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**Foreword**

Leicester is one of the most diverse and dynamic cities in the country and has enjoyed significant development in recent years.

As its largest employer and being at the centre of service provision we intend our hospital estate to evolve and to continue to play a key part in the success of the city and surrounding areas.

Ensuring a safe and appropriate environment, maintaining our facilities and delivering excellent services is at the core of what we do in the management of our estate.

Furthermore, this strategy captures the Trust’s future plans for the estate, and how the estate will support the Trust’s Clinical Strategy and service delivery, and helps to enable many elements of the Trust’s business planning process. It is consistent with best practice as understood within the health service and the management of the NHS as a whole.

Going forward the estate will both be an enabler and driver for change, supporting the delivery of our current and future clinical and other associated Trust strategies.

This strategy commits the trust to fulfil its ambition by providing, developing and maintaining a more efficient, high quality, sustainable and flexible estate which meet the operational demands and objectives of the trust to day and in the future.

We recognise that our Estate Strategy needs to be flexible in its approach to reflect the evolving NHS landscape and it likely to be subject to further iterations over coming years.

I commend this version of the Estate Strategy to you.

Karamjit Singh CBE (Chairman)

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**Main Entrance - Leicester Royal Infirmary**

Much of this work takes place ‘behind the scenes’, but a good experience of our clinical services depends on these being delivered efficiently and effectively.

Everything we do aims to put excellent healthcare at the heart of the community. To do this we need to have high quality buildings in the right places that support all our staff by providing an excellent working environment.

This Estates Strategy compliments our other Trust strategies and starts to address the challenges set by Delivering the Forward View: NHS planning guidance 2016/17-2020/21, Lord Carter’s Review on operational productivity and performance as well as Commissioner Led - Local Estates Strategies, and the Sustainability and Transformation Plan (STP) for Leicester, Leicestershire and Rutland (LLR).

**The challenge**

The health economy of the LLR footprint is going through a period of unprecedented change. We recognise the need to transform our services and, in doing so, are supporting the delivery of the STP.

We are responding to the challenge of a growing and ageing population, increasing service user expectations and a period of continued financial austerity. Therefore this strategy tells the story about how we are using our buildings to change the way we deliver healthcare services, how we are planning the use of our estate to support the Trust’s Clinical Strategy, provide a flexible estate to meet the changing healthcare environment, and to deliver, subject to public consultation, the STP reconfiguration programme to transform our estate and "Building, Care at its Best".

**Our estate vision**

This Estate Strategy sets out a number of core principles for the future use of our estate which are based on:

- Enhancing the patient experience
- Enhancing the Service Performance
- Improving and transforming the Quality of Estate
- Providing the highest possible Environmental standards
- Providing Value for Money
- Enabling Partnerships and stakeholders
- Ensuring Staff Welfare.
Executive Summary

This Estate Strategy is a key component of the Trust’s overall vision and represents our plans for future development and transformation of the estate in order to enhance the quality of the patient, visitor and staff experience.

It is presented in a way that answers three key questions:

Where are we now?
Configuration, performance and shortcomings of the estate in relation to service strategies.

Where do we want to be?
Describing the requirements to transform our estate to meet the demands of the healthcare environment, which respond to local and national priorities.

How are we going to deliver the change?
Recommendations and potential options to deliver the transformation programme.

The diagram below illustrates key components of each part of the Estate Strategy:

Our response
We are responding to the challenge of a growing and ageing population, increasing service user expectations, and a period of continued financial austerity.

The Estate Strategy has been developed in accordance with the process described by the DoH guidance ‘Developing an Estate Strategy’ and is intended to be a focused and dynamic document that demonstrates the Trust’s commitment to providing an estate that is:

- Functionally suitable for the delivery of high quality healthcare services
- Located to provide the highest level of accessibility for patients, visitor and staff; that will be socially inclusive and Equality Act compliant
- Designed and maintained to deliver a high quality clinical environment in spaces that are generic, flexible and future proofed
- Well utilised, cost effective, life-cycled and both energy and environmentally efficient
- Provides an inclusive environment i.e. one that can be used by everyone regardless of age, gender, ethnicity or disability.

The opportunity
The strategy tells the story about how we intend to use our buildings to change the way we deliver healthcare services, in particular how we are planning the use of our estate to support the Trust’s Clinical Strategy.

It is made up of numerous elements of which a key foundation stone is the reconfiguration programme and Development Control Plans which will allow the Trust, subject to consultation, to transform 3 acute sites which will in turn deliver the following benefits:

- Immediate schemes supporting service delivery
- Revenue savings
- Reduction in outstanding backlog maintenance
- Sustainable development
- The disposal of part and re-use of the Leicester General Hospital
- Capital receipts.

Everything we do aims to put excellent healthcare at the heart of the community.
1 Introduction

Welcome to the University Hospitals of Leicester NHS Trust Estate Strategy.

This document sets out the Estate Strategy for the University Hospitals of Leicester NHS Trust (the Trust), which comprises of 3 sites across Leicester, namely, Leicester Royal Infirmary (LRI), Glenfield Hospital (GH) and Leicester General Hospital (LGH), together with a small number of satellite sites across the region.

Alignment with the Sustainable Transformation Plan

Aligning with the Trust’s vision and strategic objectives the existing estate will become more efficient, more specialised and better equipped to support LLR in delivering their STP priorities for the next five years, which are:

- **Strand 1**: New models of care focused on prevention, moderating demand growth
- **Strand 2**: Service configuration to ensure clinical and financial sustainability
- **Strand 3**: Redesign pathways to deliver improved outcomes for patients and deliver core access and quality standards
- **Strand 4**: Operational efficiencies
- **Strand 5**: Getting the enablers right.

As a result, patients will have more of their care provided in the community by integrated teams with the GP practice as the foundation of care, and will only go to acute hospitals when they are acutely ill or for a planned procedure that cannot be done in a community setting.

The Estate Strategy reflects the STP vision and objectives and provides a framework for the future management and development of the estate, relative to clinical need, to support the reconfiguration ambition of transforming our acute sites.

Why does the Trust need an Estate Strategy?

This Estate Strategy sets out how the Trust will maintain a fit for purpose estate that enables delivery of high quality, safe and effective care, our Clinical Strategy priorities and the organisation’s wider five year plans.

This Estate Strategy has been developed to provide a framework, to advise the Trust’s Board in considering estate investment and rationalisation decisions and to support the delivery of the LLR STP. It provides a plan for developing and managing the estate over the next five years and is designed to meet the Trust’s service and business needs.

The diagram below sets out the link between our enablers, including the Estate Strategy and our Clinical Strategy which in turn reflects our vision, values, external and internal influences.

![Diagram](image)

**Figure 2-Illustration of Estate Strategy in context of wider Trust Policies**

Scope of the Estate Strategy

The scope of the Estate Strategy includes all of the estate we use to support our services.

Responsibility for the estate carries risk – risk of non-compliance with statutory regulations, Care Quality Commission (CQC) standards, and financial risks in relation to underutilised space, the management of backlog maintenance, the risks associated with infrastructure capacity and the risks associated with business continuity.

Managing these risks and meeting our statutory responsibility for the management of the estate make the development of an Estate Strategy essential.

Methodology

This document follows the guidance recommended by NHS Estates in its publication “Developing an Estate Strategy” and has been written in collaboration with the Trust’s clinical directorates and support departments.

The authors met with the clinical directorates to understand their specific needs arising from service development plans and subsequently developed the strategy with reference to the following documents:

- 5 Year Financial Strategy - Financial recovery plan including assumptions & high level long term financial model (LTFM) outputs, 2nd November 2017
- University Hospitals Leicester Clinical Strategy 2013/14 – 2018/19
- 2016-17 Annual Report & Accounts
- Delivering Caring at its Best – Our 5 year plan and 2016/17 priorities
- Sustainable Development Management Plan – 2017

Ownership

The Chief Executive, on behalf of The Trust, has responsibility for ensuring that there is an appropriate Estate Strategy approved by the Trust Board. The Director of Estates and Facilities is responsible for an annual review of the strategy, and its implementation.
2 Strategy Purpose

The Estate Strategy plays an important part in delivering the Trust vision to consistently deliver safe, personalised and efficient care, by prioritising people, partnerships and productivity.

The Trust has identified the need for flexibility, changing property from being a constraint to a driver and enabler for change, and in doing so the Estate Strategy is based on consolidation of the estate, development of new facilities, disposal of surplus land and buildings that will raise income for the Trust.

The Estate Strategy:

- Underpins the strategic direction of the Trust
- Supports the Clinical Strategy to improve patient pathways and improve quality of care
- Supports the outline and full business cases for the Reconfiguration Programme
- Shows a clear implementation programme over five years for transformation with tangible benefits
- Helps to provide a safer and more attractive environment for patients, visitors and staff
- Develops a vision for future capital investment and potential disinvestment
- Supports local and national priorities and targets set by the Department of Health (DoH)
- Supports and works closely with our key partners and their strategic plans within the city and across the region
- Supports the implementation of new models of clinical care
- Promotes education training and research
- Facilitates income generation opportunities
- Promotes environmental sustainability
- Reduces backlog maintenance
- Identifies opportunities for land disposals and development.

2.1 Developing the Strategy

The Estate Strategy has been developed in accordance with the process described by the DoH guidance ‘Developing an Estate Strategy’.

The process asks 3 principal questions in relation to The Trusts estate, set in the context of The Trusts objectives and service strategy, they are:

- Where are we now?
- Where do we want to be?
- How do we get there?

The strategy is forward looking, based on the commissioning intent, national policy and the emerging direction for health and social care locally.

Going forward an iterative process will need to be used to ensure alignment, and where required data or plans will be reviewed to ensure they remain current and relevant.
2.1.1 Estate Strategy Step by Step

Where we are now?
This initial stage is aimed at developing a comprehensive understanding of how well the current estate supports the delivery of services, using estates appraisal methods. For example:

- What are the key metrics of the current Estate?
- How well (or otherwise) is the Estate performing or managed?
- What are the known risks and issues with the Estate?
- What are the quality indicators saying?
- Describe the context of the current Estate
- How does the current estate limit or enhance the delivery of clinical services?

Where do we want to be?
This stage includes a detailed review of the known and anticipated service plan changes, with the aim of developing a clear understanding of current operational issues, factors likely to drive change and investment in the estate and assess the potential for service expansion or contraction in terms of estate needs.

It also takes into account the Trust’s overall Clinical Strategy, financial position and service requirements. Reference is taken from relevant strategies, to ensure strong alignment and to avoid duplication.

It assumes an awareness of these supporting documents including:

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<td>Financial Strategy</td>
<td>LLR Primary Care Estates Strategy</td>
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<td>Diagnostic Equipment Strategy</td>
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<td>Sustainability Management</td>
<td>LPT Estate Strategy</td>
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Through dialogue and engagement with key stakeholders, it has been possible to better understand the limitations posed by the current estate configuration and condition with the aim of developing potential solutions for improvement. Some of the underpinning strategies, aimed at setting the future direction of clinical services are in the early stages of development, and as part of an iterative process these will be re-visited and checked for alignment.

The output from this stage is a schedule of key strategic aims and developments for the Trust, focused on meeting the aims and objectives set out earlier. There should also be strong correlation to the Trust’s vision and values, its priorities and a direct correlation to addressing the areas identified as requiring improvement in the initial assessment of the current estate.

How are we going to deliver the change?
This final stage in the strategy development process takes the information, data and output from previous stages to develop key strategic themes and deliverables, which includes the capital investment for the reconfiguration Development Control Plans, a rolling programme of estates improvements, and the formation of disinvestment opportunities.

Triangulation and Iteration: Keeping it aligned
At each stage, reference is made to the supporting strategies and plans of the Trust, to ensure we align the outcomes for maximum benefit. The Estate Strategy is designed to fit as part of a suite of documents, with strong read across and avoiding duplication.

An example of this would be ensuring the identified accommodation needs for a particular clinical team align with the workforce plan, are affordable within the financial plan, and are underpinned by appropriate service lines that support the identified priorities of the Trust.

Review Process
Throughout the development of the Estate Strategy, we review the position of reference data, the targets we develop and also ‘sense check’ the emerging reconfiguration programme to ensure they are prudent, operationally sound and based upon firm foundations.

It is essential that such key proposals are also discussed with senior colleagues and stakeholders, ensuring a shared understanding of the drivers, priorities and rationale behind them.
3 Strategic Overview

3.1 Profile of The Trust

The Trust operates across three main sites; LRI, GH, LGH and a number of small satellite sites across the region, and is the only acute Trust serving the diverse local population of LLR; equating to approximately 1.1 million residents.

Our patients are the most important thing to us and we are constantly striving to improve the care they receive, through looking at the ways we work, ensuring our staff are highly trained, and encouraging research which allows us to offer our patients the latest technologies, techniques and medicines - and attract and retain our enviable team of more than 15,000 highly skilled staff.

Headline facts:
- Leicester City – population 348,343 (Source: Leicester(shire) Rutland Statistics and Research)
- Leicestershire County and Rutland – population 721,563 (Source: Leicester(shire) Rutland Statistics and Research)
- Total expenditure for year ending March 2017 (excluding the impact of donated assets) – £966.3m actual
- The Trust has a gross internal area of 264,736m² across three sites, LRI, GH and LGH.

In 2016/17 the Trust over achieved against its Cost Improvement Programme (CIP) of £35m through the following:
- Treating more patients via more productive theatres, outpatients and beds
- Reducing the price paid for goods and services
- Removing waste and eliminating unnecessary variation in our patients’ pathways.

Leicester’s Hospitals year at a glance – 2017

Research & Development

The Trust is one of the biggest and busiest NHS Trusts in the country and provides nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, extracorporeal membrane oxygenation (ECMO), cancer, vascular and renal disorders to reach a further two to three million patients from the rest of the country.

The Trust works closely with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with the Trust.

The Trust continues to work with many different organisations throughout the world to push the boundaries of research and develop new surgical procedures for the benefit of our patients; with around 1,000 clinical trials taking place every year, and is now home to a National Institute for Health Research (NIHR) Biomedical Research Centre which supports key research including lifestyle, diabetes, and cardio-respiratory diseases, and for the first time the Trust has been successfully designated as an NIHR Clinical Research Facility.

Our brand new space themed Children’s Research Facility officially opened on 28th June 2017 at LRI. The Research Space is a bright and welcoming place, designed for children and young people.

Furthermore, the Trust is extremely proud to have an Experimental Cancer Medicine Centre and the Hope Unit is an instrumental factor in delivering clinical trials of new cancer treatments, and is generously supported by the locally-based charity Hope Against Cancer.

The Trust is providing access to cutting edge genetic medicine for our patients by participating in the 100,000 Genomes Project. All of this means that thousands of Trust patients are amongst the first to try the latest medicines and techniques.

The heart centre at the Glenfield Hospital continues to lead the way in developing new and innovative research and techniques, such as Trans-Catheter Aortic Valve Insertion (TAVI) and the use of the suture-less valve in heart surgery. It has also become one of the world’s busiest ECMO centres and the only hospital in the UK to provide mobile ECMO therapy for both adults and children.
The Trust has one of the best vascular services nationally, with more patients surviving longer following an aneurysm repair. The move of the vascular service from the LRI to the GH provided new state of the art facilities including a hybrid theatre, enabling the development of joint working practices with cardiac surgery and cardiology to treat patients with complex cardiovascular disease.

The Trust is also proud to continue to have some of the lowest rates of hospital-acquired infections, such as C. difficile and MRSA, in the country.

**East Midlands Congenital Heart Centre**

On the 30th November 2017 NHS England (NHSE) announced that the threat to decommission heart services at the East Midlands Congenital Heart Centre (EMCHC) at GH had been lifted, meaning the centre will continue to provide lifesaving surgery for children and adults in the region. As part of the reconfiguration programme this service will move from the Glenfield Hospital to the Leicester Royal Infirmary.

The decision came after a lengthy process to reorganise congenital heart services in England after new standards of care were introduced in 2015, when NHSE had threatened to decommission heart surgery at the East Midlands Congenital Heart Centre (EMCHC) at GH.

After a public consultation, NHSE bosses said they had changed their minds but their decision was conditional on the hospital achieving "full compliance with the standards".

**Clinical Management**

The Trust’s clinical management is structured into seven groups, with each group led by a Senior Consultant in the role of Director. The seven Clinical Management Groups (CMG) are as follows:

1. **CHUGGS** - Cancer, Haematology, Urology, Gastroenterology and Surgery
2. **ESM** - Emergency and Specialist Medicine
3. **CSI** - Clinical Supporting & Imaging
4. **ITAPS** - Intensive Critical Care, Theatres, Anaesthesia, Pain and Sleep
5. **MSS** - Musculoskeletal and Specialist Surgery
6. **RRC** - Renal, Respiratory and Cardiac
7. **W&C** - Women’s and Children’s.

Each director has a clinical background, working within a clinical environment as well as providing overall leadership for the CMG.

Alongside the director the CMG’s each have a head of nursing and a CMG manager. Across the seven management groups there are fifteen 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:

- Corporate and Legal Affairs
- Estates & Facilities
- Finance and Business Services
- Human Resources (HR)
- Information Management & Technology (IM&T)
- Marketing and Communications
- Medical
- Nursing
- Operations
- Research & Development.
- Strategy.

**‘Caring at its Best’**

The Trust’s purpose is to provide ‘Caring at its best’ and staff have helped to create a set of values which are:

- We do what we say we are going to do
- When we talk to patients and their relatives we are clear about what is happening
- When we talk to colleagues we are clear about what is expected.
- We make the time to care
- If we cannot do something, we will explain why.

- We focus on what matters most
- We talk to patients, the public and colleagues about what matters most to them and we do not assume that we know best.
- We do not put off making difficult decisions if they are the right decisions
- We use money and resources responsibly.

- We are passionate and creative in our work
- We encourage and value other people’s ideas
- We seek inventive solutions to problems
- We recognise people’s achievements and celebrate success.

Patients are at the heart of all that is done at The Trust. ‘Caring at its Best’ is not just about the treatments and services provided but about giving patients the best possible experience.
3.2 Delivering Caring at its Best

The Trust first published its Strategic Direction paper in November 2012 and following the publication of the ‘NHS 5 Year Forward View’ nationally and work locally through the ‘Better Care Together’ programme and updated strategic direction was launched in 2015 setting out our plans for the coming 5 years.

Delivering Caring at its Best – Our 5 year plan 2016/17

What we know is that now more than ever we cannot be a strong, sustainable, high quality acute Trust without there being equally strong and sustainable local primary care and social care, in that sense our future and our ability to provide high quality care for the 1.1m people living in the richly diverse communities across the City and Counties is interwoven with that of our partners.

Restricted by access to capital funding we have continued to deliver what we can of our 5-year plan and ensure that it fits with the plans of partners through the STP for the local area – what we call Better Care Together.

