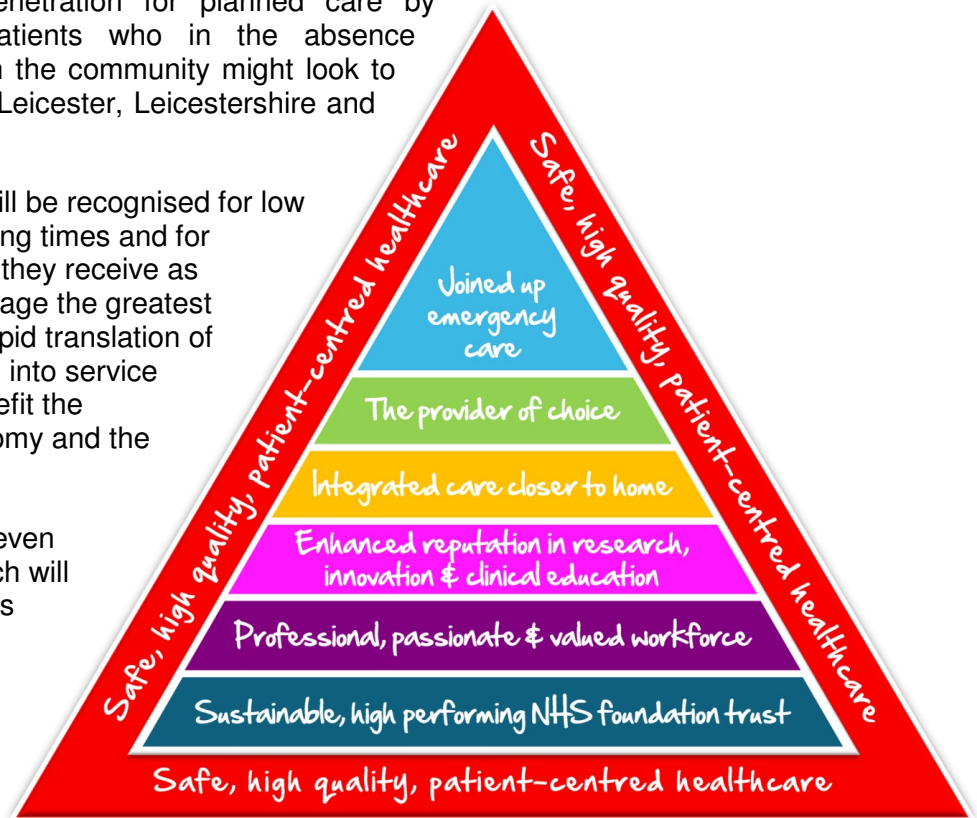
Improving quality and safety is the thread that runs through the organisation’s purpose, vision and strategy. The strategy focuses on tackling the health needs of the demographically and geographically diverse populations which were identified through robust health needs and market analysis. This has had a significant impact on the way the organisation will move forward and deliver its services.

UHL will continue to work with its partners and stakeholders to develop and implement efficient and effective models of care which ensure patients receive the right care, in the right place, at the right time.

In delivering 'Caring at its Best' the Trust will create opportunities to expand its market share for appropriate specialties - particularly focused around its tertiary services. UHL also intends to improve its market penetration for planned care by focusing on those patients who in the absence of attractive alternatives in the community might look to services outside of the Leicester, Leicestershire and Rutland borders.

In the future the Trust will be recognised for low mortality rates, low waiting times and for patients' rating the care they receive as excellent. UHL will leverage the greatest added value from the rapid translation of research and innovation into service provision which will benefit the patients, the local economy and the wider population.

The Trust has agreed seven strategic objectives which will support the delivery of its strategy:



UHL's Strategic Objectives

4.3 Trust Estate

The quality and fitness for purpose of the NHS Estate and the services that maintain it are integral to delivering high quality, safe and efficient care (Treasury Value for Money Update 2009). It is also an area of significant spend; the budget for Estates and FM Services across the Trust in 2012/ 2013 was £31m.

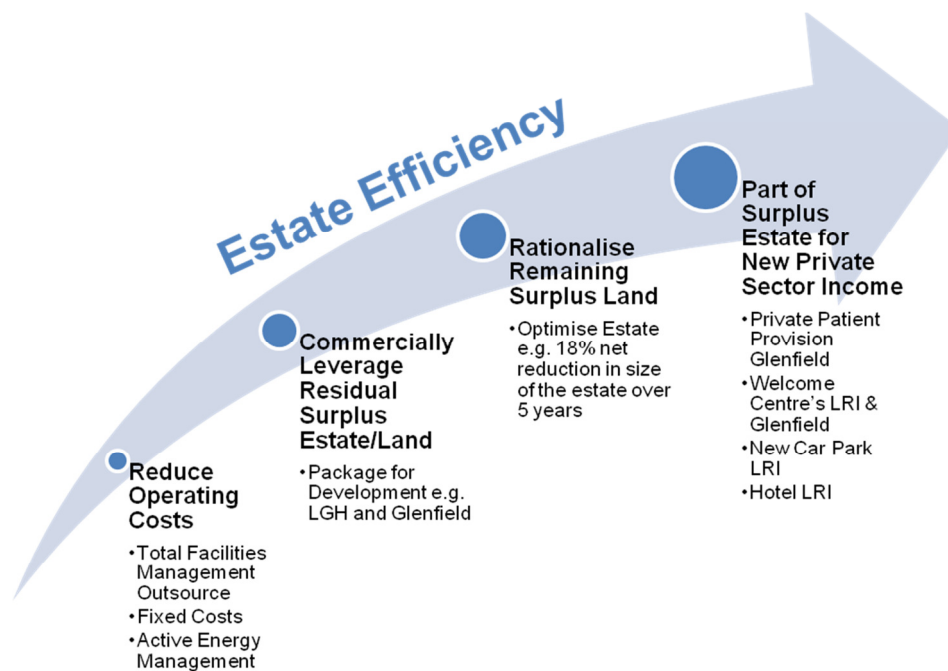
Over the last two and a half years the LLR Health Community has worked together to better understand the collective capacity and estate challenge facing local organisations. Informed by jointly commissioned analysis, the local health community has committed to a strategy to simplify, standardise and share the delivery of core Estates/ FM services and to work together in reducing the collective asset base, better utilise the residual space and capacity footprint and improve the quality of the physical environment.

Efficient estate solutions will improve frontline service provision as well as achieving improved utilisation of the estate and unlocking its embedded value. This is possible by delivering a high quality clinical and working environment for patients and staff, resulting in better levels of productivity, flexibility and patient satisfaction. This will also support cross-divisional strategies that maximise optimisation of the estate resources across UHL.

Changing lifestyles, the rise in consumerism and increased spending on the NHS have developed expectations. QIPP targets, patient experience, FT status with immediate investment to improve the Trusts estate are also to be delivered in tandem with the longer term reconfigurations whilst planning for demographic change. The Trusts estate needs to be flexible and agile to move from being a constraint to an enabler for change.

It needs to be fit for purpose, sustainable, safe and clean. Crucially it also needs to offer an excellent first impression to both patients and visitors when arriving at the Trust as well as supporting recruitment and retention; the estate is the physical manifestation of the organisation by offering an optimal healing and working environment.

