Meeting title:	Public Trust Board **public paper M**					
Date of the meeting:	1 December 2022					
Title:	**Interim Reconfiguration Post Project Assessment**					
Report presented by:	Jon Melbourne, Chief Operating Officer Simon Pizzey, Head of Strategy and Planning					
Report written by:	John Jameson, Deputy Medical Director Sarah Taylor, Deputy Chief Operating Officer					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	Executive Finance and Performance Board – September 2022 Operations & Performance Committee – October 2022 Reconfiguration Transformation Committee – November 2022					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
This report details the impact of the Interim Reconfiguration project on several organisational risks; describing the mitigation of these risks, the small number of outstanding risks and the small number of risks that have been created by the project.

Acronyms used
CMGs (Clinical Management Groups), GH (Glenfield Hospital), ICU (Intensive Care Unit), LGH (Leicester General Hospital), LRI (Leicester Royal Infirmary), Operational Performance Committee (OPC), Reconfiguration Transformation Committee (RTC), Hepatobiliary and Pancreatic (HPB), Interventional Radiology (IR), NHS England (NHSE)

Purpose of the Report

This report is to provide a post project assessment of the 'Relocate of Level 3 ICU and Associated Services off the Leicester General Hospital (LGH) Site' Full Business Case. It identifies those risks which have been mitigated by the moves, new risks identified during the project timeline and identified risks following completion of the project. It escalates specific areas of risk to ensure that members are appropriately sighted and can provide support where necessary.

Recommendation

The Trust Board is asked to:

- Note the update given and gain assurance that the initial work on this stage of the reconfiguration is complete.
- Note that NHSE have requested a post project evaluation at between 6 and 12 months post occupation, so this interim evaluation will be completed in in Spring 2023, and presented to the Executive in March before submission nationally. This will determine whether another review is needed at the 12 month mark.

Background

In 2015, the need to consolidate the acute services that were replicated across three sites was recognised by the Trust Board. The configuration of the services was suboptimal in clinical, performance and financial terms when operating as one organisation. This was exemplified by the fact that ICU (and services that depend on ICU) were located on all three sites and that there was a specific risk around the sustainability of level 3 ICU services on the LGH site due to the ability to recruit and retain staff alongside ensuring there was appropriate training for doctors in training. The Interim Reconfiguration project was considered a key building block towards acute site consolidation that would address immediate risk and that would bring significant benefits for patients by mitigating several clinical risks in the longer term.

The UHL clinical strategy included the need to deliver critical care services through the two consolidated ICUs by 2022/23; located at LRI and GH, with HDU provision remaining at the LGH. This is to ensure that UHL has the right number of augmented and critical care beds in the right locations, as well as enabling the organisation to retain Intensive Care training accreditation, recruit, and train staff, improve efficiency and sustainability of the services as well as respond to changing demands for the service.

In addition to the clinical strategy, the changes to the configurations of Level 3 critical care were a key element of the 'Better Hospitals' public consultation process led by the CCGs & UHL in 2020.

The business case was approved by the Trust Board in November 2018. The aims of the case were to:

- Maintain safe Level 3 ICU services across the three sites for nursing, medical staff, allied health professionals and all staff groups.
- Create a robust cohort of beds for Level 1 care within specialties throughout the Trust.
- Develop a suitably qualified workforce no longer spread over 3 sites.
- Create a single site surgical emergency take, which delivers a more efficient patient pathway reduce elective cancellations by separating emergency from elective work.
- Move day case activity from LRI and GH to LGH.
- Facilitate the improvement in cancer performance to achieve 62 day and 31-day metrics.
- Deliver a 24/7 critical care outreach service.

It should be noted that whilst developments were undertaken at the GH ICU, no estates works were undertaken at the LRI, and the estate continues to require improvement which is planned to be addressed as part of the wider New Hospitals & Reconfiguration programme and business as usual management of backlog maintenance.

Project Implementation

The Interim Reconfiguration project moves commenced on the 30 April 2022 and concluded with the final service moves on the 4 July 2022; it was then handed over from the reconfiguration programme to clinical and operational teams. The project was a major one for UHL and many specialist teams – including cross site moves for many services and colleagues. The impact on patients was minimised during the moves through careful planning of activity.

It is important to acknowledge the impact of these moves on many UHL staff, both personally and professionally, and this will be an important part of our evaluation.