The Trust Strategic Objectives for 2017/18 are outlined below:

- We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care.
- We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget.
- We will transform and deliver high quality and affordable HR, OH and OD services in order to make them ‘Fit for the Future’
- We will improve the experience of medical students at the Trust through a targeted action plan in order to increase the numbers wanting to stay with the Trust following their training and education.
- We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates.
- We will develop a new 5 year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership.
- We will progress our hospitals reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work.
- We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care.
- We will deliver the 2 year implementation plan for the ‘UHL Way’ and engage in the development of the ‘LLR Way’ in order to support our staff on the journey to transform services.
- We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities.
- We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust.
- We will deliver financial stability as a consequence of the priorities described here in order to make the Trust clinically and financially sustainable in the long term.
- We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty.
- We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals.
- We will form new relationships with primary care in order to enhance our joint working and improve its sustainability.

Caring at its Best Awards

The ‘Caring at its Best Awards’ reward our inspirational staff, those that live our values and deserve recognition for their amazing success and commitment to providing ‘Caring at its Best’.

Award winners are those staff members who demonstrate that they go the extra mile for colleagues and patients. They will be working examples of our values in action and role models of professionalism and courtesy, caring and compassion.

We have six award categories which reflect our values and our aim, to provide Caring at its Best. The five value categories allow staff to nominate colleagues for work and a positive caring attitude that goes above and beyond. The final category allows patients and the public to nominate a member of staff who has touched their lives and provided best care to them of their loved ones.
3.3 The financial challenge across Leicester, Leicestershire & Rutland

Health and social care organisations throughout LLR face financial challenges, as demand and demographic growth for services out-stripe the increased resources available year on year.

While there is an expectation in the health sector that the funding available will rise by c. 2% each year, equating to an additional £200m over the time of the STP, predictions for the growth in both cost and demand range from 0.5% in some areas rising to 4.73% in more specialist areas of medicine year on year.

The social care sector also faces similar challenges with demand in growth matched to a flat or reducing level of funding available to support social care services.

As articulated in the November 2016 LLR STP, without developing new ways of working the impact of increased demand creates a financial gap for health and social care of £399.3m.

Of this healthcare accounts for £341.6m of the gap, whilst social care gap equals to £57.7m over the same timeframe.

The LLR system has been aware of this continuing demand and increasing resource gap for some years and has developed a number of plans to mitigate this through the local transformation programme, known as the Better Care Together.

Overall the impact of the growth on the system is primarily in acute and specialised services. Solutions will be realised through investment in community based services to deliver care in the most appropriate settings.

CIP schemes already in place to deliver c. £175m of the required savings as articulated in the November 2016 LLR STP.

The STP sets out the actions that will need to be taken to balance the pressures of continued growth in patient demand from an ageing and growing population, and a requirement to recover and maintain delivery against national access and quality standards.

This is necessary at a time of historically low levels of financial growth in the NHS and substantial pressures on social care funding.

The single largest scheme in LLR is a programme of service redesign of acute services to transform our acute sites.

This deals with both quality and workforce issues created by the duplication of services over 2 or more sites. Once the acute reconfiguration is complete the directly attributable cost saving from this will be c. £25m each year.
3.4 Clinical Strategy

The Trust’s Clinical Strategy is focussed on delivering high-quality, patient centred services in the most appropriate setting with excellent clinical outcomes.

The Clinical Strategy reflects the changes in population demographics, outlined in the Local Authority Joint Strategic Needs Assessment (JSNA), placing the patient at the centre of service planning and design ensuring that holistic patient centred care remains at the heart of everything we do. For example services will be tailored to meet the challenges of a rising elderly population; ensuring integrated care is provided across primary, community and social care.

The Trust will work with partners to develop the infrastructure and networks to offer expertise across the health community to ensure that care for the older person is as seamless as possible.

3.5 Our Workforce Strategy

Recognising the challenges we face in developing sustainable, high quality services, our developing workforce strategy will identify and set out a number of initiatives to be factored into the future shape of our Estate and are aligned to the ‘Caring at its Best’ corporate plan. These include:

- Nursing staffing levels
- Recruitment and retention of nursing and medical staff
- Training and Development Strategy
- Flexible Workforce and Flexible Working Options
- 7 day working
- Sickness, Absence, health & Wellbeing
- Performance management.

Financial Context

People are living longer, and the NHS’s ability to treat and help manage conditions that were previously life-threatening continues to improve.

Alongside this, the NHS faces a potential funding gap of around £30 billion by 2020/21 as articulated in the NHS Five Year Forward View meaning that the NHS will need to radically transform the way it has traditionally provided care, to new and innovative models necessitating a significant shift in activity and resource from the acute sector to the community.

Across LLR this reflects a funding gap of £399.3m as articulated in the November 2016 LLR STP.

The Trust will meet its funding gap by working collaboratively with its LLR Health and Social Care partners to re-design patient care pathways to ensure that they continue to provide high quality care, outcomes and patient experience whilst delivering value for money. The Trust has an ongoing operating deficit, in part related to the current configuration of its clinical services, which do not optimise clinical adjacencies and patient pathways.

The Trust’s reconfiguration programme will optimise where its services are located as care pathways change to meet the financial challenge. The methodology supporting the future location of services will be clinically driven, evidence based, inclusive, open and transparent however will necessitate tough decisions for the health community if it is to meet the ‘value for money’ test.

Regional Centres of Excellence

The Trust is proactively responding to the national drive towards fewer regional centres of excellence for specialised services by ensuring its services deliver innovative, high quality patient care through robust Research and Development programmes which enable patients to benefit from leading edge developments in the care of specific conditions and will specifically seek to ensure it remains as a national centre of excellence for its work in Cardiac, Respiratory, Vascular, Renal, Cancer and Diabetes and significantly strengthen its portfolio of other key services to ensure they are sustainable in the future.

As a result of centralising and specialising services, the Trust will improve quality, safety and the hospital experience for patients from the time they park their car to the moment they leave; will be recognised for low mortality rates, for low waiting times, excellent care, and will save money by no longer supporting old, expensive and underutilised estate.
3.6 Information Management and Technology (IM&T)

Well implemented and supported IM&T is no longer a back office function and is critical for the effective delivery of healthcare services. It is also a key enabler of the transformation agenda underway within the NHS.

IM&T play a major supporting role in the delivery of a number of key strategic projects and programmes designed to improve the efficiency of the Trust and deliver financial savings.

Information technology will support the reconfiguration programme through:
- The provision of VOIP (Voice over Internet Protocol) and Wi-Fi infrastructure into retained locations
- The provision of mobile devices and hot-desk facilities to support the transition to smaller premises and more versatile working arrangements
- Ensuring the safety of paper records at bases being vacated
- Facilitating physical moves with technicians on-site.

We recognise that data is the key asset in the Trust for supporting both day to day clinical operations and the effective management of services and resources. Information technology is a major driver for initiating change within the organisation, with the capability to create business advantage and enhance the effectiveness and efficiency of its services.

In order to harness the benefits from developing these major aspects of IM&T it is important that developments in this area support the key objectives and priorities, both clinical and business, of the Trust.

The use of information technology in the Trust will have a dramatic impact in the way that clinical services are delivered and will contribute to improvements in the quality of services provided.

To compliment this a vision has been developed for IM&T which features the following deliverables:
- Electronic paper record (paperless out-patients as a minimum)
- Self-Check-In
- Patient Calling system that enables patients to be called on their smartphones
- Technology in PACH should be accessible to all staff and patients
- Web based Outpatient, day case and day case viewer tracking (patient pathway)
- Electronic solutions to support non-face to face consultation
- Electronic solutions that promote electronic clinic outcome letters (GP and Patient)
- Clinic room utilisation and scheduling should be electronic and link with the outpatient tracker
- Online Pre-Assessment Form / Consent / Education Material
- Integrated appointment Booking System/Waiting List Management System (including a reminder service) that integrates with the outpatient and day case trackers.
- Theatres Management System
- e-Prescribing
- Information reporting to ensure that the facility is utilised to maximum efficiency, and the requisite security, connectivity and infrastructure.

IM&T across LLR

To date the LLR community has focused on improving IM&T in four areas:
- Sharing care records
- Population data analysis
- System wide efficiencies which improve integrated working
- Supporting STP workstreams.

Our Local Digital Road Map sets out our vision for the future both for IM&T that supports the delivery of care and using technology to support patients.

In 2016/17 we had funding from the Estates and Technology Transformation Fund to deliver Electronic Record sharing.

The first phase of this project focused on determining a core dataset, working with all STP Clinical Workstreams, to identify an all-encompassing dataset for care planning.

Our priorities for 2018/19 include further development of national solutions such as improvements in data sharing, improved systems access for patients and greater interoperability between health and social care systems.

Our concrete actions for the future include:
- Shared access to paperless patient records at all clinical interfaces across LLR to improve patient outcomes and support integrated working, alongside removing the use of paper.
- Implementation of a comprehensive Electronic Patient Record within the Trust to improve quality and efficiency and facilitate sharing of records across boundaries.
- Encourage patient empowerment to drive up the use of technology to support greater self-care, improvements in health and wellbeing and access to services, alongside developing alternatives to face to face consultations.
- Support independence of patients through the use of technologies such as telehealth and assistive technology.
- Use real-time and historic data to support predictive modelling and improvements in clinical service delivery at the point of care and to support population health analysis and management for effective commissioning.

IM&T play a major supporting role in the delivery of a number of key strategic projects and programmes designed to improve the efficiency of the organisation and deliver financial savings. Information Technology is a major driver for initiating change within the organisation, with the capability to create business advantage and enhance the effectiveness and efficiency of its services.
Our vision for the estate

The Trust’s vision for the future is to “provide, develop and maintain a more efficient, high quality, sustainable and flexible estate which meets the operational demands and objectives of the Trust today and in the future”

In five years we want to have an estate which is fit for purpose and enables the delivery of high quality, safe clinical services to our patients.

This means an estate which is in good condition, functionally suitable for the services being provided, provides a “healing environment”, is environmentally sustainable, accessible to local people and is designed around changing service needs.

Objectives of the Estate Strategy

The core principles of the Estate Strategy are based upon it being both an enabler and driver for change, supporting the delivery of current and future clinical services through the interpretation of the clinical and other associated Trust strategies.

The objectives of this Estate Strategy are therefore to:

- **Service Performance** – a primary objective is to ensure that the Trust estate supports, underpins and enables optimum operational performance
- **Quality of Estate** – the Trust estate should be fit for purpose and functionally suitable and with appropriate and effective maintenance arrangements to meet the required standards.
- **Enhancing the patient experience** – to support clinical delivery we aim to provide state of the art facilities that enable clinicians to deliver treatment in a comfortable, caring, safe and uplifting environment, which enhances patient experience.
- **Effectiveness** – the estate will be utilised to its maximum and have appropriate measures in place to ensure business resilience and continuity
- **Equality and Diversity** – the Trust estate must provide facilities that are appropriate and respect the values of equality and diversity to patients, staff, visitors and all others likely to use or visit Trust premises
- **Health & Safety** – the estate will provide a safe environment to high standards of Health & Safety and statutory compliance
- **Environmental** – ensuring that our estate embraces the sustainability agenda and that new developments and refurbishment projects employ sustainable methods and techniques, making use of low and renewable energy sources and improving the energy efficiency of the existing building stock where feasible
- **Value for Money** – ensuring that all estate and facilities provision offers the best value for money
- **Partnerships and stakeholders** – working with our public sector partners and key stakeholders we will ensure we deliver a cohesive approach to strategic estate management through our investment and disinvestment programmes
- **Staff Welfare** – the Trust will endeavour to provide, in all its estate provision, fit for purpose and cost-effective facilities and amenities for staff.
- **Capital receipts** - assets are retained or disposed of according to a plan that supports service delivery and enables business development opportunities, whilst also maximising cash receipts and thereby generating funds for investment.
The management of the Trust estate.

The Figure below shows the high level structure of Estates & Facilities:

A description of each role is provided in the table below:

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Board</td>
<td>The Trust Board has overall accountability for all the activities of the organisation, which includes the management and maintenance of the Trusts estate and facilities. The Trust Board delegates the responsibility for the management and maintenance of the estate and facilities to the Chief Executive.</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>The Chief Executive has the ultimate managerial responsibility for the management and maintenance of the estate and facilities and delegates the operational day to day responsibility and authority to the Director of Estates &amp; Facilities who will manage, maintain and control the estate as set out in this Estate Strategy.</td>
</tr>
<tr>
<td>Director of Estates and Facilities</td>
<td>The Director of Estates &amp; Facilities is the principal advisor on all land, property, estate and facilities development matters to the Executive Team and the Trust Board and is supported by the Head of Service within the Estates and Facilities structure.</td>
</tr>
<tr>
<td>HR Business Partner</td>
<td>Providing HR services and support estates and facilities teams made up of circa 1700 staff. Services include recruitment and retention, disciplinary and grievance processes, strategic workforce planning, management of change and HR statistical performance management.</td>
</tr>
<tr>
<td>Office Manager and PA</td>
<td>Provides PA secretarial and administrative support to the senior management team and manage the administration and business support function for the estates and facilities team.</td>
</tr>
<tr>
<td>Head of Facilities</td>
<td>Provides strategic and operational management of the facilities teams (Soft FM services) covering patient catering, domestic services, portering and logistics, postal services, switchboard, reception services, customer service centre to all Trust premises.</td>
</tr>
<tr>
<td>Head of Capital Projects</td>
<td>The delivery of strategic estate planning and advice to support the reconfiguration programme and STP programme and the development of business cases estates annexes. Planning, design, procurement, delivery and post project evaluation of major and minor capital projects and programmes.</td>
</tr>
<tr>
<td>All Staff</td>
<td>It is the responsibility of all Trust employees and other staff using the Trust’s premises to:</td>
</tr>
<tr>
<td>Head of Estates and Property</td>
<td>Management of the Trust backlog maintenance rolling programme and infrastructure investment programme.</td>
</tr>
<tr>
<td>Head of Business, Commercial and Contracts</td>
<td>Providing strategic and operational management of the estate (Hard FM services) covering building and engineering, grounds and gardens to all Trust premises.</td>
</tr>
<tr>
<td>Head of Finance</td>
<td>Provides financial management services in relation to the delivery of all estates and facilities management functions, covering all pay and non-pay budgetary control, purchasing and invoicing.</td>
</tr>
<tr>
<td>All Staff</td>
<td>It is the responsibility of all Trust employees and other staff using the Trust’s premises to:</td>
</tr>
<tr>
<td>All Staff</td>
<td>Be familiar with all Trust and estates and facilities policies and procedures and complete all statutory, mandatory and role specific training.</td>
</tr>
</tbody>
</table>

Figure 5: High level structure of E&F
What we do - Estates & Facilities is a 24 hour service

The operational front line services provided by the Estates and Facilities team is wide ranging, accounting for 1,700 employees. Below is an overview of the operational services provided and how our staff help across Leicester, Leicestershire and Rutland:

- **Accommodation team** - support relatives with on-site accommodation at GH and look after our staff accommodation across the city.
- **Retail Catering** – manage our patient, visitor and staff restaurants.
- **Porters** – transport and patient logistics, including waste and linen.
- **Cashiers** - handle the money from retail catering and car parking.
- **Customer Service Advisors** - record all work orders and requests for relevant teams for action.
- **Post Rooms** - sort and distribute the incoming and send out letters for patient appointments and discharge information to GPs.
- **Auditors** - monitor the cleaning around the hospitals to ensure that the standards remain high at all times.
- **Patient Catering** - organise and prepare the menus and meals for patients. The meals are then distributed by the Food Assistants on the wards.
- **Car Park Attendants** - help visitors and patients on all sites, as well as giving guidance and directions.
- **Linen** - provide clean linen to the wards and supply staff with their uniforms.
- **Domestic Assistants** - work on the wards and around the hospital to ensure the environment is clean and hygienic for patients and staff.
- **Switchboard** - our switchboard operators are the first point of contact for patients and relatives ringing the hospital.
- **Gardeners** - maintain the ground and gardens.
- **Receptionists** - meet and greet visitors and help them to find the right department or service.
- **Security** - keep all the sites secure and help with any incidents that may occur.
- **Maintenance** - to keep everything going and fully functional, anything from the bedside lamp to the freezers and lifts.
Estates & Facilities Team Commitment

The Estates & Facilities team is committed to ensure a high quality estates and facility service and effective estate maintenance systems are in place that ensures:

- The continuous provision of functionally suitable facilities for healthcare provision creating a safe pleasant environment internally and externally.
- Maintenance of the integrity of the building fabric and building services, public health and utility systems, equipment and site infrastructure.
- Minimal disruption to the Trust’s operations in the delivery of the Estate & Facilities Service.
- An efficient, responsive, comprehensive and effective service which is based on sound technical and operational requirements in compliance with codes and policies of good practice and industry and statutory standards.
- All plant, equipment, buildings, utility services and site infrastructure do not cause or create any hazard to the environment and / or any person on the Trust site(s).
- A safe environment and safe working practices including the use of recognised risk assessment / management systems to ensure the standards stay high, and that any slippage is recognised and corrected.
- Fire safety is maintained incorporating continual fire training, fire risk assessment and review.
- Patients, staff and visitors perceive that the cleanliness, condition, appearance, maintenance and privacy and dignity of the estate are satisfactory.
- NHS catering services provide adequate nutrition and hydration through the choice of food and drinks for people to meet their diverse needs.
- Access and car parking arrangements meet the reasonable needs of patients, staff and visitors and are effectively managed at all times.
- An effective management of accommodation including occupancy, utilisation, leasing and licensing where appropriate and staff residences.
- A safe, effective portering service is provided that meets the needs of patients, staff and visitors and the Trust, consistent with all relevant guidance and legislation.
- The telephony and switchboard service is provided efficiently, professionally and courteously within agreed target response times.
- There is a continual drive for improvements in our environmental performance, in particular energy and water consumption, waste production and non-patient transport and the impact they have on the Trust’s carbon ‘footprint’.
- Compliance in the development, occupation and management of all land and property, including acquisitions and disposals of freehold and leasehold land and premises.
- There is an effective estate and facilities risk management process that reflects the principles within the Trust’s risk management strategy and gives assurance that Estates and Facilities risks are being identified, proactively controlled and mitigated.
5.1 NHS Regulatory and Assurance framework for Estates and Facilities

Healthcare organisations have a duty of care to patients, visitors and staff to ensure a safe and appropriate environment for healthcare. This requirement is identified in a wide range of legislation and common law. Below we have summarised some of regulatory and assurance frameworks that Estates & Facilities work within:

Assurance of estates and facilities
One of the government’s key priorities is delivering better health outcomes for patients. The quality and fitness-for-purpose of the healthcare estate is vital for the delivery of high quality, safe and efficient healthcare. Quality and fitness-for-purpose of the estate are assessed against a set of legal requirements, standards and best practice guidance.