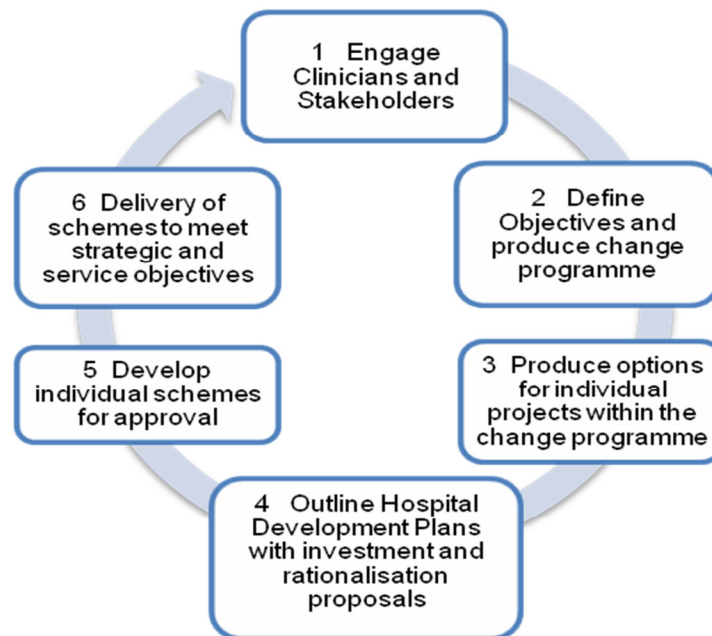
UHL is developing a Hospitals Estate Transformation Plan which is based on a strategy that consolidates the estate, develops new facilities, disposes of surplus land and buildings and encourages third party partnerships that will raise income for the Trust. This will be a cornerstone of service reconfiguration and improved utilisation of the Trust's estate. This must be balanced by organisational and public expectations about the provision of highly specialised services alongside local access to primary and secondary care, in the context of high levels of public support for the associated hospitals. It is in this context that the opportunity for significant and far reaching estate transformation will be determined.



UHL's Hospitals Estate Transformation Plan will;

- Underpin the strategic direction.
- Support the clinical strategy.
- Support the strategic outline case for the whole site reconfiguration.
- Show a clear implementation programme over five years for transformation with tangible benefits.
- Improve the patient and staff built environment, investing in improved facilities and infrastructure; greatly aiding recruitment and retention.
- Identify capital development to unlock the embedded value of Trust assets and support its ability to deliver clinical transformation and achieve QIPP efficiency savings.

The following illustrates the cycle of estate transformation incorporating review, consultation, investment, rationalisation, development and ultimate delivery of schemes to meet the Trusts strategic and service objectives.



The Hospitals Estates Transformation Plan has set out detailed strategies for its three main hospital sites. The following is considered key in supporting the Trusts service strategies specifically for the LRI:

- Remodel the emergency department and associated floor with more specialist clinicians available at the front door in support of the LRI becoming the main emergency site.
- Create a single site emergency surgical take.
- Consolidate women’s services.
- Integrate services for the growing frail elderly population which will become the national model for others to follow.
- The ‘Leicester Cancer Centre’ will continue to develop and cement its links with Cancer Research UK as a significant research and development led service.

4.4 Strategic Context – National

In March 2012 Parliament enacted the Health and Social Care Act 2012, legislation encapsulating the wide reaching changes set out in the 2010 Health White Paper ‘Equity and Excellence: Liberating the NHS’.

The legislation underpins four key themes in transforming the NHS:

- Putting patients and the public first.
- Improving health outcomes.
- Autonomy, accountability and democratic legitimacy.
- Cutting bureaucracy and improving efficiency.

The proposed scheme is aligned to government direction providing ability to drive focus on ensuring improved patient experience, safety and clinical efficiencies in delivering integrated care.

The ageing population is likely to place increasing demand on emergency departments. For further discussion of this matter see: Emergency Care 2015: Building on the Evidence (The evidence from the College of Emergency Medicine for the NHS (England) Review, Acute Care Stream), College of Emergency Medicine & British Association for Emergency Medicine, January 2008. These patients often will have infections, e.g. UTIs and D&V, and will increase the demand for isolation facilities.

The provision of unscheduled care can be understood as a four tier model which informs a whole-system approach to the pathway of care.

The tiered whole-systems approach has the following levels of response to unscheduled care:

- **Emergency Response** - specialised services in fewer hospitals (emergency department, specialised services such as trauma, stroke, primary angioplasty, vascular/emergency surgery, and emergency ambulance service). These emergency department centres will be operational 24/7 with full and continuous cover.
- **Urgent Response** – set in the community or on acute hospital sites (these would be provided from Urgent Care Centres or Polyclinics) and they might not operate 24/7. They would undertake an agreed range of urgent care services (cuts, stings, etc), alcohol and substance misuse, crisis resolution, (mental health and social care), see & treat and hear & treat.
- **Rapid/ Moderate Response** – mostly community based and undertaken in the home, polyclinics, sometimes with hospitals in-reach, these will have varying hours of access between 12 and 24 in range. These would be primarily undertaken by the GP and social services with support from diagnostic services and pharmacies etc.
- **Integrated Health & Social Care System** – consistent standards, shared protocols, timely flow, integrated workforce, training and education, care networks. Access will be determined by local demand.

The requirement for a rapid, reliable diagnostic imaging service as part of the emergency patient pathway is increasing, with growing demand for the assessment of patients with trauma, stroke, and other conditions in line with national guidance. It is likely that demand for cross-sectional imaging will continue to grow and this proposal incorporates a strategy for possible future enlargement of capacity.

The pathway of care can be overlaid on this whole-system approach, and it has four key stages:

- Identification of the need for care (by self, by carer, by professional, by other).
- Assessment of need (by telephone, by face to face).
- Initiation of right response (emergency response, urgent response, rapid/ moderate response and integrated health and social care) – outlined in more detail below.
- Follow through to closure (episode complete, planned follow-up, on-going care).

Demand on UHL's emergency services is anticipated to further increase as a result of the new NHS '111' service being introduced in September 2013. The service has been launched in other areas of the country already and early indications point to increased attendance rates at emergency departments as a result.

4.4.1 Department of Health Emergency Department Clinical Quality Indicators

The Revisions to the NHS Operating Framework for 2010/ 11 signalled the intention to replace the 4 hour waiting time standard for emergency departments with more clinically relevant indicators. The clinical quality indicators for the emergency department have been designed to present a comprehensive and balanced view of the care, and accurately reflect the experience and safety of patients and the effectiveness of the care they receive. These indicators will support patient and public expectations of high quality emergency services and allow emergency departments to demonstrate their ambition to deliver consistently excellent services which continuously improve.

These new quality indicators have been developed by Professor Matthew Cooke, National Clinical Director for Urgent and Emergency Care, working with the College of Emergency Medicine, the Royal College of Nursing and informed lay representatives.

The eight quality indicators are:

- Ambulatory care
- Unplanned re-attendance rate
- Total time spent in A&E
- Left without being seen rate
- Service experience
- Time to initial assessment
- Time to treatment
- Consultant sign off

It is expected that the design of the new emergency floor and service developments shall enable the Trust to deliver these quality indicators and provide a world class service to its catchment area.

4.5 Strategic Context – Local

In line with national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its emergency department. This has resulted in many patients waiting for excessive periods; UHL's performance is well below the standard 95% (week ending 8th June it was 86%). This reflects poor quality of care for patients, reduced clinical effectiveness, and an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

UHL's trajectory for improvement has been submitted to the NHS Trust Development Agency (NTDA) and was agreed by the Trust Board as part of the Trust's Annual Operating plan. However, poor performance may result in significant financial penalties which will impact on the Trust's ability to deliver a financial balance with potential fines of £600k per month and a potential fine of £3.25m for penalties associated with transfer from ambulance trolley to bed.