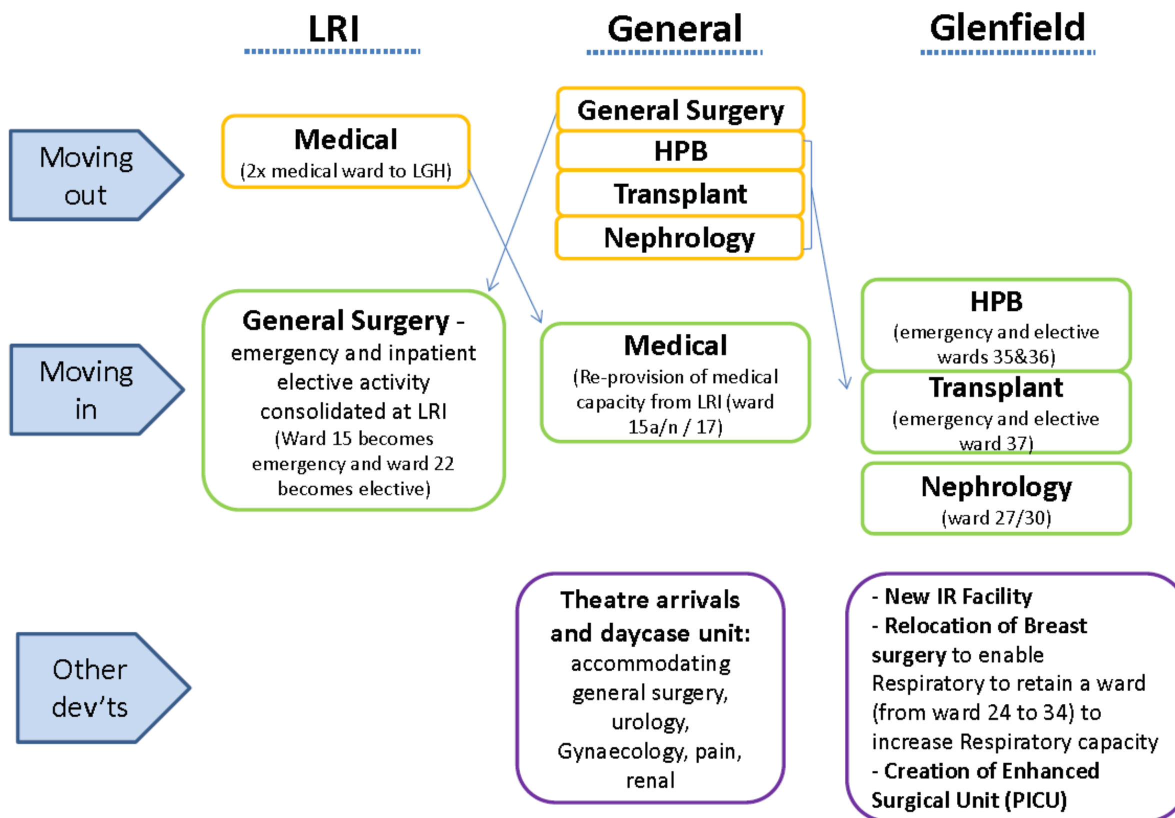
The immediate post project evaluation of the operationalisation has been completed and lessons learned shared; and impact and expected benefits will be reviewed in Spring after six months of operational consolidation, led by the Associate Director of Operations (Projects) and the Deputy Medical Director.

Original Service Location and Current Service location

There were many complex moves made as part of the Interim Reconfiguration project. The Covid-19 pandemic resulted in changes to demand, clinical pathways and how patients presented to the hospital; for this reason, there were changes required to medical ward capacity which the Interim Reconfiguration project was required to deliver that were not part of the initial scope of the project.

The table and diagram below detail the original location of the clinical services, and the new location following delivery of the project.

Service	Original Location(s)	New Location(s)
Enhanced Surgical Unit (SECU)	Not applicable	GH
General Surgery	LRI & LGH	LRI & LGH
HPB	LGH	GH
Interventional Radiology (IR)	All 3 sites	All 3 sites; GH (expanded)
Medical Ward	LRI & LGH	LRI & LGH
Nephrology	LGH	GH
Nephrology Day Case	LGH	LGH
Theatre Arrivals & Day Case Unit *(accommodating general surgery, urology, gynaecology, pain & renal)*	Not applicable	LGH
Transplant	LGH	GH
Urology	LGH	LGH



Impact on beds by site

As a result of the moving of services there has been a change in the number of beds on the three sites. There had been a net increase in the number of medical beds following the COVID pandemic when the additional capacity at the GH created for this project was filled with medical patients; so, this reflects a reduction in medical beds at the LRI site and an increase on the LGH site. The reasons for this were to accommodate an increase in surgical beds on the LRI site for emergency patients. As a result of the number of medically safe for transfer patients in medical beds on the LRI site, LGH bed capacity can be used safely. This does provide a logistical transport issue for those patients and some medical cover arrangements that are required on the LGH site which continue to be managed and mitigated by the operational and site management teams.