Regulator requirements: standards of quality and safety
The Care Quality Commission (CQC) regulates all providers of regulated health and adult social care activities in England. The CQC’s role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve and include requirements relating to:

- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Cleanliness and infection control

The CQC is responsible for assessing whether providers are meeting the registration requirements. Failure to comply with the CQC Regulations is an offence and, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, CQC has a wide range of enforcement powers that it can use if the provider is not compliant. The regulations stipulate that all premises and equipment used must be safe, clean, secure and suitable for the purpose for which they are being used, and properly used and maintained.

NHS Constitution
The NHS Constitution sets out the rights to which patients, public and staff are entitled. It also outlines the pledges that the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All healthcare organisations are required by law to take account of this Constitution in their decisions and actions.

Healthcare organisations need to “ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice” (pledge).

In order to deliver on this pledge, it specifically advises NHS organisations to take account of:

- National best-practice guidance for the design and operation of healthcare facilities;
- The NHS Premises Assurance Model (PAM).

The NHS has developed, with the support of DoH, the PAM, whose remit is to provide assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises.

Primarily aimed at providing governance and assurance to Boards of organisations, it allows organisations that provide NHS-funded care and services to better understand the effectiveness, quality and safety with which they manage their estate and facilities services and how that links to patient experience and patient safety.

Key questions are underpinned by prompt questions which require the production of evidence. Healthcare organisations should prepare and access this evidence to support their assessment of the PAM.

The model also includes reference to evidence and guidance as a helpful aide-memoire to assist in deciding the level of PAM assurance applicable to a particular healthcare site or organisation.

NHS PAM is designed to be available as a universal model to apply across a range of estates and facilities management services.

Estate Code

The NHS has a corporate responsibility to account for the stewardship of its publicly funded assets.

This includes the provision, management and operation of an efficient, safe estate that supports clinical services and strategy.

This corporate responsibility is carried by all accountable officers, Directors with responsibility for estates and facilities, and their equivalents, Chairs, Chief Executive Officers and Non-Executive Board members.

Together they have a responsibility to enact the principles set out in the Estate Code and provide leadership and work together to implement the necessary changes to provide a safe, efficient high quality healthcare estate.

HBN 00 08 A and B is the Estate Code and provides NHS expectations on the stewardship of land and buildings.

Health and safety legislation
The Health & Safety Executive (HSE) is the national regulator for workplace health and safety. The following legislation places legal duties on various duty holders:

- Workplace (Health, Safety and Welfare) Regulations
- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations
- Construction (Design and Management) Regulations
- Pressure Equipment Regulations
- Pressure Systems Safety Regulations
- Confined Space Regulations

Health Technical Memorandum (HTM)

HTMs are the main source of specific healthcare-related guidance for estates and facilities professionals. They give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

HTM 00 is supported by the HTM suite of guidance (see figure 4). The aim of HTM 00 is to ensure that everyone concerned with the managing, design, procurement and use of the healthcare facility understands the requirements (including regulatory) of the specialist, critical building and engineering technology involved. The core guidance (including professional support) is applicable to all building engineering services including those not covered by HTMs (for example, steam, gas and pressurised hot water services).

HTM 00 addresses the general principles, key policies and factors common to all engineering services within a healthcare organisation. Key issues include:

- Compliance with policy and relevant legislation
Professional support and operational policy
Design and installation
Maintenance
Training requirements.

**HTMs and the Legislative Framework**

Compliance with the guidance in the HTMs will help to meet these goals. Standards that will enable them to function efficiently, reliably and safely.

**Principles of healthcare engineering**

Patients and staff have a right to expect that engineering systems and equipment will be designed, installed, operated and maintained to standards that will enable them to function efficiently, reliably and safely. Compliance with the guidance in the HTMs will help to meet these goals.

Healthcare providers have a duty under the Health and Safety at Work etc. Act to ensure that appropriate engineering governance arrangements are in place and are managed effectively. HTMs provide best practice engineering standards and policy to enable management of this duty of care. The special nature of healthcare premises and dependency of patients on the provision of effective and efficient engineering services (in most cases 24 hours a day, seven days a week) requires that engineering staff and systems must be resilient in order to maintain the continuity of health services and ensure the ongoing safety of patients, visitors and staff.

**Engineering governance**

Engineering governance is concerned with how an organisation directs, manages and monitors its engineering activities to ensure compliance with statutory and legislative requirements while ensuring the safety of patients, visitors and staff is not compromised. See also the Construction Design and Management regulations (CDM).

Healthcare organisations need to ensure that sound policies are approved by the board of Directors. These should:

- Ensure safe processes, working practices and risk management strategies are in place to safeguard all their stakeholders and assets in order to prevent and reduce harm or loss; and
- Be backed up with adequate resources and suitably qualified, competent and trained staff.

Responsibility and, more specifically, the duty of care within a healthcare organisation are vested in the board of Directors and its supporting structure.

**Health building Notes (HBN)**

Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation / extension of existing facilities.

The HBNs provide information to support the briefing and design processes for individual projects in the NHS building programme.

All Health Technical Memoranda should be read in conjunction with the relevant parts of the Health Building Note series.

**Patient-led Assessments of the Care Environment (PLACE)**

Patient-led assessments of the care environment, (PLACE) is the system for assessing the quality of the hospital environment, which replaced Patient Environment Action Team (PEAT) inspections from April 2013. PLACE assessments apply to all hospitals delivering NHS-funded care, including day treatment centres and hospices.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviours.

The assessment is undertaken annually, and results are reported publicly to help drive improvements in the care environment. The results will show how hospitals are performing nationally.

Most importantly, patients and their representatives will make up at least 50 per cent of the assessment team, which will give them the opportunity to drive developments in the health services they receive locally.

**Trust Standing Orders (SOs) & Trust Standing Financial Instructions (SFIs)**

In line with the Trust’s Standing Orders and the Trust’s Standing Financial Instructions, the Trust shall comply as far as is practicable with the requirements of the Department of Health “Capital Investment Manual” and “Estatecode” and shall consider guidance “Best Practice in making Investments for NHS Foundation Trusts” and other such guidance as may be issued by the Independent Regulator from time to time in respect of capital investment and estate and property transactions.

**Estate Return Information Collection (ERIC)**

ERIC data enables the analysis of estates and facilities information from a range of NHS organisations including Foundation Trusts and NHS Trusts in England.

It is a mandatory requirement that returns are submitted, which in turn becomes part of the national statistics.

Statistics taken from the organisation’s annual ERIC returns are a good basis for assessment and can be used to indicate its performance relative to its peers. Most importantly, ERIC should be treated as the standard first step when analysing estate data. It is important that accurate figures to address critical infrastructure and longer term risks are presented at local and national level via ERIC in order to monitor condition of the estate assets.

The Compliance Assessment and Analysis System (CAAS)

The Compliance Assessment and Analysis System (CAAS), allows you to measure compliance with built environment standards, and further delivers, a complete Compliance Improvement Loop (CIL) for moving your compliance forwards.
CAAS provides a measure of compliance performance across a range of Key Performance Indicators. It is designed to support the NHS Premises Assurance Model (PAM) and the mandatory annual Estates Return Information Collection (ERIC) return to the DoH.

CAAS also provides a unique scoring system which allows organisations to 'drill down' and look at performance and processes to identify areas for improvement. Areas of compliance include:

- Asbestos
- Asset Management and Maintenance
- Contingency Planning
- Contract Management
- Decontamination
- Electrical Systems
- Facilities Infection Control
- Ventilation
- Fire Safety
- Health, Safety and COSHH
- Lifts
- Mechanical Systems
- Safe and Accessible Buildings
- Security Management
- Sustainability
- Waste Management

Each of the above areas are scored and assigned a % score, the CAAS assessment thresholds indicate how well an area is performing and the thresholds are as follows:

- **Green 80-95%** - good to exceptional organisation, arrangements to deliver required outputs and standards.
- **Yellow 40-79%** - an action plan is required to take this element into the Green category. More than one non-conformance to standards.
- **Red up to 39%** - Priority action, or actions required to address one or more major non-conformances to standards.

The MICAD IPR with all its current modules is used widely throughout the NHS by in excess of 100 Trusts and Health Boards. It addresses most aspects of Estates Management and includes the following modules:

<table>
<thead>
<tr>
<th>Module</th>
<th>Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property Appraisal</td>
<td>6 Facet Survey</td>
</tr>
<tr>
<td>Utilities</td>
<td>Energy</td>
</tr>
<tr>
<td></td>
<td>Carbon</td>
</tr>
<tr>
<td></td>
<td>Waste</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>Asbestos</td>
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<tr>
<td></td>
<td>Legionella</td>
</tr>
<tr>
<td>Documentation</td>
<td>Drawings</td>
</tr>
<tr>
<td></td>
<td>Documents</td>
</tr>
<tr>
<td></td>
<td>O&amp;M Manuals</td>
</tr>
<tr>
<td>Land &amp; Property</td>
<td>Terrier</td>
</tr>
<tr>
<td></td>
<td>Leases</td>
</tr>
</tbody>
</table>

The MICAD helps the Estates & Facilities team to succeed with:

- ERIC Returns

The Trust currently uses MICAD version 3.5 which is managed and controlled by a small team within the Space Management arm of the Property Team. The IPR provides an extremely user friendly Portal which can be accessed by users both within, and outside, the Trust. Here users can access a myriad of information relative to their field of expertise/interest. This will include:

- Plans
- Documents
- O&M Manuals
- Photographs
- Asbestos Data
- Survey Data
- And much more

MICAD Intranet Property Register (IPR) is the Trust’s property information system. The system connects building floor plans to room records containing information such as location, area, use, department and name of occupant.

- The Premises Assurance Model returns
- Requirements of Estate code & HBN Note 00-08
- Changing the shape of the estate to meet the requirements of service delivery strategies
- Managing backlog maintenance
- Investment Planning

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**Building Caring at its best**
MICAD in practice

Following 'Project Phoenix' and the repatriation of the Integrated Facilities Management (IFM) Team the Trust acquired MICAD which, unfortunately, had not been used for its primary purposes.

We started to rectify these issues in 2016 when we employed a CAD Technician from an Agency. Following 'Project Phoenix' and the repatriation of the Integrated Facilities Management (IFM) Team the Trust acquired MICAD which, unfortunately, had not been used for its primary purposes.

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TheMICAD system is dependent on accurate, poly-lined, CAD drawings to enable accuracy. With the right level of investment and a strong team this will become the “Single Version of the Truth” relative to all relative property matters.

MICAD in practice

Following ‘Project Phoenix’ and the repatriation of the Integrated Facilities Management (IFM) Team the Trust acquired MICAD which, unfortunately, had not been used for its primary purposes.

Estates & Facilities has strengthened the Property Team with the addition of a Systems Administrator and Systems Analyst who are working towards rectifying problems and ‘sense checking’ all of the data in MICAD. Some of the key components of MICAD are described below:

### Area Components

#### Property Appraisal
- 6 Facet Surveys

#### Health & Safety
- Asbestos
- Legionella

#### Documentation
- Drawings
- Documents
- O&M Manuals

#### Land & Property
- Terrier
- Leases & Licences

#### Portal
- Accuracy
- Ease of Access
- Promotion

#### Utilities
- Energy
- Carbon
- Waste Management

The MICAD system is dependent on accurate, poly-lined, CAD drawings to enable accuracy. With the right level of investment and a strong team this will become the “Single Version of the Truth” relative to all relative property matters.

### Room Functions -
When we inherited the system it contained over 170 room functions. These have been ‘whittled down’ and we now have a much more practical / manageable set of 82 with helpful descriptors for the uninitiated.

### CAD Drawings -
Another unfortunate consequence of IFM’s failure to update the MICAD system is that a very large percentage of CAD drawings (which form the basis of all maintenance, space management, asbestos etc. surveys and work) are both out of date and inaccurate.

We started to rectify these issues in 2016 when we employed a CAD Technician from an Agency.

### Space Occupancy / Service Lines -
Data Collected in 2014/2015 But needs to be revisited annually

“To manage services well and achieve improvements in quality and productivity, hospital trusts need to gather and analyse detailed information about the performance of services and to support clinical leaders of those services to manage their services and lead improvement. Service-line reporting (SLR) and service-line management (SLM) together offer an approach to achieving this.” (Catherine Foot, 2012)

Considering the above we are still trying to work in the background, on building Service Line related space occupancy data and are in the process of preparing a ‘League-Table’ of space occupancy costs across the Trust for consideration by The Board and CMG Heads.

There is also scope to build in;

The potential to link to the MICAD helpdesk will be extremely beneficial if we divert our helpdesk function into MICAD, as a CIP saving, in the future.

IM&T are currently trying to integrate the portal room hatching tool in to their Avanti service desk to track assets and get engineers to faults quicker.

Medical Physics are currently using the Portal to find adjacencies to X-ray areas.

Security and Car parks using the Portal to view and hatch drawings for building exit and entrance points and create patrol routes

IES Interserve environmental services have been given access to help with LPT’s current Asbestos re-inspections

Contractors have been given portal access to view and download drawings and documents to help them accurately quote and plan works etc.

Work in progress but can be rolled out quickly and access can be narrowed down from a Trust to site to building.

### MiC4C

Last year our Soft Services teams began using the MiC4C system (formerly Credits for Cleaning – now wholly owned by MICAD) for their cleaning audits and this module is being developed on an ongoing basis, proving to be a valuable asset in our “fight against grime”.

There are many benefits being realised through the symbiosis between the Soft Services team and the MICAD management team with many data/detail problems and outdated drawings being identified and noted.

The operational teams like the system and find it hugely beneficial.

Conforming to the Department of Health National Standards of Cleanliness in the UK and Ireland, the MiC4C Cleaning Audit Software allows managers to measure performance in a fully customisable, easy-to-use format.

Auditing, whilst necessary, can be an onerous part of the cleaning process. Using MiC4C and mobile technology however, cleaning audits become easier and faster which in turn can save you time and money.

MiC4C also now allows you to send remediation work requests directly to the MICAD CAFM HelpDesk.

The potential to link to the MICAD helpdesk will be extremely beneficial if we divert our helpdesk function into MICAD, as a CIP saving, in the future.

IM&T are currently trying to integrate the portal room hatching tool in to their Avanti service desk to track assets and get engineers to faults quicker.

Medical Physics are currently using the Portal to find adjacencies to X-ray areas.

Security and Car parks using the Portal to view and hatch drawings for building exit and entrance points and create patrol routes

IES Interserve environmental services have been given access to help with LPT’s current Asbestos re-inspections

Contractors have been given portal access to view and download drawings and documents to help them accurately quote and plan works etc.

Work in progress but can be rolled out quickly and access can be narrowed down from a Trust to site to building.

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6 National Policies

NHSE Five Year Forward View
The NHSE Five Year Forward View (FYFV), published in October 2014, reported that unless determined action was taken, the gap between need and NHS resources would be £30bn in 2020/21.

The FYFV sets local leaders the task of achieving the “triple aim” of improved health and wellbeing, transformed quality of care delivery, and sustainable finances. Approaches relevant to healthcare estates planning are:

- Patient needs are changing and new treatment options are emerging
- New partnerships with local communities, LAs and employers
- The need for rapid upgrade in prevention and public health
- The need for patients to gain more control of their care
- Removal of barriers to care provided by family doctors, hospitals, physical and health and social care
- More services delivered locally but others in specialist centres
- More support for patients with multiple health conditions
- Radically different care delivery options including integrated hospital and primary care providers.

NHS planning guidance sets out steps to help local organisations deliver a sustainable and transformed health service that will improve the quality of care, wellbeing and NHS finances.

The guidance is backed by £560 billion of NHS funding, including Sustainability and Transformation Funding which will support financial balance, the delivery of FYFV, and enable new investment in key priorities. As part of the planning process all NHS organisations are producing STPs.

Sir Robert Naylor Review
In March 2017 an independent report by Sir Robert Naylor was published making 17 recommendations to the Secretary of State for Health on the future of NHS property and estates.

These recommendations include:

- Prioritise land vacated by the NHS for development of residential homes, including prioritisation for use by NHS Staff.
- Proposals to improve capability and capacity to support national strategic planning and local delivery through the establishment of a new national NHS Property Board. The aim being to provide leadership to the centre and expertise and delivery support to the sustainability and transformation plans locally.
- Encouraging and incentivising local action by enabling the reinvestment of sales receipts to support local plans and even offer additional incentive funding.
- The overarching drive of these recommendations is ensuring the NHS locally is supported at a national level to develop robust, well evidenced estate plans that make best use of the capital available.
- The Trust’s strategic ambitions are in line with the Naylor review principles in aspiring to deliver an estate which is safe, cost effective and meet the future requirements of clinical services.

Government Spending Review
Additionally, the Government’s Spending Review in November 2015 committed the NHS to finding £2bn, (revised upwards to £3.3bn in Autumn Statement 2017) from NHS land sales by 2020-21 and releasing land for 26,000 houses.

The Annual Surplus Land Collection required by the DoH of each Trust, seeks to identify opportunities for the future and as part of the mandatory annual returns, the Trust has identified both the pasture land and land at the LGH as potential development sites.

Government’s Response to the Naylor Review
On 31st January 2018 the Government published its response to the Naylor Review and generally welcomes the review and its recommendations. They have confirmed that the recommendations will be implemented in conjunction with national partners and the NHS.

The review set out the progress needed on three key themes to transform the NHS estate, and the government has confirmed that they are taking action in response. The themes highlighted by the Review are:

- Leadership and capability
- National planning and funding
- Incentivising action locally.

Leadership and capacity
The response notes that a new NHS property board, of which Lord O’Shaughnessy is Chair has been formed to bring together all the key national players and to act as a single point of leadership for the health system on estate matters.

Capability at a local level is being improved by creating a new national strategic estates planning and advisory service, to help the NHS move from planning to delivery. This team has evolved over the last year by bringing together all the local strategic estates advisers into a single team to provide expert advice to the NHS.

National planning and funding
The review gave a clear estimate of the level of funding required to enable the transformation of the estate to meet the vision of the Five Year Forward View. It recommended this could be found through government capital, private finance and proceeds from the disposal of surplus NHS land.

The Chancellor, in his Autumn Budget, announced an additional £10 billion package of capital investment over the course of this Parliament. The Government has committed over £3.9 billion of capital for the NHS. This will support the NHS to increase the proceeds from the sale of surplus land to £3.3 billion.

It is expected to be supplemented by private investment, where this provides good value for money. It is likely some of this will come from the types of schemes that already fund primary care facilities. With this £10 billion package of capital investment, we will develop a pipeline of transformational STP projects over the next five years so that the NHS can deliver on the vision of the Five Year Forward View.

The government has also confirmed that it will put forward £700 million to tackle critical maintenance issues and support around plans in struggling trusts and put £200 million into support efficiency programmes, “allowing more time and money to be directed to patient care”.

Incentivising action locally
Action is being taken to incentivise local NHS organisations to take a more strategic approach to estates planning and management.

Reassurance has been given to NHS organisations, confirmed that they will be able to retain receipts from land sales, so these can be reinvested in the NHS estate, to renew and replace outdated facilities and to address backlog maintenance, in line with local priorities and STP strategies.