The department serves annual attendances of approximately 155,000; this excludes patients attending for eye emergencies and GP referrals direct to the emergency admissions units. The reasons for the increased pressure on LRI's emergency department can be summarised as follows:

- The local community is an ageing population and there has been growth in the number of frail patients and those suffering from dementia.

- UHL's emergency department serves a population of approximately 1 million, making it one of the largest emergency services departments in the country.
- There is no other emergency department within a 30 mile radius.
- The local community lack confidence in the GP out of hour's service which has increased pressure on emergency departments.

There is an unusual double peak in daily activity between early afternoon and the evening; unlike other centres it is unique in that the second peak is higher than the first with the highest attendances between 8pm and 10pm. At any one hour of the day, there may be between 1 to 16 attendances in any area of the department. There can be at least 40 patients attending the department for 3 or more hours at a time.

Nationally, there is a declining medical workforce specialising in the area of emergency services. Whilst there has been a successful recruitment drive at LRI for all levels of staff, the unit remains short-staffed and has to place a heavy reliance on agency staff, which is further exacerbated by the poor environment resulting in a difficulty recruiting. This is a contributing factor to the worsening financial performance.

The final 2012/ 13 year to date 4 hour wait figure for UHL, including the Urgent Care Centre (UCC), was 91.9% of attendances. In response to a consistent underachievement of the 4 hour target, new clinical roles were introduced and a new pathway commenced in November 2011 called 'Right Place, Right Time'. This initially resulted in a considerable improvement in the Trust's emergency department performance. However, following a number of challenging weeks of activity (with emergency department attendances 5% higher and emergency admissions 7% higher in the final quarter compared to the same period last year) achievement of the 4 hour target deteriorated.

Whilst ongoing operational improvements are being made to emergency department processes, the proposed investment and development of the emergency floor is the Trust's strategic response to ensure that there is sustained delivery of the emergency process. UHL will develop joined up emergency care by improving models of care both outside and within the hospital setting. For those who have to attend hospital, care will be provided in an environment designed to deliver a better patient experience and better quality outcomes.

The space and quality of accommodation provided for emergency care at LRI emergency department is unsuitable; flows through the department are poor and it is cramped and undersized in comparison to the latest DH guidelines. In addition, limited space for provision of an adequate number of majors cubicles compromises many elements of care and patient experience, particularly:

- Patient safety
- Privacy and dignity
- Infection control
- Patient pathways
- Ability to meet emergency department targets, including the 4 hour wait and the ambulance handover target

The above manifests itself into what ultimately becomes a far from satisfactory patient experience; in May 2013 patient complaints hit an all-time high, with the receipt of 30 formal complaints as a consequence of service received from the emergency department.

Future proofing of emergency care provision and changes in patient activity in line with national and regional models of care make it timely for the Trust to review and identify options for enhanced emergency care provision at the LRI, as well as the environment it's delivered in.

4.6 The Case for Change – Emergency Services

In order to provide the level of high quality emergency care and assessment services to comply with regulatory standards that is expected of the Trust, it is essential that the Trust ensures that its patients and staff can work and receive treatment in a safe environment and that patient treatment is efficient and timely in its delivery. In doing so, provision of adequate majors cubicles, mental health, minors, imaging, resus, paediatrics, medical assessment and supporting infrastructure accommodation/ environment will need to be able to support the specific service delivery requirements relating to the associated emergency and assessment care.

The following summarises the requirements for change:

- **ED Front Door:** In line with current guidance (DH and CEM) it is proposed that there is one front door for adult patients presenting for emergency treatment – all patients would be assessed on arrival and directed to the appropriate level of care; i.e. acute medical clinics, UCC, minors or majors. A separate front door would be provided for paediatric cases in line with National Service Framework (NSF) for Children and Young People and a dedicated ambulance entrance would also be provided.
- **Paediatrics:** UHL needs to meet the NSF for Children and Young People standards relating to discrete space and child friendly environment. The department will require an increase in cubicle numbers to cater for the attendances and the proposed growth, and will incorporate a short stay facility, including the potential shift of paediatric emergency care from an adjacent hospital.
- **Majors:** Currently there currently 28 majors spaces; 16 in bays and side rooms and 12 chairs. Activity/ capacity analysis carried out in June 2013 demonstrates that there should be a minimum of 40 majors cubicles in order to serve the attendances. The proposed change will provide the following:
 - Patient safety– providing compliant space around the bed for major incident and patient access.
 - Privacy and dignity for patient.
 - Compliance to infection control standards.
 - Patient satisfaction and sustainable enhancement of the patient experience.
 - Cubicle space to accommodate ambulance arrivals to the Trust, improving the current delays with ambulance handovers.
- **Minors:** The need to improve patient efficiencies and staff flows within the minors area of the emergency department, though significantly undersized the overall numbers slightly underprovided.
- **Imaging:** There is currently no dedicated emergency imaging suite; patients are required to attend the main imaging department. A diagnostic hub that is central for all patients within the emergency department will provide improved patient flows and reduce the time to diagnose patients. Staff efficiencies will also be enhanced by gaining back the time that staff spends each day escorting patients to the main imaging department.
- **Mental Health:** There is a need to meet requirements relating to a dedicated area (inclusive of own WC) that can be secured off from the rest of the department.

Consideration will also be given to a separate entry/ exit to the department in order to enhance compliance to Section 136 requirements.

Medical Assessment: There is an essential need to provide a triage and assessment service adjacent to the emergency department to enhance patient flows through the department, with the benefit of improved working relationships, processes and clinical effectiveness for patients.

4.7 Investment Objectives

The investment objectives for this SOC are described as follows:

Investment objective 1: Increased Capacity

- To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.

Investment objective 2: Improved Clinical Adjacencies

- To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.

Investment objective 3: Improved Efficiency

- To improve service efficiency through:
 - The elimination of service duplication caused by service separation
 - Improved clinical adjacencies
 - Improved service throughput
 - Improved emergency service targets

Investment objective 4: Improved Working Environment

- To provide a modern, safe and fit for purpose working environment for staff.
- To provide facilities that are fully compliant with NHS and other regulations.
- To provide facilities that minimise clinical risks.
- To improve staff recruitment and retention.

Investment objective 5: Service Modernisation

- To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices.

Investment objective 6: Improved Environment for Patients and their Families

- To provide modern, safe, fit for purpose facilities for patients and their families to use the Trust's services, and provide high quality, comfortable accommodation that protects privacy and dignity.

Investment objective 7: Developing a Centre of Excellence

- To enhance the Trust's reputation as a centre of excellence for training, through the provision of a centralised services in modern accommodation.

With the proposed emergency department and associated floor, the aforementioned investment objectives will manifest themselves in a number of key operational principles that translate the model of care into practice:

- customer-focused approach to patients, relatives, medical staffing and teaching;

- design for patient safety, privacy & dignity;
- aspire to a no-wait philosophy;
- effective streaming of patients to an appropriate point of care;
- the see and treat principle;
- co-ordinated ‘one-stop-shop’ approach for unplanned care providing equitable access to all agencies including mental health liaison teams, social services, etc;
- minimisation of patient moves;
- minimisation of steps in processes/ hand-offs;
- integration of diagnostic and assessment processes;
- optimised use of technology, including IT (ICRS, PACS & EPR) and near patient testing;
- using the skills and expertise of professional staff flexibly, with joint training in order to transfer skills;
- access to senior clinical opinion from the earliest point in the patient pathway and onwards;
- protocol-led care with standardisation of patient pathways integrating the input of all care practitioners (e.g. OT, social services, etc);
- improved junior training and improved skill mix.