The table below details this, showing beds for specialties that were impacted by the changes.

Site	Pre (July 2019)*	Post (July 2022)	Movement
LRI	790	790	0
GH	403	482	79
LGH	268	201	-67
Total	**1461**	**1473**	**12**
	*prior to any changes in beds due to Covid-19		

There is a shift mainly from LGH to GH related to services that need Level 3 critical care to support their emergency and elective services. The table below details the critical care beds in terms of actual capacity (physical beds) for level 3 capacity and commissioned beds*

		Post	
Site	Pre	Actual capacity	Currently commissioned*
LRI	19	22	21.5
GH	21	31	25.5
LGH	9	9	2.0
Total	**49**	**62**	**49**

**Defined as beds that are currently staffed and equipped to meet demand. The number of commissioned beds and need for further funding to increase capacity is reviewed as part of the annual planning process.*

High scoring risks mitigated by the changes

Several risks were identified as part of the project, 18 of which scored 20 or above. The key themes of which were workforce, operational, financial, and reputational.

The risks related to workforce and the impact of moving services which had the potential to deteriorate skill mix or sub-specialty knowledge both in and out of hours was a risk across a number of different services. The financial and reputational risks were related to delivering the project within the timeframe and envelope, and operational risks were related to theatre capacity and patient flow. A thematic review of the risks identified demonstrated that 16 of the 18 were fully mitigated; with theatre capacity and patient flow remaining risks for the organisation and have not been fully mitigated because of the project.

There were many other project risks, and a full assessment on these risks will be completed in the review recommended in this paper. There were also some new risks which have been added as a result of the reconfiguration – including in patient flow and capacity changes on sites. These will be reviewed more fully in the post project evaluation.

Lessons Learned

As part of the closure of the project, a thorough lessons learned exercise has been carried out, the detailed findings of which were presented at the Executive Strategy Board in November. The key findings were around the following six aspects of the project:

- Project governance and leadership
- Planning and Scope
- Finance –including procurement
- Communication and staff engagement
- Capital project/construction
- Support service (FM/IT/logistics) to enact the moves.

The lessons learned that have been captured will significantly help to shape future large-scale projects, including the Elective Hub. This is attached as appendix 1.

Aims, benefits and impact

It was recognised at OPC that given that the delivery of the project was completed in July 2022, it is therefore too early to assess whether all the expected benefits have been delivered and to what extent. It is proposed that a full post project evaluation report is presented to RTC, OPC and Trust Board in August 2023. The report will provide a more in-depth review of the actual impact, whether the aims of the project have been achieved and if there are further actions required.

NHSE have requested a post project evaluation at between 6 and 12 months post occupation, so this interim evaluation will be completed in in Spring 2023, and presented to the Executive in March before submission nationally. This will determine whether another review is needed at the 12 month mark.

An early assessment of the expected benefits is included in the table below.

Aims of approved business case	Current position
Maintain safe Level 3 ICU services across the three sites for nursing, medical staff, allied health professionals and all staff groups.	Whilst recruitment into all vacancies has improved there is still significant risks with ongoing ability to meet required levels.
Create a robust cohort of beds for Level 1 care within specialties throughout the Trust	Complete; SECU is an enhanced care unit at the GH. There is further work required at LRI.
Develop a suitably qualified workforce no longer spread over 3 sites	This will be addressed in the August 2023 post project evaluation.
Create a single site surgical emergency take, which delivers a more efficient patient pathway reduce elective cancellations by separating emergency from elective work	An initial assessment of a recent data (October 2022) shows a reduction in the number of patients cancelled on the day as a result of a lack of ward bed or lack of ICU bed. There are improvements in Urology, with 7.9% of patients having been cancelled on the day in October 2022 compared to 16% in October 2021. More in-depth analysis is required to fully understand the impact of the move on elective cancellations and will be addressed in the August 2023 post project evaluation.
Move day case activity from LRI and GH to LGH	Complete. The impact of the project on the volume of day case activity will be addressed in the August 2023 post project evaluation.
Improve cancer performance in line with national drivers to achieve 62 day and 31-day metrics	This will be addressed in the August 2023 post project evaluation.
Deliver a 24/7 critical care outreach service.	Complete.

Conclusion

The high level aims of the project that are described in this document have been delivered, and the project implementation successful. Many high scoring risks being fully mitigated, with the exception of theatre capacity and some aspects of patient flow. Some new risks have emerged, including in patient flow, and we will explore these further in the project evaluation.

An in-depth analysis on the expected benefits and impact will be carried out and presented to the Board in March/ April 2023; thus allowing 6 - 12 months of optimal working for the services impacted by the project.