Where surplus land is developed for housing, NHS staff will be given the right of first refusal on any affordable homes built.
6.1 Carter Review

"Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" DoH, February 2016

The Carter Review looked at productivity and efficiency in English non-specialist acute hospitals using a series of metrics and benchmarks to enable comparison.

Significant and unwarranted variation in costs and practice were identified which, if addressed, could save the NHS £5bn.

Issues identified include:

- Significant variation in facilities management costs
- Corporate and administration costs varied between Trusts at 6%-11% of income with Trusts failing to capture the benefits of scale
- Potential for efficiency savings of £1bn from better management of estates, such as lighting, heating and space utilisation, with one trust using 12% for non-clinical purposes, while another used over two-thirds
- Variation in the use of space, with clinical space occupation ranging from 11% to 65%.

Carter highlighted imperfections in the data reported by individual trusts including ERIC returns and stressed the importance of recording and reporting data accurately. The Review recommends:

"Every trust has a strategic estates and facilities plan in place, including in the short term, a cost reduction plan for 2016-17 based on the model hospital data and benchmarks, and in the longer term, a plan for investment and reconfiguration where appropriate for their whole estate, taking into account The Trust’s future service requirements” and

"All trusts estates and facilities departments should operate at or above the median benchmarks for the operational management of their estates and facilities functions by April 2017 with all trusts having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.”

Figure 8-Carter Dashboard
The Carter report also sets specific targets for Trust’s to meet and report on yearly which includes:

- Unused floor area should be less than 2.5% (AWP 9%)
- Non-clinical floor area should be less than 35% (AWP 33%)
- Should have Benchmarked estates cost reduction plan
- Should have Reconfiguration investment plan
- Should have Energy-saving investment.

On an annual basis the Trust develops its own Carter dashboard that illustrates the trust performance against the Carter targets. An example of the dashboard is below.

**Model Hospitals**

As part of the review, a ‘model hospital’ has been developed which will advise NHS trusts on the most efficient allocation of resources and allows hospitals to measure performance against other trusts.

The aim is to empower NHS leaders by giving them the necessary data and support to highlight areas to improve care for patients and make savings which can be reinvested in frontline care.
Joint Strategic Needs Assessment (JSNA) Leicester, Leicestershire and Rutland

A Joint Strategic Needs Assessment (JSNA) is a statutory requirement (Health and Social Care Act 2012) placed upon the Directors of Public Health, Adult and Children’s Services in all local authorities to guide the commissioning of local health, wellbeing and social care services.

The JSNA provides a systematic method for reviewing the short and long term health and wellbeing needs of a local population. This JSNA is an important starting point for strategy development and commissioning decisions.

The Trust predominantly provides services for the populations of Leicester, Leicestershire and Rutland - each have a JSNA that was last updated in 2015, to address the needs of the population and future demographic changes.

As people grow older, there is a higher prevalence of long term illness and disability. The number of people living with long term conditions will grow as a population ages. Furthermore, many people will have multiple conditions, meaning their care needs are more complex.

From a health need perspective there is a marked variation in life expectancy across LLR with the main factors contributing to mortality being cardiovascular disease (CVD) and respiratory. Any plans for service improvement must respond to these challenges and make a significant contribution towards better outcomes.

Extracts from the Leicester City, Leicestershire and Rutland JSNAs are shown below in figure 6:

The 2015 JSNA priorities

The most significant driver of health needs for the Leicestershire population is increased life expectancy of the population.

In 2013 the total population for Leicestershire was estimated at 661,600 people of which 126,100 people were estimated to be 65 years and over, and 33,400 were 85 years and over. 153,200 of the Leicestershire population were under 20 years of age, see figure 7:

The population of Leicestershire is growing – between 2012 and 2037 (25 years) it has been projected that the total population of Leicestershire will grow by 15% to over 750,000.

However this growth is not uniform across the age groups as follows:

- 190% increase in people aged 85 years and over
- 56% increase in people aged 65 – 84 years
- 7% increase in children and young people aged 0-24 years
- 2% decrease in the working age population (25 – 64 years)

Leicester City Council

Levels of deprivation across the city of Leicester are shown in figure 11. By national quintiles (fifths) of neighbourhoods or Lower Layer Super Output Areas (LSOAs). This shows Leicester has more areas of higher deprivation than England. The red areas in the map are within the 20% most deprived areas in England (quintile 1) and the blue areas are within the 20% least deprived areas in England (quintile 5). If deprivation in Leicester was similar to England, there would be an equal number of areas within each of the five quintiles.

Leicester has 192 LSOAs. There are three LSOAs (2%) in Leicester which fall within the fifth (20%) least deprived in England overall. These are in the South Knighton area.

Eighty-three or 43% of LSOAs lie within the fifth (20%) most deprived areas of England. A further 59 or 31% lie in the two fifths (40%) most deprived in England.

This equates to 76% of Leicester’s population living in the two fifths (40%) most deprived areas in England (compared with 40% of England’s population overall who do so).

Looking at the 10% most deprived LSOA’s by domain, compared with England as a whole Leicester has:

- Fewer areas in the Barriers to Housing and Services domain
- Between one and two times more areas with deprivation in the Health Deprivation and Disability, Employment and the Living Environment domains
- More than twice the percentage of areas with deprivation in the Income and Crime domains and the Income Deprivation Affecting Children supplementary domain
- More than three times the percentage of areas with deprivation in the Education, Skills and Training domain and the Income Deprivation Affecting Older People supplementary domain.
Leicestershire County Council
In 2015, the population of Leicestershire was 675,300 people. Of these, 153,800 people were aged 0-19 years (22.8%), 116,300 people were aged 65-84 years (17.2%) and 17,000 people were aged 85 years and over (2.5%).

The population of Leicestershire is growing and by 2039 the total population is predicted to reach 784,400 people, a total population growth of 17.4% compared with 2014. However, this growth is not uniform across the different age bands. In the next 25 years, the population is predicted to grow as follows:

- A 13% increase in children and young people age 0-19 years (153,600 people to 173,000);
- A 4% increase in the working age population age 20-64 (from 384,400 people to 399,000);
- A 49% increase in people aged 65-84 year olds (from 113,400 people to 168,500); and
- A 162% increase in the oldest population group of people aged 85 years and over (from 16,700 people to 43,700).

Although relatively affluent as a whole, analysis of the 'housing and environment' domain of the Index of Multiple Deprivation shows that Leicestershire faces challenges around housing and access to services.

The figures for life expectancy, healthy life expectancy and population change make it clear that Leicestershire's population is undergoing rapid change. It is estimated that 56,000 men and 58,000 women are living in the 'age gap' between healthy life expectancy and life expectancy, potentially in poor health. This accounts for 17% of the population in the county.

Around two-thirds of deaths among the under 75s are caused by diseases and illness that are largely avoidable, including cancer and diseases of the circulatory system. Many of the direct causes are due to lifestyle related factors and are preceded by long periods of ill-health.

Health Summary of Leicestershire 2017
- Children with excess weight aged 4-5 years is similar to the national average
- Children with excess weight aged 10-11 years is significantly better than the national average
- Excess weight in adults is similar to the national average
- The percentage of physical active adults is similar to the national average

- Admissions to hospital for alcohol specific conditions for under18s and all ages are both significantly better than the national average
- Smoking prevalence is significantly better than the national average
- Under 18 conceptions (teenage pregnancy rate) is significantly better than the national average
- Recorded diabetes is significantly worse than the national average
- Life expectancy for both males and females is significantly better than the national average
- Healthy life expectancy for males is similar to the national average and healthy life expectancy for females is significantly better than the national average.

Rutland County Council
Conversely, Rutland is ranked one of the most affluent counties in England: of 149 Upper Tier Local Authorities in 2010, Rutland ranked 148 (with 1 being the most deprived and 149 being the least deprived).

In the last three years of health profiles released by Public Health England (2013 – 15), Rutland has ranked the first in the 10 best performing local authority districts for levels of deprivation.

In 2010 when placed in a national context, while there was no ward ranked in the two most deprived quintiles nationally, two wards were in the middle quintile – Uppingham and Oakham North West, see figure 8.
8 Where we are now?

The Current Estate

The Trust estate has a total floor area of 264,736m² consisting of building stock that is varied age, design, configuration and condition.

The table below summaries the size of the estate:

<table>
<thead>
<tr>
<th>Areas</th>
<th>Unit</th>
<th>LRI</th>
<th>Glenfield</th>
<th>LGH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIA</td>
<td>m²</td>
<td>120,289</td>
<td>71,481</td>
<td>72,966</td>
<td>264,736</td>
</tr>
<tr>
<td>Occupied area</td>
<td>m²</td>
<td>120,289</td>
<td>59,104</td>
<td>57,989</td>
<td>237,291</td>
</tr>
<tr>
<td>Clinical Space</td>
<td>m²</td>
<td>89,132</td>
<td>45,017</td>
<td>46,531</td>
<td>180,680</td>
</tr>
<tr>
<td>Non Clinical</td>
<td>m²</td>
<td>31,024</td>
<td>13,951</td>
<td>11,322</td>
<td>56,297</td>
</tr>
<tr>
<td>Site area</td>
<td>Ha</td>
<td>10.02</td>
<td>31.01</td>
<td>28.35</td>
<td>69.38</td>
</tr>
</tbody>
</table>

Table 1 Size of Trust Estate

Headline Summary

We have presented some ‘headline facts’ of the Trust estate. From this you can that there is a wide range of issues across the Trust estate with varying degrees of risk.

Data Source

2016/17 Estates Return Information Collection (ERIC).
**8.1 Glenfield Hospital**

**Location**
GH is located three miles northwest of Leicester city centre on the A50 and can be accessed by car and public transport. A hopper service is also available between sites and runs at regular intervals.

**Services**
The hospital provide a range of services including a specialist heart centre and currently have a bed provision of 411. Services provided on site include:

- Allergy services in hospital
- Cardiac surgery
- Colorectal cancer services
- Cardiology
- Restorative dentistry
- Orthodontics
- Intensive care
- Lung cancer services
- Nephrology
- Occupational therapy services
- Orthopaedics
- Physiotherapy
- Respiratory medicine
- Rheumatology
- Surgery – breast
- Vascular surgery
- Paediatric cardiology (EMCHC)
- Cardiothoracic surgery
- Adult cardiology
- Breast surgery & screening

**Building Stock**
The majority of the estate consists of a two storey interconnected building providing 45,017m² of clinical space and 13,951m² of non-clinical space.

Leicestershire Partnership Trust NHS Trust is also located on this site adjacent to the main hospital buildings.

**Backlog Maintenance**
The current backlog maintenance cost for the GH stands at £17,447,195 which is broken down by:

- Backlog - £16,040,510
- Critical Infrastructure Risk - £1,406,685

**Running Costs**
The total running cost for 2016/17 for the GH was £19,624,965, which is broken down by:

- Hard FM - £7,442,604
- Soft FM - £5,337,656
- Fixed Costs - £6,844,705

**Site Infrastructure**
A range of site infrastructure works to enable to reconfiguration programme and at GH has been calculated to cost in the region of £10,700,000.
8.2 Leicester Royal Infirmary

Location
The LRI site is located on the southern edge of the city centre. The site is located on the A594 through Leicester providing easy access to main bus routes that serve the wider city and is also close to the Train Station. A hopper service is also available from the Train Station to the site and runs at regular intervals.

Services
LRI is the main acute site for The Trust in Leicester with a bed provision of currently 1007. Services delivered from this site include:

- Accident and emergency services
- Allergy services in hospital
- Cancer services
- Colorectal cancer services
- Dementia services
- Diagnostic endoscopy
- Dermatology
- Emergency abdominal surgery
- Ear, nose and throat
- Endocrinology and metabolic medicine
- Gastrointestinal and liver services
- Gastrointestinal cancer services
- General medicine
- General surgery
- Physiotherapy
- Plastic surgery
- Vascular OPD
- Geriatric medicine
- Gynaecology
- Haematology
- Head and neck cancer services
- Imaging services
- Immunology
- Intensive care
- Trauma
- Occupational therapy services
- Oncology – clinical
- Ophthalmology
- Oral and maxillofacial surgery
- Pain management
- Respiratory medicine
- Rheumatology
- Stroke

Building Stock
The buildings on the site are varied, predominantly multi storey blocks however there is a grade II listed building providing 89,132m² of clinical space and 31,024 m² of non-clinical space. The site has expanded over time to meet increased demand and is in need of upgrading in parts.

Backlog Maintenance
The current backlog maintenance cost for the LRI stands at £38,838,862 which is broken down by:
- Backlog - £33,842,178
- Critical Infrastructure Risk - £4,996,684

Running Costs
The total running cost for 2016/17 for the LRI was £43,144,198 which is broken down by:
- Hard FM - £12,804,625
- Soft FM - £16,573,676
- Fixed Costs - £13,765,897

Site Infrastructure
A range of site infrastructure works to enable to reconfiguration programme and at LRI has been calculated to cost in the region of £6,900,000.
8.3 Leicester General Hospital

Site Access
The LGH is on the outskirts of Leicester in Evington on the A6030. It is about three miles east of Leicester city centre. Bus services are provided to the area and a hopper service is also available from the Train Station to the site which runs at regular intervals.

Services
This hospital houses the Diabetes Centre of Excellence which is delivered from this site this has a current bed provision of 383. Other services include:

- Bariatric surgery
- Colorectal cancer services
- Dermatology
- Diabetic medicine
- Emergency abdominal surgery
- Endocrine and thyroid surgery
- Gastrointestinal and liver services
- General surgery
- Geriatric medicine
- Imaging services
- Gynaecology
- Intensive care
- Maternity services
- Nephrology
- Occupational therapy services
- Orthopaedics
- Orthotics and prosthetics
- Pain management
- Physiotherapy
- Rheumatology
- Sports and exercise medicine
- Urology

Building Stock
The buildings on this site are a mixture of Victorian ‘nightingale’ wards and more recent low level block design construction providing 46,531m² of clinical space and 11,322m² of non-clinical space.

Backlog Maintenance
The current backlog maintenance cost for the LRI stands at £30,829,242 which is broken down by:

- Backlog - £28,049,469
- Critical Infrastructure Risk - £2,779,773

Running Costs
The total running cost for 2016/17 for the GH was £22,053,165, which is broken down by:

- Hard FM - £8,045,552
- Soft FM - £6,958,718
- Fixed Costs - £7,048,894

Site Infrastructure
A range of site infrastructure works to enable to reconfiguration programme and at LRI has been calculated to cost in the region of £1,030,000.
8.4 Recent investment

Major investment projects delivered across the estate in the last three years include:

**The new Emergency Floor at the Leicester Royal Infirmary**
This is a £43.3 million approved scheme being delivered in 2 phases. Phase 1 is the new Emergency Department (ED) which went live on April 26th 2017. Phase 2 is the development of medical and frailty assessment units, which will be constructed in the space previously occupied by the ED and surrounding areas, due to complete in spring 2018.

**New models of care for Vascular services at Glenfield Hospital**
The new vascular unit at GH is a £13.2 million scheme which has delivered a new ward with vascular studies unit, a new hybrid theatre, and an interventional radiology suite.

In order to meet the National Specialised Services standards for a Level One Centre, Vascular services transferred to GH in May 2017 to co-locate with cardiac and cardio-thoracic surgery, and will provide access to a new Hybrid Theatre.

**New Adult Emergency Floor – Leicester Royal Infirmary**
**Children’s Internal Play Area – Leicester Royal Infirmary**

**Vascular Services – Glenfield Hospital**
The new multi-storey car park at the Leicester Royal Infirmary, completed March 2016
Our new five-storey car park includes:
- 21 disabled spaces on the ground floor

**East Midlands Congenital Heart Centre (EMCH) at the Glenfield Hospital**
We have recently opened the newly refurbished Ward 30 offering fantastic new facilities, which will help us to continue to grow our service and provide the best environment for our patients and families. Facilities are being prepared at the LRI to ensure co-location with children’s services. These include:
- 17 bed children’s ward
- Additional 11 bedrooms
- 2 single rooms for adolescents
- Children’s internal play area
- Parents sitting room and kitchen
- New treatment room
- New nurse station.
<table>
<thead>
<tr>
<th><strong>PET CT Scanner</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose built facility at LRI to provide PET CT scanning facilities, with additional provision for external mobile hook up.</td>
</tr>
<tr>
<td><strong>Value - Alliance Medical/ Central Government Funded</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emergency Floor – Phase 2 /GPAU</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refurbishment of the old facility at LRI following opening of the new emergency department to create a new hot floor consisting of AMU, AFU, ACB, EFU, EDU and a new GP assessment Unit.</td>
</tr>
<tr>
<td><strong>Value - £9,583,149</strong> (included within the Emergency Floor Phase 1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Discharge Lounge</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion of an existing Discharge lounge at LRI to enable use for patients in beds.</td>
</tr>
<tr>
<td><strong>Value - £40,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emergency Floor – Phase 3 Expansion of GPAU</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Makeover of old Clinic 1 to create a waiting area and treatment rooms for the new GPAU at LRI.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Wayfinding</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>LRI internal and external wayfinding signage following the opening of the new Emergency Department and the closure of the Balmoral Reception.</td>
</tr>
<tr>
<td><strong>Value - £25,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Mortuary Flooring at LRI and GH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim works to repair the floor to meet Human Tissue Authority Standards and installation or bariatric post mortem table.</td>
</tr>
<tr>
<td><strong>Value - £72,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cat Lab F Scanner at GH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Installation of a Cat Lab F Scanner at GH.</td>
</tr>
</tbody>
</table>
9 How the estate is performing?

9.1 Estate Condition

The physical condition profile examines the building structure and fabric together with mechanical and electrical engineering installations. It shows what proportion of the building area is in one of five categories, and the backlog cost to upgrade these areas to acceptable standards (that is at least Estate Code condition category B). Categories for physical condition are as follows:

- **A** – Buildings where elements are as new and can be expected to perform adequately for their full normal life. No immediate expenditure is required except for routine operational maintenance.
- **B** – Building is in an acceptable condition for its use. Operationally safe and exhibits only minor deterioration.
- No immediate major expenditure required except that for minor repairs, upgrading and routine operational maintenance. Buildings in this category have a life expectancy of at least 10 years for existing use without major repairs and upgrading.
- **C** – Buildings that are operational but where major repair or replacement will be needed soon. That is within three years for building elements and one year for engineering.
- **D** – Buildings that are not in an acceptable condition for existing use and elements of which run serious risk of imminent breakdown.
- **X** – A rating added to C or D to indicate that it is impossible to improve the element without replacement.