4.8 Benefits Criteria

This investment will deliver the following high-level strategic and operational benefits. Benefits are expressed as follows:

- CRB = cash releasing benefits (e.g. avoided costs)
- Non-CRB = non-cash releasing benefits (e.g. staff time saved)
- QB = quantifiable benefits (e.g. achievement of targets)
- Non-QB = non quantifiable or qualitative benefits (e.g. improvements in staff morale)

Benefits Criteria are grouped by investment objective as follows:

Investment Objective	Stakeholder Group	Benefit	Summary Benefit Criteria
1. Increased Capacity • To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets	Patients	Non-QB = patients can be confident of being treated at the LRI QB = patients will receive appropriate care in appropriate facilities	Increased Capacity
	Trust/ Staff	QB = Trust is able to accommodate increased demand for services resulting from population growth QB = Trust meets its	

		targeted emergency rates QB = Trust is able to modernise services by introducing new service models QB = Trust is able to increase its income by undertaking additional activity	
	Health Community	Non-QB = LRI is accessible to all patients who need emergency treatment	
<p>2. Improved Clinical Adjacencies</p> <ul style="list-style-type: none"> To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk 	Patients	Non-QB = improved way finding for patients Non-QB = Ease of access around the hospital site, with associated departments close together QB = reduction in treatment delays caused by non-optimal facilities	Clinical Adjacencies
	Trust/ Staff	CRB = increased staffing efficiencies as a consequence of pathway redesign Non-QB = improved supervision of staff Non-QB = improved working relationships between teams	
	Health Community	Non-QB = improved layout of hospital site Non-QB = reduction in clinical risks	
<p>3. Improved Efficiency</p> <p>To improve service efficiency through:</p> <ul style="list-style-type: none"> Improved clinical adjacencies Improved service throughput 	Patients	CRB = deflection of patients to correct location of care Non-QB = services easier to use and access because they are co-located QB = treatment delays reduced	Efficient Service Delivery

<ul style="list-style-type: none"> Improved emergency service targets 	Trust/ Staff	QB = improved access target rates QB = improved throughput in the emergency department	
	Health Community	QB = more efficient Trust performance	
<p>4. Improved Working Environment</p> <ul style="list-style-type: none"> To provide a modern, safe and fit for purpose working environment for staff. To provide facilities that are fully compliant with NHS and other regulations To provide facilities that minimise clinical risks 	Trust/ Staff	Non-QB = improved communications between staff Non-QB = improvement in staff morale Non-QB = staff are able to provide best practice service models QB = Facilities are fully compliant Non-QB = improved management of emergencies QB = Reduction in identified clinical risks associated with current facilities	Working Environment
	Health Community	Non-QB = increased confidence in Trust services	
<p>5. Service Modernisation</p> <ul style="list-style-type: none"> To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices 	Patients	Non-QB = Patients receive services based on best practice Non-QB = patient care pathways are streamlined	Service Modernisation
	Trust/ Staff	Non-QB = Trust staff can provide services based on best practice QB = expanded roles are introduced QB = New agreed care pathways are implemented	
	Health Community	Non-QB = Modern services based on best practice available to all patients	
<p>6. Improved Environment for</p>	Trust Staff	QB = increased capacity to deliver high quality services	Improved Patient Environment

<p>Patients & Families</p> <ul style="list-style-type: none"> To provide modern, safe, fit for purpose facilities that attract patients and their families to use the Trust's services, and provide high quality, comfortable accommodation that protects privacy and dignity 	<p>Health Community</p>	<p>QB = increase in number of resuscitation rooms QB = increase in high dependency cubicles QB = increased minor injury cubicles QB = Dedicated paediatric facility QB = improved access to the services Non-QB = improved patient satisfaction QB = improved facilities for relative and families</p>	
<p>7. Developing a centre of excellence:</p> <ul style="list-style-type: none"> To improve staff recruitment and retention To enhance the Trust's reputation as a centre of excellence for training, through the provision of centralised services in modern accommodation 	<p>Trust/ Staff</p>	<p>QB: Staff recruitment improves QB: Staff retention improves NQB: enhances the skills of the staff working in the department NQB: Assures the Trust's future as a training centre</p>	<p>Achieving Excellence</p>
<p>Health Community</p>	<p>NQB: A Centre of Excellence is developed</p>		

4.9 Risks

Risks to the project have been assessed using the Five Case Model proforma, as shown below. As part of the development of the FBC the Trust will be develop and implement a Risk Management Strategy and Plan to ensure that risks are managed comprehensively and in an integrated manner. It will use the clinical groups established to support the design and development activities to identify all risks and to develop mitigation plans. The Project Board will oversee risk, and all high scoring risks will be included on the Trust Risk Register.

Main Risk	Counter Measures
<p>1. Business Risks</p> <ul style="list-style-type: none"> Access to capital Affordability Delay 	<ul style="list-style-type: none"> The Trust's agreed financial plans propose that the project will be funded through a combination of its capital programme and loan finance obtained via the NTDA. Affordability will be managed through innovative design and where necessary value engineering whilst maintaining scope.

Main Risk	Counter Measures
<p>2. Design & Development Risks</p> <ul style="list-style-type: none"> • Supplier • Specification • Timescale • Change Management • Project Management 	<ul style="list-style-type: none"> ▪ The Trust appointed project partner and project management/ design team (Interserve Support Services/ CSL Health) will mitigate the design and development risks.
<p>3. Implementation Risks</p> <ul style="list-style-type: none"> • Supplier • Timescale • Specification and data transfer • Cost risks • Change management and project management 	<ul style="list-style-type: none"> ▪ Continued use of the partnership arrangement via Lot 2 will provide the Trust with a Guaranteed Maximum Price (GMP) and a contractual mechanism for robust management of change. ▪ The project partner plans to undertake the construction via its supply chain.
<p>4. Operational Risks</p>	<ul style="list-style-type: none"> ▪ The Trust will identify and manage all risks associated with its current operations. ▪ It will work with its project partner to assess and mitigate any risks associated with the construction and commissioning.

4.10 Constraints

The main constraints affecting the project are:

- Construction will take place on a fully operational site, and the sequencing and project timetable will be constrained by the need to maintain safe operations at all times.
- Options for construction are severely limited due to the highly developed nature of the current site.
- Service continuity must be maintained at all times.

4.11 Dependencies

The main dependencies affecting the project are:

- Depending on the option selected as the preferred option, the Trust will need to undertake a series of enabling works to support the project. One key enabler is the temporary move of outpatients 1 to 4 to the Brandon Unit on the Leicester General Hospital site. Any delay in achieving these enabling works will impact adversely on the project timetable and costs.
- Another is the relocation of the public entrance from the Balmoral building as part of the proposed Welcome Centre scheme.

- The project overall is dependent on the Trust securing the majority of capital through support from the NTDA.

5. Economic Case

In accordance with Departmental Capital Investment Manuals and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector) this section of the SOC documents the range and associated development of options that have been considered in response to the case of need.

5.1 Development of Options

The original scope defined the need to re-provide the emergency department into what is currently out-patients 1 to 4, after which the existing emergency department area would be refurbished for the use of the remaining emergency floor function.

The floor area required was defined as approximately 6000m² and was generated in part by the forecast activity and demographic growth defined by two models used by the Trust; the McKinsey (a whole health economy model developed to forecast the future clinical sustainability of LLR) and Finnamore (a clinical activity model used by UHL) models. Both models anticipate a 'left shift' in activity away from the emergency department to urgent care and GP's, suggesting a smaller space envelope would be required in comparison to that defined by a standard approach to demand and capacity modelling.