It demonstrates what proportion of the building area is in each of the Estatecode condition categories. Condition ‘B’ is deemed the acceptable condition for an estate. The table below lists the condition of the estate, by percentage:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>1%</td>
</tr>
<tr>
<td>B(C)</td>
<td>4%</td>
</tr>
<tr>
<td>C</td>
<td>68%</td>
</tr>
<tr>
<td>D</td>
<td>26%</td>
</tr>
<tr>
<td>DX</td>
<td>1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

9.2 Estate Backlog maintenance

Using data extracted from 2016/17 ERIC return, the outstanding backlog per site has been quantified as:

<table>
<thead>
<tr>
<th>Site</th>
<th>Backlog £</th>
<th>Critical Infrastructure Risk £</th>
<th>Total Backlog £</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRI</td>
<td>£33,842,178</td>
<td>£4,996,684</td>
<td>£38,838,862</td>
</tr>
<tr>
<td>GH</td>
<td>£16,040,510</td>
<td>£1,406,685</td>
<td>£17,447,195</td>
</tr>
<tr>
<td>LGH</td>
<td>£28,049,469</td>
<td>£2,779,773</td>
<td>£30,829,242</td>
</tr>
<tr>
<td>Total</td>
<td>£77,932,157</td>
<td>£9,183,142</td>
<td>£87,115,299</td>
</tr>
</tbody>
</table>

The Trust’s overall backlog position is circa £87m (ERIC 2016/17).

This primarily relates to the cost to bring the physical condition of the estate back to condition B as defined by DoH guidance Estatecode but also includes some Statutory Compliance elements. The methodology for establishing the backlog position follows the DoH guidance and is risk based.
9.3 Age Profile of The Trust Estate

The below pie chart shows the age profile of the Trust estate. This indicates that most of the estate across all three sites was built between 1965 and 1994.

The following pie charts show the age profile of the Trust estate by hospital site. Key points to note include:

- Most of the estate across all three sites was built between 1965 and 1994.
- LGH had undergone significant expansion between the years 1965-1984.
- LGH underwent significant expansion between the years 1965-1984 and LRI’s one standout period of development was 1975-1984.
- Less than 14% of the LGH estate was built after 1994.
Photo Gallery

Leicester Royal Infirmary – 1907

Leicester Royal Infirmary – circa 1930s

Leicester Royal Infirmary – circa 1771

Horse Ambulances of the Fire Brigade outside main entrance of Queen Victoria Wing, Leicester General Hospital - 1902

Samuel Odames Nightingale Ward, Leicester Royal Infirmary – circa 1910

Leicester Royal Infirmary – circa 1771

NHS University Hospitals of Leicester

Building Caring at its best
9.4 Estate Running costs

Total Running Costs by Site and Overall

In 2016/17, the total running costs for the Trust estate, which includes Hard and Soft FM as well as estates fixed finance costs was £84m.

The totals for each site are as follows:

<table>
<thead>
<tr>
<th>Site</th>
<th>Soft FM</th>
<th>Hard FM</th>
<th>Fixed Costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRI</td>
<td>£16,573,676</td>
<td>£12,804,625</td>
<td>£13,765,897</td>
<td>£43,144,198</td>
</tr>
<tr>
<td>GH</td>
<td>£5,337,656</td>
<td>£7,442,604</td>
<td>£6,844,705</td>
<td>£19,624,965</td>
</tr>
<tr>
<td>LGH</td>
<td>£6,844,705</td>
<td>£8,045,552</td>
<td>£7,048,894</td>
<td>£22,053,165</td>
</tr>
<tr>
<td>Total</td>
<td>£28,870,050</td>
<td>£28,292,782</td>
<td>£27,659,496</td>
<td>£84,822,328</td>
</tr>
</tbody>
</table>

Facilities Management

In 2016/17, a total of £57,162,832 was spent annually on the facilities management of the Trust estate.

Soft and Hard FM is typically broken down by the following cost types:

**Hard FM**
- Estates and Property Maintenance
- Electro Bio Medical Maintenance (EBME) costs
- Energy Services
- Other Hard FM costs
- Waste disposal services (Total of all Waste costs reported).
- Water Services
- Sewage Services
- Grounds and Garden Maintenance Costs

**Soft FM**
- Cleaning (domestic) services
- Other Soft FM (Hotel Services) costs
- Inpatient food services
- Portering services
- Laundry & Linen services

Fixed Costs

In 2016/17, a total of £27,659,496 was spent on fixed costs for the management of the Trust estate.

Fixed costs for Estates & Facilities typically includes the following:

- Rent
- Rates
- Depreciation
- Staff

The chart below illustrates how the fixed cost spend per annum is broken down per site.

**Table 2 Running Costs of Trust Estate**

<table>
<thead>
<tr>
<th>Site</th>
<th>Soft FM</th>
<th>Hard FM</th>
<th>Fixed Costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRI</td>
<td>£137,689</td>
<td>£128,046</td>
<td>£137,659</td>
<td>£431,442</td>
</tr>
<tr>
<td>GH</td>
<td>£37,442</td>
<td>£6,844</td>
<td>£7,048</td>
<td>£51,334</td>
</tr>
<tr>
<td>LGH</td>
<td>£6,844</td>
<td>£8,045</td>
<td>£7,048</td>
<td>£22,053</td>
</tr>
<tr>
<td>Total</td>
<td>£276,595</td>
<td>£28,293</td>
<td>£27,659</td>
<td>£84,822</td>
</tr>
</tbody>
</table>

**Chart 3 Total running costs by site**

**Chart 4 Facilities Management spend per annum per site**

**Chart 5 Fixed Costs per annum per site**
### 9.5 Estate Space Utilisation

#### Space across the Trust
The graph below shows how much gross internal floor area, in m², at each site as well as how much of it is occupied.

#### Floor area occupied
The graph below shows how well, in percentage terms, each hospital is utilised in terms of floor area. LGH is the most underutilised site with more than 20% of space being unused. LRI is the most utilised with all of the space being currently used.

#### How the occupied floor area is used
The graph below shows how each hospital is using their occupied floor space in two categories, either clinical or non-clinical. LGH has the highest percentage of clinical floor space being used and LRI the lowest.

![Chart 7 Space Utilisation per site](image1.png)

![Chart 8 Percentage site utilisation per site](image2.png)

![Chart 6 Occupied floor area usage per site](image3.png)
9.6 Care Quality Commission

The Care quality Commission (CQC) Quality Report is designed to provide judgement on the quality of care provided. It is based on findings from an inspection of the Trust, information from the CQC’s ‘Intelligent Monitoring’ system, and information from patients, the public and other organisations.

The Trust was last inspected in 2017 under the new inspection methodology and has been giving a “Requiring Improvement” rating.

During this most recent inspection the areas that required improvement from the 2014 were followed up for inspection. A wide range of data, including patient and staff surveys, hospital performance information and the views of local partner organisations was assessed. The inspection teams visited all three hospital locations (LRI, GH, and LGH).

The inspection asks the following five questions of every service and provider being inspected:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well led?

The 2017 inspection was led by:

- Chair: Judith Gillow, Non-Executive Director of an Acute Trust and Senior Nurse advisor to Health Education Wessex.
- Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a consultant surgeon, a medical consultant, registered nurses, allied health professionals, midwives and junior doctors.

These were also supported by two experts by experience that had personal experience of using, or caring for someone who used the type of service being inspected.

The latest CQC inspection for the Trust, published in January 2017, found that The Trust ‘requires improvement.’ The CQC made a number of comments on specific services, for example staffing issues with a split site Maternity service, a lack of critical care beds and the consequential cancellation of elective procedures, quality of the environment and clinical process issues in outpatient clinics. They noted that the rationalisation of the LGH site was required in order to address a number of these issues, and to maximise clinical safety and quality, minimise clinical risk, protect elective capacity, ease staffing and recruitment pressures and improve the patient journey and experience.

The below diagram shows how Trust scored across the five questions on average with an overall score also being shown:

9.7 Compliance Assessment and Analysis System

A CAAS audit was carried out in 2017. The Trust was able to answer 537 out of a possible 545, with 8 questions ignored as not applicable. This has given the Trust an average CAAS score of 3.7 out of a possible 5.0 or 74%.

However a number of priority areas for action have been identified, these are as follows:

- Mechanical Systems
- Sustainability
- Fire Safety
- Contractor Management
- Ventilation
- CAAS Action Plans.

Each of these areas is detailed with what action is required in the CAAS report.

The conclusion from the CAAS is that the CAAS system is proving to be a useful tool to measure Estates and Facilities related services against P.Is.

Levels of compliance to CAAS standards are relatively stable when compared to the last report findings. Action plans for each element of CAAS are developed to focus on continuing improvement between each reporting period.

Future recommendations from the CAAS include:

- Continue to utilise the CAAS system and report high level performance
- Map each quarterly results against the previous quarterly audit to provide a trend analysis going forward.
- Ensure that actions from CAAS are monitored and reviewed by the CAAS Administrator (Estates and Facilities Information Manager) on a quarterly basis and ensure that serious non-conformances are alerted to the Estates and Facilities Senior Management Team for review and to be forwarded for inclusion on the Trust Risk Register, as appropriate.
9.8 Premises Assurance Model (PAM)

The Premises Assurance Model (PAM) has been developed by the DoH to provide assurance for Boards on estates and facilities management on a consistent, national basis, prompting investigation and stimulating dialogue on utilisation, management and alignment with strategic objectives.

PAM involves a structured process of self-assessment questions on specific legislation or estate guidance under five domains:

- Safety (Hard and Soft FM)
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance.

The main benefits of PAM are to demonstrate robust systems are in place to assure safety of premises and associated services; provide a consistent, NHS wide basis to measure compliance; prioritise investment decisions to raise standards in the most advantageous way.

The chart to the left shows how the Trust scored on average across the five domains following the 2016/17 assessment.

It is worth noting that the Trust has been in a transitional period (reporting on the first 12 months) following the repatriation of Estates & Facilities (E&F) services back to an “in-house” service model, and this has made the 2016/17 PAM assessment period somewhat of an ‘outlier’ due to the exceptional circumstances experienced during this period.

The PAM assessment has not identified any high level concerns or risks. Some moderate risks do exist around policy gaps, resources and the lack of risk assessments and action plans in some areas i.e. the Trust’s Sustainability Development Management Plan (SDMP) and updating the Estate Strategy.

Another area identified as requiring improvement following the repatriation of outsourced E&F services back to an “in-house” service provision is the review, training and appointment of Authorised Persons and Competent Persons across the Estates Specialist Services.

This is led by externally appointed and Independent Authorising Engineers’ who have now been formally appointed by the Trust to provide guidance and assurance.

9.9 Patient-led Assessments of the Care Environment (PLACE)

PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50 per cent patient assessors.

PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment’s cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

The following locations are appraised in the assessment:

- Wards (MH/LD/Acute and Community Hospitals/Hospices/Treatment centres)
- Communal areas

The following criteria are appraised in the assessment (some are tailored to suit specific areas):

- Cleanliness
- Food
- Privacy, Dignity & Wellbeing
- Condition, Appearance & Maintenance
- Dementia
- Disability

The above results are from the PLACE assessment carried out at the Trust during May 2017, and can be summarised as:
2017 PLACE Average results

| University Hospitals of Leicester NHS Trust | 86.09 % |
| UK Average | 87.51 % |
| Difference | 1.41 % |

It is important to note that whilst the process could be considered as subjective with potential for significant variation within assessment teams and organisations, the results are reported nationally and constitute part of the Carter efficiency and quality metrics as well as being utilised by NHS Improvement as a measure of quality and performance.

Overall the results from the latest PLACE are promising with particularly strong results and improvements in ‘Cleanliness’ and ‘Food & Hydration’.

This year’s scores show that ‘cleanliness’ scores for each hospital have improved in comparison to previous years. ‘Condition & Appearance’ also improved although there is still a requirement for ongoing investment into ward refurbishment and in particular public toilet areas.

GH in particular scored 98.69% on cleanliness which was above the national average. Other impressive scores were recorded in ‘Food & Hydration’ at LRI and in ‘Disability’ and ‘Dementia’ at GH (in comparison to the national averages).

LGH scored lower than the national average in four of the six categories, although there was improvement across all areas, LGH is still falling short in the PLACE assessment compared to the national average.

9.10 Sustainability

The Trust has made considerable progress in recent years through a series of internal initiatives and improvement schemes toward environmental and sustainability performance improvements.

Following the most recent PAM assessment a Sustainability Development Management Plan (SDMP) has been prepared for the Trust.

The SDMP sets out the Trust’s commitment to supporting and implementing sustainability across a wide and diverse range of services and procurement initiatives.

The plan outlines the main projects that have been designed to provide the necessary deliverables required to implement an effective sustainable environment and foundation for our future, ensuring our quality commitment to “providing a sustainable, safe and welcoming environment from where clinical care of the highest standard can be delivered”.

To oversee implementation a Chair has been appointed to represent the Energy and Sustainability Groups which has been established by the Estates and Facilities Technical Compliance Team and this forum will provide Technical and Statutory Compliance guidance in support of our Sustainability Strategy.

The Technical Compliance Team have advised and promoted elements of sustainability, to ensure that all new projects, new works and refurbishments incorporate the most effective “Low Carbon Technology” available within limited resources.

We completed the various Statutory Annual Reports as listed below at the required time and are on target for the 2017 deadline for submitting the next set of returns.

- Estates Return Information Collection (ERIC)
- Premises Assurance Model Report (PAM)
- European Union Emissions Trading Scheme (EUETS)
- Carbon Reduction Commitment (CRC)
- Combined Heat & Power Quality Assurance (CHPQA).

### Energy and Sustainability Projects

During 2016/17 the Estates and Facilities have successfully built/refurbished and commissioned the following which have all included the use of “Low Carbon Technology” and the incorporation energy efficient management strategies, inclusive of LED, Variable Speed drives, High efficiency Pumps and Motors, Building Management Systems, insulation, boilers and general application of good working practices and good housekeeping. Key projects included:

- New Emergency Department Floor (A&E) - (LRI)
- Refurbishment of Theatre Recovery with additional bed bays to enhance activity performance (LRI) & (GH)
- New Hybrid Theatre (GH) and General Refurbishment/ upgrade to the Theatres (LRI)
- Remodel of Ward 23 to a new stage of the art Vascular Investigation and treatment Unit (GH)
- Remodel of an area to provide another state of the art Angiology Unit (GH)
- Various LED Lighting schemes (LGH).

This period the new Combined Heat & Power (CHP) units have improved their availability as they have been fine tuned to the sites demand:

<table>
<thead>
<tr>
<th>Feb 16 - Jan 17 12 months</th>
<th>Leicester Royal Infirmary</th>
<th>Glenfield Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHP gas used</td>
<td>28,277,817</td>
<td>14,805,964</td>
<td>43,083,781</td>
</tr>
<tr>
<td>CHP Elec Generated</td>
<td>12,592,641</td>
<td>5,670,067</td>
<td>18,262,708</td>
</tr>
<tr>
<td>CHP Heat Generated</td>
<td>7,658,900</td>
<td>5,846,100</td>
<td>13,505,000</td>
</tr>
<tr>
<td>Est. CO2 Saving</td>
<td>2,721</td>
<td>1,394</td>
<td>4,116</td>
</tr>
<tr>
<td>hours run</td>
<td>7,855</td>
<td>7,426</td>
<td>15,281</td>
</tr>
<tr>
<td>Est. Cost Saving</td>
<td>£472,193</td>
<td>£228,433</td>
<td>£700,626</td>
</tr>
</tbody>
</table>

Table 3 CHP Statistics

**40**
9.11 Site Infrastructure

Between 2016 and 2017 the Trust commissioned Capita Engineering to review the infrastructure requirements of the Trust in relation to capacity to support reconfiguration, adherence to compliance with statutory regulation, mandatory requirements and best practice, condition and resilience.

To this end a project group was established to analyse the Capita Engineering reports and develop an investment strategy to deliver safe, sustainable, resilient and compliant services supporting the 5 year plan and beyond.

High level summary of report recommendations

The table below details the main recommendations of the report. It also identifies the category of the investment i.e. Reconfiguration or condition etc. along with a high level cost estimates for the work.

All costs include an estimate of cost associated with design, project management fees, civil works and VAT. A summary of the cost is listed below:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Reconfig.</th>
<th>Condition</th>
<th>Compliance</th>
<th>Resilience</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRI</td>
<td>£3,780,000</td>
<td>£6,930,000</td>
<td>£588,000</td>
<td>£5,740,000</td>
<td>£17,038,000</td>
</tr>
<tr>
<td>GH</td>
<td>£10,696,000</td>
<td>£1,148,000</td>
<td>£560,000</td>
<td>£588,000</td>
<td>£12,184,000</td>
</tr>
<tr>
<td>Total</td>
<td>£14,476,000</td>
<td>£8,078,000</td>
<td>£1,148,000</td>
<td>£6,290,000</td>
<td>£29,222,000</td>
</tr>
</tbody>
</table>

Table 4 Investment Categories by Hospital

Description of costs:

- **Reconfiguration** – site infrastructure improvement works associated with the reconfiguration programme to address any infrastructure investments required within the curtilage of the development.
- **Condition** – costs to improve the condition of site infrastructure assets that are significantly beyond their life expectancy.
- **Compliance** – costs to overhaul non-compliant systems, assets and processes.
- **Resilience** – costs to improve and maintain building resilience in the event of key plant failure or the loss of incoming utility supply such as gas, electricity or water.

Unknowns and additional scope

The Capita report identifies a number of actions which cannot be costed at this stage. The most significant unknown is the cost of increasing the amount of electrical supply that we can take from the national grid network. It is likely that the Trust will be required to contribute financially to the cost of installing new cables to their primary substations. This issue relates to both LRI and GH.

The most significant cost is likely to be at GH where the local substations are believed to be at or near maximum capacity. Substations are located in Groby, Enderby and Beaumont Leys.

New external network cables involve extensive civil works, digging up public roads and footpaths. The estimated cost of such installations is c. £1m per mile. As part of the work of the project group we are applying for an increase in our authorised supply capacity. This will lead to clarity relating to potential cost to the Trust.

The scope of the work undertaken by Capita Engineering was limited to site distribution networks. This means that the distribution around particular buildings is not included. The project group has decided that distribution around key buildings will be brought into scope. For example Balmoral Building will house the Children’s Hospital but the current electrical distribution system does not allow for safe isolation or connection of electrical loads without isolating the whole building including Theatres and ICU. The project group will develop plans to install a new distribution system as an enabler for the Children’s hospital project.

Investment priorities

The value of the infrastructure business case is likely to be circa £30m. At the time of writing, capital availability is very limited. The current draft capital plan for 2017/18 allows £900k for reconfiguration infrastructure and £500k for condition and compliance. On this basis the following actions will be prioritised:

**Reconfiguration**

The priority will be to provide the infrastructure to enable the move of East Midlands Congenital Heart Centre to the LRI by December 2018. This will involve providing electrical and medical gas supplies for 3 theatres, a PICU, a cardiac ward and a MRI facility.

**Condition**

Issues relating to condition of existing plant equipment and distribution networks often represent the biggest risk to business continuity. In the last 12 months strategic investments in main boiler house equipment supplying heating and hot water to LRI and distribution of chilled water to the operating theatres have been brought forward due to catastrophic failures. It is therefore important to prioritise foreseeable risk due to poor condition.

To this end investments are planned in electrical infrastructure and the provision of medical air at the Leicester Royal Infirmary.

Infrastructure Review - Next Stage

Whilst there are a number of items categorised as ‘red’ in the survey the engineers have noted that immediate replacement of equipment that has gone beyond the recommended life expectancy is not necessary, as the equipment has been well maintained.

In addition where load information is not available due to limited data, recommendations have been made for further metering and/or testing.

The following areas of work will therefore need to be developed at the next stage of the infrastructure:

- Carry out approximate assessment of new mechanical and electrical load requirements for the DCP developments to understand overall increase in site requirements based on rules of thumb.
- Assess the impact of the proposed developments and identify the future load growth pattern.
- Overlay the DCP onto the current load to identify the impact of the proposed development on the existing infrastructure.
- Provide high level upgrade proposals and/or options required to cater for the DCP developments with proposed time lines.
- Where necessary lodge enquiries with Distribution Network Operator (DNO) to understand the extent of DNO infrastructure reinforcement/enhancement works required by DNO.
- Discuss and review incoming gas, water and electrical supply capacities with local utilities/shippers in relation to the development plan.
- Assessment of all medical gas systems as set out in separate Medical Gas Services Report. Works to be carried out by Medical Gas specialist appointed by the Trust.
9.12 Key Estate Performance Indicators

These Performance Indicators (P.I.s) are produced using combined information from NHS Digital including Estates Returns Information Collection (ERIC), DoH Finance data collection and other information sources. A summary of the P.I.s is provided below:

Performance Indicators 2015/16
The P.I.s illustrate the percentile grouping for other Trusts within the Acute Teaching cluster. This allows a direct comparison between the Trust’s performance and that of comparable Trusts.

P.I.s in Green indicate limited or no problems, Amber P.I.s show minor problems while Red P.I.s indicate some concerns.

From this table you can see the sporadic performance of the Trust, with good performance across the ‘Effectiveness – Productivity’ theme which focuses in on space utilisation, and with poor performance across the ‘Quality – Patient experience’ theme.

This illustrates and reinforces the need for improvement and investment across the Trust estate.

Future Performance Management of the Estate
Each P.I and its derivative ERIC data will be reviewed in detail and an action plan devised to improve the relevant performance factor within the Estate Strategy and the overall objectives of the Estate Strategy Vision.

The various and disparate performance measures involved in the management of the Estate are to be reviewed, standardised and made more relevant to our future estate.

The measures will include, among other things:

- The existing ERIC P.Is (probably modified as noted above)
- Level of Maintenance requests/defects outstanding on a monthly basis
- Progress against Sustainability Management Implementation Plan
- Number of projects completed to time and cost
- Number of post project evaluations, stage reached, feedback given.

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Unit</th>
<th>Trust Metric</th>
<th>2015-16 QUARTILES FOR ACUTE - TEACHING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1 - Efficiency - Cost</td>
<td>£/m²</td>
<td>389.02</td>
<td>173.78, 276.92, 337.50, 398.38, 679.46</td>
</tr>
<tr>
<td>Domain 2 - Effectiveness - Productivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of empty space</td>
<td>%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Amount of underutilised space</td>
<td>%</td>
<td>0</td>
<td>9.20%</td>
</tr>
<tr>
<td>Amount of non-clinical space</td>
<td>%</td>
<td>80.50%</td>
<td>23.12</td>
</tr>
<tr>
<td>Total income earned per area</td>
<td>£/m²</td>
<td>3,387</td>
<td>3,448</td>
</tr>
<tr>
<td>Domain 3 - Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported Critical Infrastructure Risk (CIR) Area</td>
<td>£/m²</td>
<td>27.53</td>
<td>34.69</td>
</tr>
<tr>
<td>Domain 4a - Quality - Patient Environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition, Appearance and Maintenance</td>
<td>%</td>
<td>80.30%</td>
<td>88.93</td>
</tr>
<tr>
<td>Privacy, Dignity, Wellbeing</td>
<td>%</td>
<td>75.04%</td>
<td>78.16</td>
</tr>
<tr>
<td>Condition, Appearance and Maintenance</td>
<td>%</td>
<td>80.23%</td>
<td>88.83</td>
</tr>
<tr>
<td>Domain 4b - Quality - Infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total reported backlog maintenance</td>
<td>£/m²</td>
<td>294.67</td>
<td>234.39</td>
</tr>
<tr>
<td>Amount of functionally suitable space</td>
<td>%</td>
<td>90.85%</td>
<td>89.8</td>
</tr>
<tr>
<td>Domain 5 - Organisation Governance &amp; Processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital investment required to eliminate CAF</td>
<td>£</td>
<td>7,039,684</td>
<td>7,103,162</td>
</tr>
<tr>
<td>Capital investment required to eliminate backlog</td>
<td>£</td>
<td>7,530,480</td>
<td>7,743,332</td>
</tr>
</tbody>
</table>

Table 5 KPI Scores for UHL
9.13 Trust Performance in Comparison to other Trusts

This section summarises the Trust estate backlog in comparison to other Trusts. The below graphs outline performance of 21 Trusts across the country (including the Trust) and these are split up into 4 different categories of backlog in order of severity (Low risk/Moderate risk/Significant risk/High risk).

Low risk
The Trust is amongst the poorest performing Trusts regarding the level of low risk backlog maintenance required. The total amount the Trust has forecast for low risk backlog maintenance is £31,095,499, this is amongst the 3 worst performing Trusts behind Barts & The London (£41,019,415) and Addenbrookes (£56,092,862). The best performing Trust in this section was Pennine who only had a low risk backlog cost of £142,000 followed closely by Guy's & St Thomas with £349,824.

Chart 8 Low Risk Backlog

Moderate Risk
The Trust is the worst performing Trust of those recorded. The Trust’s total amount of moderate risk backlog amounts to £37,055,255 this is considerably more than the next poorest performing Trust which is Barts & The London that has a moderate risk backlog of £31,474,296. The best performing Trust is again Pennine.

Chart 9 Moderate Risk Backlog

Significant Risk
The Trust performs a lot better in this category of backlog maintenance than it did in low and moderate risk, the total amount forecast for significant backlog maintenance at the Trust is £6,199,622, The Trust is also a lot closer to the best performing Trusts rather than the worst performing (best performing Uni. Birmingham £1,092,000 / worst performing Imperial £346,949,532).

Chart 10 Significant Risk Backlog

High Risk
The Trust is in the best performing half of Trusts that had their high risk backlog recorded, the total amount of high risk backlog forecast for the Trust is £840,062, the best performing Trust for high risk backlog was South Manchester (£343,398) with the worst being Imperial (£320,950,051) followed by Barts & The London (£28,559,026).

Chart 11 High Risk Backlog
### 9.14 Estate Occupancy Costs

This section focuses on Occupancy Costs and aims to compare how the Trust performed during 2016/17 in relation to comparable Trusts (i.e. those within the All Acute Teaching Trust category).

The Median is the midpoint of all comparable Trusts and gives a high level indication of areas of improvement as well as highlighting categories where the Trust is currently performing well.

The information contained within this section is obtained from ERIC data 2016/17.

<table>
<thead>
<tr>
<th>Description</th>
<th>Median</th>
<th>The Trust</th>
<th>LRI</th>
<th>GH</th>
<th>LGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy £/m²</td>
<td>£26.22</td>
<td>£22.04</td>
<td>£22.67</td>
<td>£16.56</td>
<td>£26.38</td>
</tr>
<tr>
<td>Water / Sewerage £/m²</td>
<td>£2.55</td>
<td>£3.90</td>
<td>£3.59</td>
<td>£3.21</td>
<td>£4.89</td>
</tr>
<tr>
<td>Waste £/m²</td>
<td>£3.24</td>
<td>£3.96</td>
<td>£4.74</td>
<td>£3.07</td>
<td>£3.55</td>
</tr>
<tr>
<td>Maintenance £/m²</td>
<td>£29.89</td>
<td>£50.98</td>
<td>£42.55</td>
<td>£59.13</td>
<td>£56.90</td>
</tr>
<tr>
<td>Grounds / Gardens £/m²</td>
<td>£0.68</td>
<td>£1.02</td>
<td>£0.11</td>
<td>£1.81</td>
<td>£1.74</td>
</tr>
<tr>
<td>Cleaning £/m²</td>
<td>£36.14</td>
<td>£29.65</td>
<td>£37.26</td>
<td>£20.58</td>
<td>£26.00</td>
</tr>
<tr>
<td>Operations £/m²</td>
<td>£98.82</td>
<td>£111.55</td>
<td>£110.93</td>
<td>£104.36</td>
<td>£119.45</td>
</tr>
</tbody>
</table>

Table 6 Estate occupancy costs

Similarly to the ERIC PIs, the Trust performs sporadically against the median benchmark.

The two data sets that are below the Median are Energy and Cleaning costs, whereas the other 5 datasets are above the median, illustrating real scope for performance improvement.

Figures derived from the Trust’s NHS Trust ERIC Report 16/17.
9.15 Estates and Facilities Capital Plan

The Trust faces a number of challenges and competing priorities when allocating estates capital funds.

There is a need to balance expenditure on condition and compliance issues with qualitative issues around the patient environment. Investments fall into the following categories:

- Contractual / Pre-commitments
- Statutory Compliance
- General Compliance
- Business Risk
- Strategic Schemes
- Schemes Driving Revenue Savings
- Other investments.

Whilst it would appear obvious to only invest in the highest risk issues account needs to be taken of the practicalities in terms of access and the need to avoid negative effects on other parts of the business such as the quality of the patient experience and return on investment.

The capital investment plan has been informed by the Estates & Facilities risk review process.

Analysis of 5 Year Capital Plan Costs

Total estimated backlog capital plan cost from initial plan to 2023 is forecast at £62,821,000.

The table shows the forecast spend on backlog over the next 5 years.

The largest proportion of the cost is to be spent on Business Risk/Safe Maintenance with a total of £23,656,000, followed by statutory risk with a total of £17,640,000.

Over the next 5 years spend capital spend will peak at £10,940,000 per annum in 2020/21, falling to £7,090,000 in 2022/23 and 2023/24.

<table>
<thead>
<tr>
<th>Cost Type</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>21/22</th>
<th>22/23</th>
<th>23/24</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual Risk / pre-committed</td>
<td>200</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>Statutory Risk</td>
<td>3,370</td>
<td>3,600</td>
<td>2,800</td>
<td>2,690</td>
<td>2,590</td>
<td>2,590</td>
<td>17,640</td>
</tr>
<tr>
<td>Mandatory / General Compliance</td>
<td>1,880</td>
<td>2,000</td>
<td>2,000</td>
<td>1,460</td>
<td>1,460</td>
<td>1,460</td>
<td>10,200</td>
</tr>
<tr>
<td>Business Risk</td>
<td>3,833</td>
<td>4,183</td>
<td>5,600</td>
<td>4,400</td>
<td>2,820</td>
<td>2,820</td>
<td>23,656</td>
</tr>
<tr>
<td>Strategic priority</td>
<td>500</td>
<td>500</td>
<td>540</td>
<td>220</td>
<td>220</td>
<td>220</td>
<td>2,200</td>
</tr>
<tr>
<td>Schemes driving revenue benefit</td>
<td>125</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>125</td>
</tr>
<tr>
<td>Aseptic Suite</td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>URI Mortuary</td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Sub-total - Estates and Facilities</td>
<td>10,508</td>
<td>10,283</td>
<td>10,940</td>
<td>9,710</td>
<td>7,090</td>
<td>7,090</td>
<td>55,021</td>
</tr>
<tr>
<td>MEU Installation Costs</td>
<td>1,900</td>
<td>1,500</td>
<td>1,500</td>
<td>900</td>
<td>900</td>
<td>900</td>
<td>7,800</td>
</tr>
<tr>
<td>Grand Total</td>
<td>12,408</td>
<td>11,783</td>
<td>12,440</td>
<td>9,610</td>
<td>7,990</td>
<td>7,990</td>
<td>62,821</td>
</tr>
</tbody>
</table>

Table 8 Forecast backlog spend

There is a need to balance expenditure based on condition, risk and compliance issues with qualitative issues around the patient environment. The Trust’s proposed capital plan between 18/19 and 22/23 stands at £62.8m.
9.16 Risk Management

Estates & Facilities have taken a "strategic and proactive" approach to risk management moving away from a tactical and fear driven approach.

The output of this approach is twofold. Firstly, it is to identify and prioritise risks to allow them to be escalated, where appropriate, onto the Trust’s Datix risk register. Risks scoring 15 or above are captured on a monthly basis by the Trust Risk management Team and are reported to the Trust Executive Team. The Trust Board receive quarterly reports of new and existing risks scoring 15 and above.

The second element of this twofold approach to Estates & Facilities risk management is to inform the Trust’s capital plan by utilising a risk based approach for prioritising capital investment. Estates & Facilities have developed a weighted scoring system across a range of performance and strategic elements to refine priorities where there are a number of risks scored at similar levels using the Trust’s 5 x 5 scoring matrix.

This approach supersedes the previous approach that was mainly based on the findings from a 6 facet survey carried out in 2012/13 and subjective input from managers.

Estates & Facilities Risk Management Process

Each month a multi-disciplinary Estates & Facilities Capital Risk Management Group meet to review new and existing risks. This allows representatives to identify, review and score each risk and provide a consistent approach to Estates & Facilities risk management.

Risks are identified using a number of subjective and objective tools, including:

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Fears and concerns</td>
<td>▪ Performance data, estate and equipment intelligence</td>
</tr>
<tr>
<td>▪ Observations and perceptions</td>
<td>▪ Operational services, risk assessments and business continuity plans.</td>
</tr>
<tr>
<td>▪ Local tactical understandings</td>
<td>▪ Compliance Assessment &amp; Analysis System (CAAS), Department of Health Premises Assurance Model (PAM) and audit findings.</td>
</tr>
<tr>
<td>▪</td>
<td>▪ Independent specialist reports.</td>
</tr>
<tr>
<td>▪</td>
<td>▪ Incidents, alerts and notifications.</td>
</tr>
<tr>
<td>▪</td>
<td>▪ Alignment to Trust objectives and strategic plans.</td>
</tr>
</tbody>
</table>

The Estates & Facilities risk management process has been transformed by implementing the following process:

1. Trust Risk Management Assessment form completed by risk owner.
2. If scoring 15 or above is achieved the risk assessment form is sent to the line manager.
3. The line manager reviews the risk assessment and forwards it to the Statutory Compliance Manager for review at the monthly Estates & Facilities Capital Risk Management Group and for inclusion on the E&F risk register. Each risk is categorised as a ‘theme’ as indicated in figure 1; current E&F risks 15 and above mapped against themes.
4. Relevant Risks scoring 15 or above are sent to the Estates & Facilities Senior Management Team (SMT) for review. Approved risks are then ‘signed-off’ by SMT for inclusion on the Trust Datix risk register.
5. The Statutory Compliance Manager will upload the risk into the Datix risk register module and co-ordinate the reviews until the risk is closed.
6. Risks put on the Datix Risk Register scoring 15 or above are captured by the Trust’s Risk Management team. A monthly report is produced for distribution to CMG/Corporate Management Group leads and the Trust Executive Team. This process supports the ‘closed loop’ reporting methodology highlighted in figure 2.
7. For risks considered to present 'serious or imminent' danger, the risk review process can be fast tracked by presenting a completed risk assessment form to a member of the Estates & Facilities SMT.

When 15 and above risks are put onto the Trust’s Datix risk register, they are independently monitored by the Trust’s Risk Management team and are visible up to Board level through the Trust’s established risk and assurance governance procedures.

Estates & Facilities will continue maintain their own risk register, as many of the 300+ risks are in effect, sub-risks of the ones put onto the Trust Datix risk register.

In addition, the Estates & Facilities risk register is able to refine and prioritise risk using the unique scoring system in the table below. Each element has a weighting and can be scored between 1 and 5.

The example below shows the total score (205) if all elements are scored a maximum of 5.

| Safety Risk to Patients | 5 |
| Safety risk to staff | 5 |
| Statutory compliance | 5 |
| Functional suitability | 5 |
| Carter compliance | 5 |
| Quality standards | 5 |
| Environmental improvements | 5 |
| Physical condition | 5 |
| National requirements (CQC/PLACE) | 5 |
| Revenue cost benefits | 5 |
| Business risk - financial | 5 |
| Business risk - continuity | 5 |
| Limited life investment | 5 |
| Critical infrastructure | 5 |
| Corporate objective | 5 |

**Weighted score** 205

*Table 9 Example of Trust risk register*
### Current risks 15 and above mapped against themes:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Description</th>
<th>Risk Escalation Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>Clinical Strategy</td>
<td>Five Year Plan</td>
<td>Trust Board</td>
</tr>
<tr>
<td>C</td>
<td>Capital Development</td>
<td>Financial Position</td>
<td>EQB/EPB/Exec. Team</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td></td>
<td>Feedback Loop</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
<td>UHL Risk Management</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10 Current Trust risks

### Risk Escalation Process

1. **IDENTIFY IMPACTS**
   - STP
   - Clinical Strategy
   - Five Year Plan
   - Backlog
   - Capital Development
   - Financial Position

2. **ESTATES & FACILITIES RISK REGISTER (escalate if 15 or above)**
3. **RISK ASSESSMENT (escalate if 15 or above)**

Table 11 Risk themes
Where do we want to be?

Introduction

In the next five years, the Trust will become an internationally renowned Trust known for placing quality, safety and innovation at the heart of service provision. Specialist services, research and teaching will be developed and built upon to offer faster access to high quality care, provision of experienced staff, all resulting in an improved patient experience.

Overall, the Trust estate will become more efficient and more specialised with more non-urgent care delivered in the community. We will deliver responsive multi-disciplinary consultant-led clinical services 7 days a week providing high quality services in a financially affordable and sustainable way. We will play a leading role in ensuring the rapid translation of research and innovation into services which will benefit our patients and the wider population.

As a member of the LLR Estates Forum, the Trust will work in partnership with other NHS providers to develop and provide truly pioneering, integrated services for elective care across Leicestershire, ensuring that care pathways are seamless across health and social care agencies, reflect best practice, deliver care closer to home in the most appropriate setting and improve patient experience and access.

As a result of centralising and specialising services, we will improve quality, safety and the hospital experience for our patients from the time they park their car to the moment they leave; we will be recognised for our low mortality rates, for low waiting times and for patients’ rating the care they receive as excellent.

We will save money by no longer supporting old, expensive and underutilised estate. This will enable us to make a cash surplus as a viable Trust at the end of each year which we will use to fund improvements to our existing services and the creation of new, innovative services supported by research and development.