Through consultation with all key stakeholders it became apparent that activity in the emergency department in terms of majors and resus will continue to grow with an aging population, which was a view supported by the Executive Team at its meeting on the 18th June 2013, leading to consensus that it would be catastrophic in terms of improving service delivery and department performance to undersize the emergency department and associated floor.

Analysis of models of care and associated patient pathways that have been implemented in what are considered exemplar emergency departments across the UK with similar attendance rates supports the aforementioned rationale at this stage in that the proposed 6000 m² may not sufficient to suitably locate the emergency floor in its entirety. It is therefore crucial to design flexible facilities that can meet the increasing acute need of patients whilst following the principals of the 'left shift' in attendance rates.

Continuing with these principles has led to the following being undertaken to further define the options available:

- Establishment of a **Project Governance and Stakeholder Structure**.
- Outline review of **Site Infrastructure and Services**.
 - Review of available structural and mechanical and electrical services schematics to understand development potential of the available options.
 - Review of models of care - this has included understanding the operational delivery of the emergency floor and its clinical outputs. A review has also taken place to establish how the new development on the main site would integrate with the existing facilities and operations; consequently a detailed 'Emergency Floor Patient Flows and Adjacencies' diagram has been developed in full consultation with the leading emergency floor consultants - the diagram can be found in Appendix A.
- **Demand and Capacity Modelling** – determining the volume of service to be delivered in the future, and their space requirements; a copy of which is attached as Appendix B.
- **Schedules of Accommodation** – an experienced healthcare planner has developed an indicative understanding of the overall foot print required to realise the outputs of the

demand and capacity modelling. This has been produced in parallel with that denoted in the relevant NHS Health Building Note (HBN) guidance documents and cross referenced to the Trusts service model.

The table below identifies some of the major differences between the current facilities and that proposed:

Zone/ Function Proposed Rooms	Current	Proposed	
Resus	6	12	Detailed modelling required at FBC stage because these rooms are large and expensive, and are not flexible for other use.
Adult initial assessment bays	4 (6)	10	Further modelling work will refine assumptions about treatment times and peak flows into the unit.
Adult initial assessment rooms	3	4	Further modelling work will refine assumptions about treatment times and peak flows into the unit.
Adult Major	16 cubicles, 12 chairs	40	Further modelling work will refine assumptions about treatment times and peak flows into the unit.
Adult Minor	9	11	Based on benchmark data - to be validated at FBC with detailed analysis.
Paeds initial assessment rooms	1	4	Based on benchmark data - to be validated at FBC with detailed analysis.
Paeds Treatment	10	15	Based on benchmark data - to be validated at FBC with detailed analysis.
Paeds short stay assessment	0	12	Based on benchmark data - to be validated at FBC with detailed analysis – currently ward based.
Eye Casualty	0	4	Based on 12,000 future attendances demographic growth – currently in ophthalmology.
Urgent Care Centre	8	11	Based on up to 75,000 attendances demographic growth.
EDU + EFU	16	13 (EDU only)	Based on benchmark data. To be validated at OBC with detailed analysis. Recent schemes tending to have towards 100 or more if space allows.
Mental health assessment rooms	1	3	Based on benchmark data - to be validated at FBC with detailed analysis.
Medical assessment beds (inc. AFU, EFU, ACB, rapid assessment)	62 (exc EFU)	89	Based on benchmark data - to be validated at FBC with detailed analysis.
Acute medicine clinic rooms	4	4	Based on benchmark data - to be validated at FBC with detailed analysis.
Surgical assessment trolleys	0	14	Based on benchmark data - to be validated at FBC with detailed analysis.
Surgical assessment rooms	0	3	Based on benchmark data - to be validated at FBC with detailed analysis.

Short stay medical & ambulatory care unit	15	20	Option to locate elsewhere
Total	167 (169)	269	
Plain film X-Ray		3	Excludes work from fracture clinic
CT Scanner		1	Immediately adjacent to resus.

As a result of undertaking high level demand and capacity modelling of the emergency department and assessment areas, the outputs of the schedules of accommodation have determined a space requirement of approximately 8,000m².

Analysis suggests this size of development is not attainable in the proposed area on the LRI nor affordable, though a 10% reduction in foot print would be a practical solution, thus suggesting an area of 7,200m². This 10% decrease is considered achievable due to the 8,000m² being based on HBN guidance which is only fully attributed to new build developments, and refurbishments of this nature would expect to see a practical decrease in space allocation; such an approach was successfully implemented on the recently delivered NICU scheme which received full clinical endorsement.

It should also be noted that the schedule of accommodation was produced with a view to understand the maximum space envelope required and is still to be fully developed by implementing the use of 'flexible space' within each department as well as across the emergency floor as a whole. This level of detail will be understood as part of the detailed design process undertaken during the FBC, and is fully expected to rationalise the proposed requirement.

This high level option development exercise suggests it prudent to financially appraise a long list of options that allows for a 6,000m² and 7,200m² sized scheme alongside other suitable comparators; in this instance suitable comparators will be options appraising a 'do nothing', 'a do minimum' as well as undertaking a 'new build' approach.

5.2 Long List of Options

The Trust has identified its long list of options as follows:

Long list of options	Descriptions
Do Nothing	No investment at all
Do Minimum	Bring facilities up to Category B standard in current locations
Refurbishment of existing areas to accommodate emergency department and associated assessment areas (approximately 6,000m ²).	Option 1
Refurbishment of existing areas and part new build to accommodate emergency department and associated assessment areas (approximately 7,200m ²).	Option 2
New Build relocating the emergency department and assessment areas in an appropriate area of the LRI site, taking consideration of essential emergency department flows and adjacencies	Option 3

(approximately 8,000m²).

The Trust has rejected the ‘do nothing’ option as it is no longer clinically safe or sustainable to retain the current facilities for emergency services, nor will this option meet the Trust’s business and strategic objectives. The Trust cannot meet current or future demands for services without additional facilities.

The Trust has rejected the ‘do minimum’ option for the refurbishment of current facilities for the same reasons. Addressing backlog maintenance issues in the emergency department will not meet the Trust’s business and strategic objectives, nor can the Trust meet future demands for services in these facilities.

The Trust has rejected the ‘new build’ option primarily due to the limited sites available on the LRI to develop the required amount of space that is considered acceptable with regards to fulfilling the Trusts obligation to provide emergency services that has associated departments and functions with appropriate adjacencies, enabling suitable patient flows. A new build option will also need to adhere to HBN guidance more stringently over and above that of a refurbishment based option, and current demand and capacity modelling suggests a space requirement of approximately 8,000m², which is deemed unaffordable with an indicative capital requirement in the region of £50m.

The Trust has therefore selected options 1 and 2 to financially appraise at a high level for the purpose of this SOC; determining the affordability of both options in terms of the capital and revenue demand that will be placed on the Trust as a consequence of delivering.

Option 1	Option 2
Refurbishment of existing areas to accommodate emergency department and associated assessment areas (approximately 6,000m ²).	Refurbishment of existing areas and part new build to accommodate emergency department and associated assessment areas (approximately 7,200m ²).

5.3 Options Appraisal: Financial

The size of the space requirement and proposed build approach is different for the two options.

Option 1 will see the refurbishment of existing areas to accommodate the emergency floor and assessment areas; requiring approximately 6,000m² as defined by earlier Trust modelling incorporating a ‘left shift’ approach (McKinsey’s).

Option 2 will see the refurbishment of existing areas and part new build to accommodate the emergency department and assessment areas; requiring approximately 7,200m² as defined by more recent demand and capacity modelling in line with both service aspirations and HBN guidance.