Objectives of the Estate Strategy

The strategic direction for estates is to act as an enabler of the Trust’s clinical strategy. The objectives of this Estate Strategy are therefore to:

- **Service Performance** – a primary objective is to ensure that the Trust estate supports, underpins and enables optimum operational performance
- **Quality of Estate** – the Trust premises should be fit for purpose and functionally suitable and with appropriate and effective maintenance arrangements to meet the required standards.
- **Enhancing the patient experience** – to support clinical delivery we aim to provide state of the art facilities that enable clinicians to deliver treatment in a comfortable, caring, safe and uplifting environment, which enhances patient experience.
- **Effectiveness** – the estate will be utilised to its maximum and have appropriate measures in place to ensure business resilience and continuity
- **Equity and Diversity** – the Trust estate must provide facilities that are appropriate and respect the values of equality and diversity to patients, staff, visitors and all others likely to use or visit Trust premises
- **Health & Safety** – the estates will provide a safe environment to high standards of Health & Safety and statutory compliance
- **Environmental** – ensuring that our estate embraces the sustainability agenda and that new developments and refurbishment projects employ sustainable methods and techniques, making use of low and renewable energy sources and improving the energy efficiency of the existing building stock where feasible
- **Value for Money** – ensuring that all estate and facilities provision offers the best value for money
- **Partnerships and stakeholders** – working with our public sector partners and key stakeholders we will ensure we deliver a cohesive approach to strategic estate management through our investment and disinvestment programmes
- **Staff Welfare** – the Trust will endeavour to provide, in all its estate provision, fit for purpose and cost-effective facilities and amenities for staff.

- **Capital receipts** - assets are retained or disposed of according to a plan that supports service delivery and enables business development opportunities, whilst also maximising cash receipts and thereby generating funds for investment.

Where Do We Want To Be – Critical Success Factors

Below we have listed a set of critical success factors to support investment decisions, and include:

- Delivering the reconfiguration programme by transforming our acute sites
- Disposing of the least appropriate estate to realise proceeds for investment in improving quality
- Reconfiguring the estate to enable transformed services to be delivered from appropriately located, cost effective sites
- Reducing non compliance
- Reducing backlog maintenance
- Embedding sustainable resource use through a whole life cycle approach to planning and capital development
- Improving continuity in procurement of business technology systems and solutions for data storage, access and communications on capital projects
- Improving space utilisation through service consolidation, functional patient and staff flows and agile working to increase efficiency and value for money.

Aligning the estate with the LLR STP requires full engagement with partners

Full engagement with the LLR Estates Forum is vitally important to ensure strategies are aligned and service users’ requirements are clearly articulated in developments emerging from the LLR STP.

The aim of the Estate Strategy is to enable implementation of the Clinical Strategy by providing a robust framework to guide future estate investment decision making and to support the delivery of the STP priority strands.
10.1 Corporate & Clinical Strategy
Implications for the Estate

The Trust reconfiguration programme is consistent with the LLR STP and
the Trust’s Clinical Strategy. The reconfiguration programme forms an
integral part of the LLR STP plans to reach financial and clinical
sustainability from April 2023.

Key to the success of the STP in LLR is that all public estate is utilised to
its potential to provide a joined up approach to seven day clinical services.
This principle of estate utilisation, which broadens into co-design of
integrated health and social care services, benefits all health and social
care partners.

In addition to the Trust’s focus on the acute estate, the three CCGs in LLR
have been proactive in developing robust primary care estate plans. In
2016 up to £7 million for 11 projects was secured which will be delivered
over the next four years. As part of this process the CCGs were required to
agree the revenue investment required for each project which has been
factored into the financial plans for each CCG.

Partner Support

The reconfiguration programme has been well socialised with
commissioners, patients and the public. The Trust’s 5 year plan was
published in 2015 and again in 2016/17, and the clinical services strategy
in the 5 year plan clearly describe the intention, subject to consultation,
to focus acute services at the LRI and GH, with the LGH retaining diabetes
services and other Leicestershire Partnership NHS Trust services.

The STP, which articulates inter alia the Trust’s reconfiguration
programme, was signed off unanimously by all five NHS Boards (The
Trust, Leicester Partnership NHS Trust, East Leicestershire and Rutland
CCG, West Leicestershire CCG and Leicester City CCG) at a joint meeting
in September 2016. Toby Sanders, STP Lead, has provided the following
statement of support:

“The Trust capital plan has been developed to support the delivery
of both the Trust’s Clinical Strategy and the LLR STP. The
requirement for capital comes from the significant and sustained
underinvestment in the Trust’s acute estate, the need to support
clinical sustainability, improve quality of care for patients and to
deliver an effective and affordable service. Since the submission of
the draft STP in November 2016, LLR has taken the opportunity to
review its bed assumptions set out in the draft STP; as a result
this has increased the residual bed requirement. This capital plan
reflects the changes to those bed assumptions. Given the
alignment of the capital plan to the STP there is support from all
partners of the STP, including commissioner support.”

Consultation

Patient and Public Involvement (PPI) groups have been widely involved in
the development of the reconfiguration plans and at a system leadership
level. A number of public engagement events have been held and the
programme has been presented to the Health and Wellbeing Boards and
Overview & Scrutiny Committees. No immediate adverse reaction has
been given ahead of the formal public consultation.

Whilst a significant quantity of public engagement has been undertaken,
the STP strand entitled ‘Service configuration to ensure clinical and
financial sustainability’ is still subject to and dependent on the outcome of
formal public consultation. It has been agreed by the STP System
Leadership Team that LLR will consult on the Trust service reconfiguration
separately to the consultation for community hospital provision. The Trust
consultation will include the consolidation of acute care onto mainly two
hospital sites (LRI & GH), consolidation of acute maternity provision onto
one site (LRI) and subject to preferences expressed during consultation,
provision of a standalone Birth Centre at the LGH.

Once this is complete we are confident that, subject to NHS England
support, we will be in a position to move to formal public consultation on
the service reconfiguration decisions regarding new pathways and models
care.

If the outcome of consultation is not supportive, this could either delay
the programme or require us to develop an alternative plan. This is
however not felt to be likely on the basis of pre-consultation engagement
to date.

10.2 Reconfiguration Plans

The current, three acute site configuration is an accident of history, not
design, and is suboptimal in clinical, performance and financial terms,
which has a direct impact on patient outcomes and experience.

Reconfiguration Model

This results in duplication, sometimes triplication of services, which is an
inefficient model. Clinical resources are therefore spread too thinly making
services operationally unstable. Many planned, elective and outpatient
services currently run alongside emergency services and as a result when
emergency pressures increase, it is elective patients who suffer delays
and last minute cancellations.

Over the last two decades there has been sustained under-investment in
the Trust’s acute estate relative to other acute hospitals across the UK.
There is a significant backlog maintenance requirement which will be
reduced substantially through the reconfiguration programme and
consolidation of services onto mainly, two sites and a change of use for
LGH.

Consultation

Evidence indicates that patients, and particularly elderly patients, spend
too long recovering in large acute hospitals and potentially deteriorating
as a result, when they would be better served by rehabilitation services in
their own home or in a community hospital. A “Home First” principle will
be adopted where there is an integrated care offer for people living with
frailty and complex needs. The focus will be to ensure that people can
remain in their own homes. When this is not possible and they have to be
treated in hospital, it will be ensured that their discharge is appropriately

Figure 14-Reconfiguration Programme
planned to enable them to get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

The combination of providing care for patients closer to home, and the consolidation of acute services onto two sites will allow a focus on growing The Trust’s specialised, teaching and research portfolio.

Through the Better Care Together and Better Care Fund programme progress has already been made on this, including the development of home based beds and integrated health and social care teams supporting patients in their home. This work will be continued through the proposals around integrated place based teams. Although shifting the balance of care in the system is one of the important drivers behind the acute reconfiguration plans, they are also driven by two other factors.

- **Clinical resources are spread too thinly, making services operationally unstable.** By focussing resources on two sites, outcomes for patients can be improved through increased consultant presence and earlier regular senior clinical decision making;
- **The Trust’s financial recovery is directly linked to site consolidation.** The “reconfiguration dividend” has been calculated at circa £25m per annum recurrent savings, which is the "structural" element of the current deficit.

**Future Bed Model**

In order to consider the impact of the above interventions and the associated planned efficiencies, work has been undertaken to understand the future acute bed capacity requirements.

The following bed bridge describes the outcome of this modelling which will take acute beds from the current level of 1975 to 2048 by 2020/21:

**STP Progress to date**

The STP submission in November 2016 reflected a reduction of 243 acute beds in The Trust, resulting in a future bed base of 1697.

In response to feedback (1st February 2017) from the NHS England Director of Commissioning Operations and the NHS Improvement Portfolio Director, LLR have reviewed the reconfiguration plans that deliver new models of care in order to validate the number of beds needed in the acute sector.

The scale of reduction has been moderated: detailed analysis by work stream leads on interventions in relation to the new ‘care test’ has resulted in an increase in beds required in the acute sector above that stated in the November 2016 STP.

Whilst this still represents an ambitious programme of transformation with intervention in the community to prevent admission, it is more realistic.

We anticipate increasing its existing bed base by 73 beds (4%), whilst negating the anticipated increase required to accommodate growth until 2020/21 (208 beds).

Through new ways of working and with a new service configuration, we will mitigate against the growth of 208 acute beds by 2020/21:

<table>
<thead>
<tr>
<th>Scheme of Work</th>
<th>Equivalent Reduction in Day Case Beds</th>
<th>Equivalent Reduction in Inpatient Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Length of Stay efficiency</td>
<td>-</td>
<td>134</td>
</tr>
<tr>
<td>Prevent 4,000 avoidable admissions through integrated discharge teams across the STP</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>Reduce elective demand</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Provide more planned elective work in the community with partners</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td>Total Equivalent Bed Reduction</td>
<td>22</td>
<td>186</td>
</tr>
<tr>
<td></td>
<td></td>
<td>208</td>
</tr>
</tbody>
</table>

**Table 12 Reduction in bed utilisation**

Consolidation onto two acute sites is still essential to deliver the Clinical Strategy, whilst enabling the disposal of the majority of the LGH site which is directly linked to financial recovery.

The “reconfiguration dividend” is calculated at **£24.5m** per annum recurrent savings, accounting for the structural element of The Trust’s current deficit.
10.3 Enabling Projects

Below we provide a summary of a number of enabling projects that will support the delivery of the reconfiguration programme, and in turn help to realise both financial and transformational benefits in-line with the objectives of the Estate Strategy.

10.3.1 Corporate Services Review

The Trust’s Corporate Services are configured into nine Corporate Directorates with an additional separate Directorate for Estates and Facilities.

This structure has evolved over time; Corporate Services have become fragmented with duplication, inefficiency and missed opportunities for greater productivity characterising service delivery.

The Trust cannot deliver high quality care for its patients and a professionally fulfilling environment for its staff without the high performing strategic enablement and transactional interfaces that Corporate Services can collectively provide. The current structure can be described as a traditional public service model with few, if any, true shared services components.

The principal project deliverables of the Corporate Services Review include the development and delivery of a Corporate Services function that is both affordable and ‘Fit for the Future’, and includes:

- Clear vision and shared purpose for Corporate Services aligned and integrated to the Trust strategy.
- Improvement of workforce engagement, recruitment and retention amongst Corporate Services staff.
- An efficient, agile working environment across all Corporate Services supported by appropriate leadership, culture shift, and technology to meet customer requirements.
- Opportunity for Corporate Services to diversify revenue streams with commercial activity and potential for growth.
- Delivery of the Trust apportioned contribution to LLR STP 2017/18 back office savings of £577,000.
- Delivery of the Trust 2017/18 Corporate Services supplementary CIP savings of £606,000.

The key drivers for the project include:

- Cost and efficiency savings for the Trust across each service area/line – for 2017/18 transformation, PYE CIP savings of £606,000 are required in addition to savings already identified for 2017/18 by each service area. It is likely that year on year CIP savings will be required and thus transformational change will become the only way to deliver Corporate Services that will be ‘Fit for the Future’.
- Transformation and realignment of the services to better support and enable the Trust’s target Operating Model and key priorities for the future
- Collaboration with STP partners to enable and support the wider system, as well as reduce running costs of the ‘back office’ – options for collaboration and/or shared services will be explored.
- The LLR STP includes projected savings for The Trust of £577,000 per annum of a combined LLR total of £750,000 per annum.
- The Trust’s contribution should not be delivered in addition to its internal CIP programme except in instances where the total combined CIP for a service area is less than it’s pro rata allocation e.g. Legal Services and Trust Administration.
- Delivery of the Carter report recommendations, e.g. shared services and the cost of corporate/back office functions to be no more than 7% of income by April 2018 and no more than 6% by April 2020.

A clear vision, shared sense of purpose and collective responsibility is currently missing across The Trust Corporate Services as a whole; this project offers the opportunity for radical service transformation and the development of Corporate Services that are fit for the future.
**10.3.2 Outpatients Transformation – Paperless Outpatients by 2020**

Internally it is recognised, and there is a high level of support, for improving IT capability across our out-patient services. During a visit to Queen Elizabeth Hospital Birmingham, to look at their Digital “Fast followers” IT programme, opportunity was taken to explore how they had moved to implement a paperless fully digital run out patient service. There is wide support for this direction of travel across the organisation and this will form part of the Trusts Digital by 2020 Strategy. The key pillars of work to achieve this are listed below:

- Intelligence
- Communications
- Patient History
- Diagnose and Treat
- Medical device Integration
- Scheduling
- Patient Identification
- Real Time Patient Location.

The priority projects, identified as “must do’s” for this year, that will impact out patients are:

- E-referrals – By October 2018 all GP referrals need to be made electronically. The Trust will not receive income for paper referrals accepted after this date.
- Electronic ordering via ICE (pilot currently underway in Haematology) – electronic requesting of tests and investigations.
- E-referral training application – Training version of the electronic referral system to allow staff to understand how to use the new electronic referral system.
- ICE Hardware resilience/upgrade – Upgrade of the hardware system

There is currently a repository in place that will enable to Trust to store electronic referrals from GP’s which will support the national imperative to eliminate paper referrals by October 2018.

**10.3.3 Theatres Project: LRI & GH**

There are a number of clinical drivers for change which have resulted in the need to review theatres across the Trust. These include:

- Increasingly demanding standards for infection control e.g.: laminar flow ventilation
- Increasingly flexible estate to help deliver increasing demand and technological advances e.g.: Robotics and laparoscopic theatres
- The current aged estate will require increasing periods of maintenance reducing the available operational capacity within theatres
- The project aims to improve the provision of theatres to provide the best care possible by centralizing services where necessary. Governance arrangements within the development of a large reconfiguration project are key to ensuring the delivery of the project against its objectives.

**Benefits of the Theatre’s project will include:**

- Enhancement of the Central Operating Departments (COD) at the LRI & GH thereby enabling the move of surgical specialties off the LGH
- A sustainable, long term configuration of theatres to meet future clinical need of patients
- Opportunity to improve theatres and associated facilities, upgrading where necessary to condition B1
- Delivery of an efficient and affordable service model that transforms services, offers innovative and effective workforce models and enables delivery of the long term CIP
- Future proofed capacity based on robust activity modelling
- Alignment to the LLR Better Care Together Strategy; and the Trust’s 5 Year Plan and Clinical Strategy.

The vision is to create a future proofed estate to meet the needs of patients with increasingly complex surgical disease in the highest quality built environment to facilitate the technological advances in the surgical management of patients.

**10.3.4 Pharmacy**

The vision to support the delivery of the new model of care for pharmacy is to deliver excellent medicine optimisation for all patients, through valuing and investing in our staff, developing services at the forefront of research and emerging technologies, and giving patients access to safe high quality medicines in the right place at the right time by tailoring medicines to individuals, reducing adverse harm and enhancing compliance.

NHS Benchmarking data and the emerging Model Hospital metrics provide assurance that pharmacy is an effective and efficient service, performing above average in key areas including: access to 7 day services; operational performance metrics; cost effective medicines procurement; clinical pharmacy focus including the percentage of pharmacists actively prescribing.

This is despite lower than average staffing costs. Our medicines costs are lower than peer trusts.

Pharmacy’s key focus and plans are centred on the delivery of:

- Hospital Pharmacy Transformation Programme (HPTP) by 2020 in line with Carter recommendations
- Sustainability and Transformation Plans (STPs)
- 7 day working
- Organisational development – including recruitment and retention, and development of new roles to support skill mix and medical/nursing workforce gaps.
- Optimising technology to support quality and efficiency improvements.

These plans underpin the department strategy to deliver a high quality, innovative and outward-facing service against an expanding workload and limited resources. They embrace looking at different ways of working to maximise efficiency and skill mix, while supporting new service developments.

Recent examples include development of Pharmacist led clinics and the ED Medicine Housekeeper post, left shift of services to LLR Alliance and dose banding work in Oncology and Haematology/Aseptics to address increasing workload demands. We have an ambitious draft HPTP that has been supported by The Trust and positively received by NHSG.

**The vision for the future is underpinned by valuing and investing in our staff, developing services at the forefront of research and technologies, and giving patients access to safe, high quality medicines, in the right place and at the right time.**
10.3.5 Medical Physics

The Medical Physics department is comprised of 7 sections; Clinical Engineering, Nuclear Medicine, Radiation Protection, New-born Hearing Screening, Electrodiagnostics (EDS) and Urodynamics; and Radiotherapy Physics.

The sections are relatively small and specialised; some provide direct patient diagnostics and therapeutics, others support the delivery of care across the Trust and wider. Staff are mostly Healthcare Scientists with some administration and managerial support. The levels of appointment are across all bandings from Apprentice to Assistant Healthcare Science Practitioners, Healthcare Science Practitioners and Clinical Scientists up to Consultant level.

Our model of care is to continue to support and deliver specialist services within the Trust, whilst moving to 2 sites (Nuclear Medicine has already moved but other sections are based at LGH); where appropriate, to move some services into the community, and to support services outside the Trust using the expertise and skills provided by Medical Physics at the Trust.

Moving services from the LGH site will not necessarily be difficult to achieve; but the provision of adequate space at the LRI and GH sites will be critical to being able to function and deliver services.

Most Medical Physics services can be relocated to any setting; but at the pull of the customer; rather than being the driving force for change. Therefore Medical Physics services are not planning to move into the community setting. Instead we are able to relocate if other services (e.g. Urology) were to do so.

Clinical Engineering and Radiation Protection are currently the main provider of Medical Physics services in the community setting; but both services work out of main bases within the Trust. The doubling up of services is not required and can be easily provided from the acute setting.

NHS Physics are also already serving the community; via outpatient clinics across the county and a small domiciliary service. The main bulk of the patients seen by this service will however remain in the acute setting within maternity.

The provision of Medical Physics services will not fundamentally change on the next 5 years; although technological advances in Nuclear Medicine, PET-CT and Radiotherapy will impact on how these services are delivered.