A summary of areas and costs is shown below.

Option	Area	Indicative Cost
1	Refurbishment of existing areas to accommodate emergency department and associated assessment areas (approximately 6,000m ²).	£38,071,264
2	Refurbishment of existing areas and part new build to	£43,120,000

accommodate emergency department and associated assessment areas (approximately 7,200m²).

These cost estimates have been produced by the project team and will require further development and validation as part of the FBC process.

Costs exclude optimism bias as would be expected at this stage; but include nominal amounts for new equipment purchases, consultant fees, contingencies and value added tax (VAT).

- The Trust has excluded optimism bias at this stage but will carry out a full assessment for the subsequent business case stages.
- A nominal amount has been included for new equipment, this amount does not include for replacement of major pieces of equipment such as x-ray machines and/ or CT scanners as these (it is assumed) will be transferred from existing locations or funded separately through the Trust’s managed equipment service.
- Enabling costs are currently excluded as the relevant schemes are to be separately funded.

5.4 Options Appraisal: Non-Financial

The Trust’s appointed **project management and design team** have appraised the site options from an architectural and practical perspective and have identified the following advantages and disadvantages:

Option 1
Refurbishment of existing areas to accommodate emergency department and associated assessment areas (approximately 6,000m ²).
<p>Advantages</p> <ul style="list-style-type: none"> • Refurbishment, phased approach, keeping disruption to a minimum • Space requirement exists without the need to undertake any extension/ new build works • Improve patient flows will improve patients privacy and dignity when moving between departments • Almost certain affordability envelope • Improved recruitment and retention <p>Disadvantages</p> <ul style="list-style-type: none"> • Confined by existing build envelope • Utilising this space may end up sizing the emergency department and assessment areas smaller than required from a clinical delivery perspective • May not be a long term solution if demographic growth and associated demand increases beyond the capacity of the emergency department
Option 2
Refurbishment of existing areas and part new build to accommodate emergency department and associated assessment areas (approximately 7,200m ²).
<p>Advantages</p> <ul style="list-style-type: none"> • Space allocation would potentially meet the outputs of the demand and capacity modelling,

enabling service improvement and increased patient safety

- Clinically endorsed environment
- Improve patient flows will improve patients privacy and dignity when moving between departments
- New build/ extension would radically improve façade of current building
- Improved recruitment and retention

Disadvantages

- Although deemed affordable at this stage pending further financial analysis, the affordability envelope may be stretched in comparison to option 1
- Development of existing façade will require extensive planning to avoid disruption to current blue light entrance and service delivery

The Trust has not yet undertaken a formal non-financial appraisal of these options against its benefits criteria and the project’s critical success factors. This appraisal will be undertaken as part of the FBC process.

5.5 Short Listed Options

The recommended shortlist of options for appraisal at FBC is therefore as follows:

Long List of Options	Description	Cost	Short Listed Options
Do Nothing	No investment at all	Nil	X
Do Minimum	Bring facilities up to Category B standard in current locations	£317,000	X
Refurbishment of existing areas to accommodate emergency department and associated assessment areas (approximately 6,000m ²).	Option 1	£38,071,264	√
Refurbishment of existing areas and part new build to accommodate emergency department and associated assessment areas (approximately 7,200m ²).	Option 2	£43,120,000	√
New Build (approximately 8,000m ²).	Option 3	£50,192,727	X

Option 3 clearly meets expectation from a standard demand and capacity modelling perspective that has been developed in parallel with both clinical aspiration and ‘new build’ HBN guidance, though indicative analysis deems it unaffordable from a capital and revenue perspective. There is also issue with the lack of suitable sites available on the LRI site to undertaken the development whilst maintaining critical service adjacencies and patient flows.

Although option 1 fully demonstrates the ethos behind the ‘left shift’ in emergency department attendance and reduced area requirement as a consequence, it has been deemed too much of a risk by both clinicians and the Trust Executive Team to potentially size the proposed

development too small against that demonstrated by other organisations that provide what is considered exemplar emergency department and associated service provision.

Option 2 therefore demonstrates a space allocation that will potentially meet the increase in activity currently modelled for the emergency department in terms of majors and resus, which is expected to grow with an aging population. However, further detailed demand and capacity modelling is required to confirm this anticipated trend, which will then confirm the actual size of environment required to deliver an optimum emergency service, which is currently 20% greater than option 1 in terms of both space and capital funding requirements.

As a consequence it is for this SOC to demonstrate affordability for a proposed scheme that could range from an approximate size of 6,000m² to 7,200m² and a capital consequence of £38m to £43m.

6. Commercial Case

This section of the SOC describes the proposed procurement strategy for the investment.

6.1 Commercial Strategy

The quality and fitness for purpose of the NHS Estate and the services that maintain it are integral to delivering high quality, safe and efficient care (Treasury Value for Money Update 2009). It is also an area of significant spend. The indicative budget for Estates and FM Services across the Trust in 2012/ 2013 is £31m.

Over the last two and a half years the Leicester, Leicestershire and Rutland (LLR) Health Community has worked together to better understand the collective capacity and estate challenge facing local organisations. Informed by jointly commissioned analysis, the local health community has committed to a strategy to simplify, standardise and share the delivery of core Estates/ FM services and to work together in reducing the collective asset base, better utilise the residual space and capacity footprint and improve the quality of the physical environment.

A joint procurement strategy has been pursued and the appointment of a single outsourced provider made. Our private sector partner for Estates and FM is Interserve Support Services.

The procurement is divided into two lots; the first relates to the delivery and management of core Estates and FM Services for example cleaning, catering and portering (Lot 1), and the second creates the opportunity to utilise managerial, professional and technical support for wider strategic estate transformation (Lot 2). A framework contract has been adopted which gives flexibility and choice to the parties of the contract, whilst transferring the volume risk to the private sector partner.

Interserve Support Services have partnered with Capita Symonds Limited (CSL) Health to provide the Trust with specific health strategic management services to enable robust delivery across all aspects of health estates management, and Interserve Construction for the build capability.

6.2 Procurement Strategy

Interserve/ CSL Health have been commissioned through a Lot 2 agreement, which negates the need for UHL to undertake a further formal procurement process for the Project Management, Design and Construction phases of the emergency floor project. As a consequence CSL Health will provide the project management and architect led design team professional services and Interserve will undertake the construction and delivery of the build itself.

Interserve/ CSL Health have worked with the Trust to develop this SOC, and will continue to work through the detailed design and Full Business Case stages in order to achieve a robust Guaranteed Maximum Price (GMP) for the construction phase of the project that provides a quality build as well as proves to be value for money.

The scheme will be delivered on the same basis as a P21 plus programme using the NEC form of contract.

7. Financial Case

7.1 Introduction

The purpose of this section is to set out the forecast financial implications of the short listed options as set out in the Economic Case and the proposed deal (as described in the Commercial Case).

The Trust was formed in April 2000 and has achieved its financial targets over the past 12 years. The financial results for 2011/ 12 and 2012/ 13 show that the Trust made a surplus of £88k and £91k respectively - details for future years are set out below.

The short listed options have undergone a rigorous level of scrutiny as far as practicably possible for this stage in business case proceedings, and have proved to be robust in terms of the delivery of significant clinical benefits. It is now important to ensure that these options will be affordable to the Trust and will remain so.

The emergency department was built to accommodate c100,000 cases per annum. However current and recent activity levels are in excess of 50% above this level. In 2012/ 13 the Trust saw c155,000 cases.

This level of activity has resulted in many patients waiting excessive periods; reflecting poor clinical care for the patient and reduced clinical effectiveness. In addition to meeting a clinical need the proposed development will assist the Trust in meeting the 95% emergency department target.

It is also important to note at this point that in 2012/ 13 the cost of the emergency department exceeded its income by approximately £8m.

For the ease of reference, this financial case will appraise option 1 for affordability in both capital and revenue terms and will then deem whether option 2 is also affordable as a result of a 20% uplift in both space and capital funding requirements, and the revenue impact as a consequence.

7.2 Impact on the Trust's Income & Expenditure Account

The anticipated impact of the project over the next 5 years is set out in table below. Table denoting the Trust's current I&E projections.

Forecast Income & Expenditure (LTFM extract)	Forecast 2013/ 14 £m	Forecast 2014/ 15 £m	Forecast 2015/ 16 £m	Forecast 2016/ 17 £m	Forecast 2017/ 18 £m
NHS acute activity	618.1	613.8	613.2	613.3	613.3
Non NHS clinical revenue	8.1	8.2	8.3	8.4	8.4
Other operating income	102.3	101.6	101.8	102.1	102.4
Total operating revenue & income	728.5	723.5	723.4	723.8	724.2
Operating expenses					
Employee benefit expenses	-434.5	-425.7	-421.3	-417.1	-414.2

Drug expenses	-63.2	-64.2	-65.4	-66.7	-68.1
Clinical supplies & services expenses	-81.5	-81.7	-81.9	-82.2	-82.7
Other operating expenses	-103.2	-104.1	-105.1	-106.5	-107.8
Total operating expenses	-682.5	-675.6	-673.7	-672.4	-672.7
EBI TDA	46.0	47.9	49.6	51.4	51.4
Non-operating expenses, Total	-44.2	-44.2	-44.2	-44.2	-44.2
Surplus (deficit) before tech adjustments	1.8	3.7	5.4	7.2	7.2
EBI TDA %	6%	7%	7%	7%	7%
Net surplus %	0%	1%	1%	1%	1%

Income figures in this table are consistent with the Trust Integrated Business Plan (IBP) and Long Term Financial Model (LTFM).

Expenditure figures are also consistent with the IBP and LTFM. These include agreed CIPs.

The flowing table shows the impact of the investment on the Trusts income and expenditure. Included in the figures are savings and the impact of increased capital charges as a result of this investment. Further details of savings are shown below and the assumptions on capital charges are set out in section on capital cash flow below.

7.3 Savings

In the financial year 2012/ 13 the emergency department generated income of £26m and incurred costs of £34m.

A key driver to this £8m shortfall is the use of agency staff, which costs the department and Trust £4m in the year. Analysis indicates that on average the cost to the Trust for agency member of staff is double that of a similarly qualified employee. Whilst evidence from similar schemes suggests that recruitment and retention improves following investment.

Based on this, reducing agency staff usage by 50% would save c£1m, i.e. net of employee costs.

In addition there are a number of other areas which contribute to the £8m and these will be addressed as part of the overall emergency department project.

Together this is expected to produce savings of at least £2m which is c6% of the current cost base and 25% of the current shortfall.

We have also assumed that any increase in activity will be cost neutral. The Trust recognises that given the current shortfall savings will be needed to achieve this.

The above assumptions will be further reviewed and validated at FBC stage when more detailed plans will be developed as a result of detailed demand and capacity modelling.

Impact on Trust's Income & Expenditure account

	2013/ 14 £000's	2014/ 15 £000's	2015/ 16 £000's	2016/ 17 £000's	2017/ 18 £000's
Net position as per LTFM	1,800	3,700	5,400	7,200	7,200
Reduction in agency costs			394	1,015	980
Other savings			700	1,400	1,400
Capital charges			-1,094	-2,415	-2,380
Revised net position	1,800	3,700	5,400	7,200	7,200

The income and expenditure account shows that the revenue consequences of the project are affordable throughout both the construction period and the ensuing years.

7.4 Capital Cash Flows

Capital requirements and sources are summarised in the following table. The capital charges figures above have been calculated in line with Trust policy using the following assumptions:

- Property, plant and equipment is only capitalised if it is held for use in delivering services or administrative purposes.
- Where a large asset such as building includes a number of components with significantly different lives the components are treated as separate assets and depreciated over their own useful economic lives.
- All assets are measured initially at cost representing those costs directly attributable to constructing the scheme and bringing it to its location and condition necessary for it to be operational in the manner intended. All assets are then subsequently measured at fair value.
- Revaluations are performed every three years and with sufficient regularity to ensure that carrying amounts are not materially different from those which would be determined at the end of a reporting period.

In order to ensure the net book value of the investment is at a fair value we will request the District Valuer (DV) undertake a valuation when the asset is brought into use.

Experience from similar schemes both from within and outside of the Trust indicate that the DV will value the asset at c30% of the construction cost.

Therefore it has been assumed impairment on 30% for the purposes of this SOC. The impairment is not applied to the equipment.

It is also important to note that impairments are a technical adjustment and are an allowable exception to the financial control total.

The Trust uses the following periods for depreciation:

- Buildings 5 to 96 years
- Plant and Machinery 7 years
- Furniture and equipment 7 years

- IT Equipment 3 to 5 years

With regard to this project we have separately identified equipment and assumed a split of 65% building and 35% engineering on the balance of expenditure (net of impairment). We have then applied depreciation on 60 years to the building and 30 years to mechanical and electrical engineering systems, reflecting the differing expected useful economic lives.

These assumptions together with those in the section on the source and application of funds underpin the figures shown below. Details supporting these calculations are in the financial appendix.

Capital Charge Summary

Capital charge summary	2015/ 16 £000's	2016/ 17 £000's	2017/ 18 £	2018/ 19 £	2019/ 20 £
Increase in depreciation	593,531	1,424,474	1,424,474	1,424,474	1,424,474
Increase in RoR	500,442	990,498	955,183	905,326	855,470
Increase in capital charges	1,093,973	2,414,972	2,379,657	2,329,800	2,279,944

7.5 Summary of Capital Cash Flows – Sources & Applications

The following table shows the Trust has identified a window of capital requirement and has also identified relevant sources of capital funding. Capital Cash flows are offset by income from the Trust's own resources, together with funding which will be supported by the NTDA.

For the purpose of modelling option 1, the Trust will require a total of £38,071,264, £5,000,000 of which will be funded from Trust capital and we have assumed that £33,071,264 will be available through Strategic Transitional Support Fund from the NTDA.

The costs shown below do not include any transition costs and exclude the costs associated with the relocation of the out patients department.

The overall cash flow has been derived with reference to the programme of works.

Emergency department reconfiguration

ED Reconfiguration	2013/ 14 (£)	2014/ 15 (£)	2015/ 16 (£)	2016/ 17 (£)	Total (£)
Capital expenditure	4,306,615	17,226,460	16,538,189		38,071,264
Funded by:					
Strategic transitional support	0	16,533,075	16,538,189		33,071,264
Trust resources	4,306,615	693,385			5,000,000
Total funding	4,306,615	17,226,460	16,538,189		38,071,264

7.6 Impact on the Balance Sheet

The impact of the scheme on the Trust's balance sheet as set out in the LTFM has been examined below and is shown in the following table.

Impact on Trust Balance Sheet

Balance sheet	2013/ 14 £000's	2014/ 15 £000's	2015/ 16 £000's	2016/ 17 £000's	2017/ 18 £000's
Fixed assets per LTFM		355,276	365,704	365,159	367,280
Impairment on new building coming into use (DV likely revaluation)			-9,475		
Depreciation					
Actual spend on redevelopment	4,307	17,226	16,538		
Revised closing fixed assets			394,301		

It is anticipated that in 2015/ 16 cost will be moved from 'assets under construction' to fixed assets and at this time the impairment as described above will take place. This is reflected in the table above.

7.7 Sensitivity

As has been described earlier in the SOC, proposed emergency department activity is anticipated to increase and as a consequence the impact of a 20% increase in required space and capital funding needs to be financially appraised. The key impact would be to increase the space required by 20% from approximately 6,000m² to 7,200 m², subsequently increasing construction costs to from approximately £38m to £43m.

Assuming the same level of impairment (at 30%) the capital charges would rise to £2.7m from the current £2.4m.

In this situation the Trust's mitigation strategy would be to identify additional savings from the £8m shortfall outlined above.

7.8 Affordability

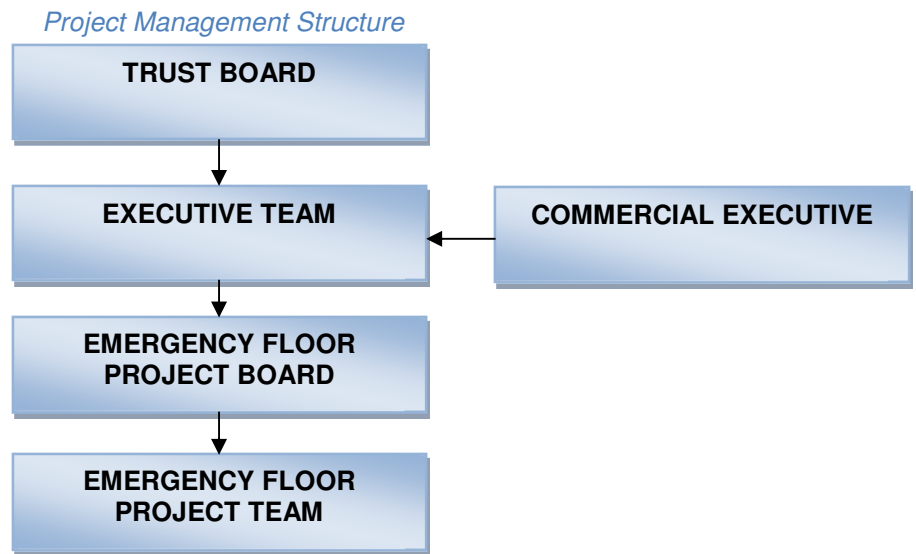
As can be seen from the analysis above the proposed scheme is deemed affordable, and at this stage so is a 20% uplift in capital funding required to develop a scheme with space requirement of approximately 7,200m².

8. Management Case

8.1 Programme Management Arrangements

The project will be managed by the University Hospitals Leicester NHS Trust. The Project Board has the responsibility to drive forward and deliver the outcomes and benefits of the project, being the reconfiguration of Level 1 Balmoral Building into an emergency floor.

Members will provide resource and specific commitment to support the project manager to deliver the outline deliverables. The project structure is as follows:



The Emergency Floor Project Board is the main executive body for the proposed development. It is accountable to the Executive Team and the Trust Board for the delivery of the Trust's Investment and Corporate objectives. The Project Board will report monthly to both the Executive Team and the Trust Board regarding progress of the development, risks and financial consequences.

8.2 Project Board Role & Responsibilities

The Project Board is ultimately responsible for assurance that the project remains on course to deliver the end product or output in line with the Strategic Business Case. Throughout the life of the project, the Project Board will be responsible for ensuring key elements of the project occur including:

- Sign off the Project Initiation Document;
- Ensuring adequate resources are deployed into the project to enable delivery; inclusive of the appointment of a Project Manager and advisors as appropriate;
- Receive reports from the Project Manager and monitor progress/ authorise slippage;
- Review risks, issues and exceptions and determine appropriate course of action based on recommendations from the Project Manager;
- Exercise functional and financial authority to support the project;
- Sign off project stages/ closure.

The end stage of the project will result in the completion, handover and commissioning of the new facility. The Project Board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the Business Case.

8.3 Membership of the Project Board

The Project Board has been set up in line with PRINCE 2 Project Methodology (the agreed NHS method for delivery of Capital Projects). Therefore, the Project Team has a Senior Responsible Officer, Project Director, Project Manager and specialist resources to deliver the scheme as required. The Senior Project Board Members are as follows:

- Senior RO/Project Owner – John Adler, Chief Executive, UHL
- Project Director – Nicky Topham, Programme Director of Reconfiguration, UHL
- Project Manager – Chris Turner, Associate Director, Capita Symonds
- Senior Supplier – Stephen Samuels, Director of Interserve

In order to ensure successful delivery of the development, the Project Board is made up of Healthcare and Capital Investment specialist, as follows:

Member	Title
Dr Kevin Harris	Chair/ Medical Director
Nicky Topham	Project Director/ Programme Director of Reconfiguration, UHL
Chris Turner	Project Manager/ Associate Director, Capita Symonds
Stephen Samuels	Senior Supplier/ Director of Interserve, UHL Facilities Management
Victoria Powell	Senior Consultant, Capita Symonds
Andrew Seddon	Director of Finance
Phil Walmsley	Head of Operations
TBC	Senior User/ Acute Divisional Director or Representative
TBC	Senior User/ Planned Care Divisional Director or Representative
TBC	Senior User/ Woman's & Children's Divisional Director or Representative
Kim Wilding	Senior User/ UCC Divisional Manager or Representative
Nigel Bond	LLR Facilities Management Company

The Project Board meeting will be chaired by the Medical Director, Dr Kevin Harris and in his absence the Project Director. The Project Director can nominate a deputy to chair as required.

The Trust has appointed 'Interserve/ CSL Health as its design team and construction partner for the design and development phase of the project. In addition the Project Manager will engage a number of professionals to deliver the technical detail of the development, such as:

- Cliniplan Ltd – Healthcare activity modelling and planning
- Capita Symonds – Healthcare Planners
- Capita Symonds – Architects & Design
- Capital Symonds – Financial & Economic Modelling

8.4 Programme Milestones

The detailed Programme for the development is dependent on the preferred option and dates may change as a result, however indicative milestones for delivery are as follows:

Milestone	Date
Preparation of Strategic Outline Case	10 th Jun 2013
Strategic Outline Case Trust Board Approval	27 th Jun 2013
Strategic Outline Case to NTDA	5 th Jul 2013
Detailed Design complete	30 th Sept 2013
Financial Plan complete	31 st Oct 2013
Full Business Case submission to UHL	8 th Nov 2013
Full Business Case completion	28 th Nov 2013
Full Business Case Approval (internal & external)	31 st Dec 2013
Phase 1 Construction commences	Jan 2014
Handover	Oct 2014
Trust Commissioning Period	Oct 2014
Trust Operational	Nov 2014

8.5 Programme Quality & Assurance Management

The development will be managed in line with the Trust preferred methodology for Project Management, PRINCE 2. As part of the methodology, the Project Team are to ensure that regular reporting is maintained to the Project Board regarding progress, risk, issues and financial reporting. In addition, the Project Manager will ensure that the project is delivered in line with Managing Successful Projects Office of Government Commerce (OGC) Guidance.

9. Appendices

Appendix A | Emergency Floor Patient Flows & Adjacencies

Appendix B | Financial Analysis

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CAPITA SYMONDS



- Essential
- Important
- Desirable

Emergency Floor Patient Flows & Adjacencies