However, Medical Physics will have a key role to play as the reconfiguration of services across the LLR region takes shape. This will be most prominent in the following 2 key areas:

- As an enabler of other services – NHSP, Urodynamics and EDS are movable and can be easily co-located with the functions they support. Clinical Engineering is perhaps the biggest enabling service within Medical Physics. Through the provision of expanding medical equipment libraries and telemedicine technologies, efficiencies in the provision of other services and the objective of moving care closer to home can be achieved.

- As a compliance agent – Clinical Engineering and Radiation Protection will play a key part in ensuring the Trust and community services achieve and maintain compliance with regulatory and national standards.

This is a protection role and will ensure the Trust and community organisations do not run the risk of prosecution, enforcement action, financial penalties or reputational loss.

It is likely that Medical Physics services across LLR will need to grow in the next 5 years in order to support the Better Care Together strategy. The delivery of specialised services will require investment in modern, cutting edge technologies, advanced medical equipment and state of the art imaging technology. This will require enhanced medical equipment management services and enhanced radiation protection.

The vision to support the delivery of a new model of care within Medical Physics is to be a strong, well-recognised, value for money Medical Physics Department with a reputation for innovation and excellence with recognised benefits to patients, the Trust, research partners and external clients; and opportunities for staff.
**10.3.6 Imaging**

Imaging at the Trust is working closely with all the site reconfiguration programmes to ensure excellent diagnostic services are available to support clinical need in the two acute sites.

Diagnostic Imaging continues to expand, it is expected that the 5% year on year overall increase will continue (MRI expanding at 10%).

The absorption of the community imaging service into the Trust team will bring economies of scale and opportunities for pathway development outside the acute sites. Plans will be developed and refined over the coming year in collaboration with the ‘better care together’ work stream. The development of the STP will impact on these plans and as the requirements and challenges become clearer plans for a system wide approach to the use of imaging will evolve.

The discussion has provoked debate around what diagnostic imaging is specialist, what should be delivered in acute centres, the need to look at care closer to home and the left shift, what could and should be delivered in community hospitals, and the cost implications of all of the above.

The success of recent projects, such as the abdominal mass and imaging cancer pathways will be replicated across other specialties, leading to a more joined up approach to the use of imaging.

The discussion has provoked debate around what diagnostic imaging is specialist, what should be delivered in acute centres, the need to look at care closer to home and the left shift, what could and should be delivered in community hospitals, and the cost implications of all of the above.

The success of recent projects, such as the abdominal mass and imaging cancer pathways will be replicated across other specialties, leading to a more joined up approach to the use of imaging.

Imaging’s vision is to deliver clinically excellent imaging for all patients in the right place at the right time whilst continuing to develop services at the forefront of research and emerging technologies.

**10.3.7 Nutrition and Diabetic Service**

The Nutrition & Dietetic Service is a provider of highly specialist and expert services on a local, specialist and tertiary referral basis.

The service consists of three distinct sections: Adult Critical Care, Surgery & Cancer Services, Adult Complex Chronic Disease Services and Women’s & Children’s Services which sits professionally within Clinical Support & Imaging CMG with staff & services deployed across all CMG’s specialties and sub-specialities. Clinical staff include Senior Specialist Dietitians the latter of which many have Extended Scope Roles, Specialist Nutrition Nurses, Senior Dietitians, Dietitians supported clinically by Dietetic Assistants and Dietetic Assistant Practitioners. There is some administrative and managerial support.

Direct patient services are provided for all inpatients, assessment units, outpatients (the majority of which are joint consultant/MDT clinic models & a few are stand-alone booked dietetic clinics), day-case units e.g. chemotherapy and radiotherapy suites, structured education groups e.g. diabetes and coeliac disease, telephone Consultation clinics post discharge & part of a defined clinical care pathway. There is also a well-defined service training and educating healthcare professionals to deliver evidence based nutritional and diet care to patient’s e.g. nutritional screening, 1st line nutritional care, renal & diabetes diets.

The scope of services provided is vast across nutrition and dietetic care of patients including:

- Nutrition Support modalities include Nutritional screening and interventions such as oral nutritional support, enteral tube feeding and parental nutrition.
- Specialist diet interventions used to control or treat diseases and parental nutrition.

Our model of care is to continue to support and deliver specialist services within the Trust, whilst moving to 2 sites and supporting the STP. Where appropriate to move some services into the community e.g. as part of Consultant/MDT clinics in Community Hospitals and other sites, structured education groups in locality based destinations also support services outside the Trust using the expertise and skills provided by Nutrition & Dietetics at the Trust e.g. training of LPT dietitians.

NHS Benchmarking for Dietetics published in 2016 provided assurance that The Trusts Nutrition and Dietetic Service is an effective and productive service, performing in the top quartile for all key areas access, activity, performance and finance. This is despite lower than average clinical, professional and management staffing levels than other large teaching Trusts with subsequent costs per inpatient and outpatient being lower than peer Trusts providing assurance of cost effectiveness as well.

Delivery priorities for the Nutrition and Dietetic Service are:

- Workforce planning – with a flexible workforce to meet patient needs across 7 days
- Organisational development – with extended and advanced new roles to support specialist skill mix gaps
- Information technology – to support patient safety and efficiency programmes
- STPs – supporting left shift to the LLR Alliance and Primary Health Care.

The nutrition and dietetic new model of care vision is to provide an evidence based and highly specialist service which is timely and responsive bringing the right diagnosis and treatment to each patient by a highly motivated and caring workforce working in partnership with other practitioners and agencies.

**10.3.8 Breast Imaging**

The Breast Imaging service wants to promote evidence based imaging services within the specialised pathways and to continue to develop our services through a combination of clinical excellence, research and high quality training to become a centre of excellence for breast imaging and education.

**NHS Cancer Screening Programme**

The NHS Cancer Screening Programme is operated by Public Health England. Its role is to provide national management, coordination, and quality assurance of the three cancer screening programmes for breast, cervical, and bowel cancer.

**Public Health England**

Public Health England’s mission is to protect and improve the nation’s health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the DoH.

**Breast Screening Programme**

Women between the ages of 50 and 70 are invited for regular breast screening (every three years) under a national programme. Some women outside this age group are also screened as part of the NHS Breast Screening Programme, either through self or as part of a research trial.

Imaging’s vision is to deliver clinically excellent imaging for all patients in the right place at the right time whilst continuing to develop services at the forefront of research and emerging technologies.
Screening is intended to detect breast cancer at an early stage when there is a better chance of successful treatment.

For LLR women are invited to attend for screening at our purpose-built breast care centre at the GH or alternatively at one of our three mobile units which aims to make screening more accessible to all those invited. Some women aged 47 to 49 and 71 to 73 are also being invited for breast screening as part of a national randomised trial.

In addition to the screening activity our symptomatic and surveillance demand is approximately 18,000 per year. The symptomatic service provides a one-stop 2WW referral clinic (delivered parallel by Breast Surgeons & Radiologists).

The LLR breast screening programme is the largest in the East Midlands and one of the largest in England. Our Breast Screening population is 160,000.

For LLR women are invited to attend for screening at our purpose-built breast care centre at the GH or alternatively at one of our three mobile units which aims to make screening more accessible to all those invited.

The Children’s Hospital forms part of Trust’s Women and Children’s Clinical Management Group (CMG). The vast majority of children’s services are currently located at the LRI, with the exception of the East Midlands Congenital Heart Centre (EMCHC) and orthodontics, which are both currently based at the Glenfield Hospital (GH). The EMCHC are planned to be moved as part of the reconfiguration programme to ensure co-location with other children’s services at LRI.

The Children’s Hospital will be based at LRI and will encompass the following paediatric specialties:

- Anaesthesia
- Allergy
- Audiology
- Day Care (medical and surgical)
- Dental Surgery
- Dermatology
- East Midlands Congenital Heart Centre (Cardiology and Cardiac Surgery)
- ENT
- Endocrine and Diabetes
- ECMO (EMCHC)
- Gastroenterology
- General Medicine
- General Surgery
- Haematology (non-malignant)
- High Dependency Unit (HDU)
- Infectious diseases (PIID)
- Maxillofacial surgery
- Metabolic
- Nephrology
- Neurology
- Oncology and malignant Haematology
- Ophthalmology
- Orthodontics and Restorative Dentistry
- Orthopaedic Surgery
- Paediatric Intensive Care Unit (PICU)
- Plastic Surgery
- Respiratory and Long Term Ventilation
- Rheumatology
- Urology
- Immunology (PIID)

In addition to this, Imaging, Diagnostic and Support services are provided to support all these specialties.

The East Midlands Congenital Heart Centre (comprising children’s cardiac ward, outpatients and cardiac PICU) is currently based at the Glenfield, however is due to move to the LRI to be collocated with the rest of children’s by July 2019. This is the first phase of the Children’s Hospital Project, which plans to bring together all children’s services into a defined area of the LRI site.

The vision for Leicester Children’s Hospital is to deliver the vast majority of its services from Leicester Royal Infirmary in the state of the art, future proofed facilities.

10.3.9 Leicester Children’s Hospital

Leicester Children’s Hospital provides a range of paediatric services which includes:

- Secondary Paediatric Services to just over one million residents of Leicester, Leicestershire and Rutland (LLR)
- Tertiary Paediatric Services to the population of LLR and patients from surrounding counties
- Quaternary Paediatric Services (e.g. Primary Ciliary Dyskinesia and ECMO) to the population of LLR and patients from across the country.

The Children’s Hospital is the largest in the East Midlands and one of the largest in England. Our Breast Screening population is 160,000.

10.3.10 LRI Beds & the Golden Appeal

The Trust recognises that older people living with frailty and people living with dementia are no longer a cohort of patients – they are the patient and therefore we should act accordingly – by launching this appeal we are doing just that.

The Trust has six designated older peoples’ wards at LRI, wards that are not conducive to the care of older people, older people living with frailty and people living with dementia. This Project aims to transform these environments into areas of excellence, designed, equipped and resourced to provide the highest quality of care for older people, older people living with frailty and people living with dementia and to provide environments where staff can care for their patients in a safe, dignified and compassionate way.

The Leicester Hospitals Charity Golden Appeal links to the Trust priorities, particularly the five year strategy and aligns with the Trust Strategy April 2016 – March 2019 Strategic Priority 3: Improving the Experience of People with Dementia and their Carers / Dementia Friendly Environments.

Imaging’s vision is to deliver clinically excellent imaging for all patients in the right place at the right time whilst continuing to develop services at the forefront of research and emerging technologies.
11 How are we going to deliver the change?

The future vision for the estate is critically driven by the STP for local healthcare; estate is an enabler of planned service change.

This section sets out the journey the Trust has to take in order to respond to the transformation plan by developing and defining options required to facilitate delivery of, in estate terms, Trusts clinical strategy. The section also sets out key projects, consequential capital investment requirements and any potential land and property disposals.

11.1 Delivery plan

A strategic plan is only as good as the implementation programme for delivering the goals and initiatives that are identified.

Implementation is always the difficult part of effective strategic planning; the detail and the planning must be robust with the availability of the right tools to execute the plan and supporting this is also the recognition that communication is key to success.

Given the level of potential demand for estate investment, there will be difficult choices and decisions to make and it will be necessary to strike a balance between new build and major refurbishment aspirations and essential maintenance, to ensure legislation compliance and business continuity.

Where there is a major change there will be complexity, risk, many interdependencies to manage, conflicting priorities to resolve and going forward the need to recognise the difference between ‘Business as Usual’ activities against ‘Transformational’ activities, and the delivery of each need to treated differently, and therefore specific processes, tools and techniques are required to manage the change process to achieve a required business outcome.

Context

The LLR STP sets out the actions that are needed across the health and care system over the next five years in order to improve health outcomes for patients and ensure our services are safe and high quality, within the financial resources available.

The STP identifies the essential need for the Trust to consolidate onto two acute sites to deliver its clinical reconfiguration strategy, whilst enabling the disposal of the majority of the LGH site which is directly linked to returning the Trust to financial balance.

The capital requirement to enable this consolidation is £397.5m. This funding has been requested via the STP Capital application for funding from the 2017 autumn budget.

The Development Control Plans (DCP’s) across the 3 sites take the core elements of the Trusts strategic intent and Clinical Strategy as clearly articulated within the STP and demonstrates how the estate will enable and support delivery, and is aligned to the recommendations made within both the Carter (2015) and Naylor (2017) reports which stress the need for estate rationalisation and efficiency.

The Reconfiguration Programme underpins both the STP the Estate Strategy and enables the health economy to deliver a sustainable, clinically effective and affordable service in the future; by allowing the Trust to move all acute care onto the LRI and GH, whilst enhancing critical care provision, creating a single site maternity hospital and protecting planned elective activity.

Through the STP modelling an agreed future bed number has been agreed which has been modelled through to specialty level. This has been reflected throughout the DCP development process and provides the basis of capacity demand vs estate supply.

This has now been revised to 1,836 in-patient beds, 175 day-case beds within the Trust estate and 37 beds to a community setting; 2048.

The DCP’s provide a response to the 2048 requirement via a series of major Reconfiguration Projects. This is supported by projected utilisation data on Theatre, Outpatient & Day-case, Intensive Care Beds, Imaging and associated infrastructure assessments. It assumes that all other supporting services, such as therapies, that are impacted by any service shift are captured within individual project scope.

The Reconfiguration Programme consists of a series of service relocations designed to sequentially decant the LGH site and reconfigure both the LRI and the GH in order to provide improved clinical adjacencies, patient experience and financial efficiencies.

The development of the Reconfiguration Programme and DCP’s at this point in time is high level but clearly demonstrates the scale and complexity of the task. On-going work will further define project scope by demonstrating how the LGH can be safely and efficiently decommissioned.

There are 4 fundamental elements underpinning the DCP’s which provide clarity and robust information regarding: Costs, Programme and Dependencies – How long it will take and in what sequence.

A series of stakeholder workshops and meetings have taken place to thoroughly assess and re-assess assumptions with regards to area, scope, opportunities and constraints to reach agreement with regards to the stated fundamental elements.

The outputs of this have informed the Trusts STP bid for funding to deliver the Reconfiguration Programme. It forms the basis of a 5 year programme at a cost of £397m. (including £30.8m already identified for the move of ICU level 3 and associated services)

In addition to the bid for central resources there are supplementary projects that will be funded internally via the Trusts own funding, charitable appeals and commercial ventures.
DCP Journey
The development of the DCP has taken approximately 18 months, and there have been two previous iterations before arriving at the final plan:

<table>
<thead>
<tr>
<th>Version</th>
<th>Value</th>
<th>Date</th>
<th>Process</th>
</tr>
</thead>
</table>
| 1       | £590m   | March '17 | Full estate refurbishment  
|         |         |        | Flexibility of application of HBN & HTM  
|         |         |        | Review of cost model rates  
|         |         |        | Only Reconfiguration projects  
|         |         |        | Review of programme and inflation  
|         |         |        | Review of On-Costs |
| 2       | £460m   | April '17 | New build to modular  
|         |         |        | Reduction to specific project costs e.g. Back office |
| 3       | £397m   | May '17  | Change to new build Maternity Hospital  
|         |         |        | Modular to new build |

High level principles for site development
The DCP, subject to consultation, is based upon the principles of moving from 3 to 2 sites over 5 year programme (2048 Bed Bridge), and in turn providing:
- Clinically sustainable services
- Financial sustainability and return on investment
- Workforce flexibility
- Improved productivity & efficiency of estate
- Future proofed facilities

The Reconfiguration Givens
Below we have listed the ‘Givens’ for the reconfiguration programme that have agreed by the Trust Reconfiguration Programme Board:

<table>
<thead>
<tr>
<th>Estates Deliverables: Carter and Naylor Metrics</th>
<th>Return on Investment Payback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconfiguration Programme: £397.5m capital</td>
<td>Timescales: 2022/23</td>
</tr>
<tr>
<td>Delivers 3 to 2 acute sites</td>
<td>Return on Investment Payback</td>
</tr>
</tbody>
</table>

What does this mean for the Leicester General Hospital?
Subject to the formal public consultation, the plan remains for emergency and specialist services to be moved to the LRI and GH. The Leicester Diabetes Centre of Excellence (and some connected services) will remain at the LGH and will continue to expand to become the pre-eminent diabetes research institute in the UK. In addition a GP access service and Imaging services are planned to be retained.

The LGH will also continue to house other health and social care services. The Evington Centre will continue to provide community beds, and it is likely that this will incorporate a stroke rehabilitation ward.

Joint health and social care teams delivering services in people’s homes will continue to have a base at the site. Leicester City CCG are also considering using a small portion of the LGH as a centre for a primary care hub providing extended hours GP services and associated diagnostics.

What does this mean for the Leicester Royal Infirmary?
The LRI will continue to be the primary site for emergency care. The Leicester Royal Infirmary will see a consolidation of maternity and gynaecology services, as well as the creation of a ‘super ICU’. The paediatric element of the East Midlands Congenital Heart Centre (currently at the GH) will move to the Leicester Royal Infirmary, subject to the outcome of the national consultation process, as part of the vision to create a fully integrated children’s hospital and in order to meet national standards.

What does this mean for the Glenfield Hospital?
The GH will grow as services move from both the LGH and the LRI. The relocation of the Vascular service from the LRI was the first of these moves and has taken place, to creating a complete cardiovascular centre. ICU, some surgical and Renal services (including transplant), will move from the LGH to the GH into new build wards. The Trust also intends to build a new planned ambulatory care centre at the GH which will offer outpatient and day case care with a stay of up to 23 hours.

Consolidating acute services onto two sites includes the development of the following physical assets through a series of capital projects:

DCP outputs
The DCP has been ‘fixed’ at a point in time and will deliver the following outputs:
- Identification of the major projects
- Robust cost profile at £397.5m
- Sequential delivery based on clinical safety/dependencies
- Site Plans that will control site development
- High level, supply vs demand, 2048.
## Financial Breakdown of Reconfiguration Programme
Below is a breakdown of the costs for each project that makes up the reconfiguration programme:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relocation of ICU Capacity and Associated Services</td>
<td>£30.80</td>
</tr>
<tr>
<td>EMCHC / Gynaecology</td>
<td>£7.98</td>
</tr>
<tr>
<td>EMCHC – CRL Funded</td>
<td>£8.92</td>
</tr>
<tr>
<td>Admissions Unit Phase 1</td>
<td>£2.94</td>
</tr>
<tr>
<td>ICU expansion LRI</td>
<td>£16.14</td>
</tr>
<tr>
<td>Maternity</td>
<td>£95.61</td>
</tr>
<tr>
<td>CH Expansion (PACH, In patient wards and In patient theatres)</td>
<td>£155.59</td>
</tr>
<tr>
<td>Children’s</td>
<td>£22.08</td>
</tr>
<tr>
<td>ICU Expansion GH</td>
<td>£3.63</td>
</tr>
<tr>
<td>LRI Inpatients</td>
<td>£6.39</td>
</tr>
<tr>
<td>Glenfield in patients</td>
<td>£1.02</td>
</tr>
<tr>
<td>LRI Ancillary projects</td>
<td>£1.48</td>
</tr>
<tr>
<td>Glenfield Ancillary projects</td>
<td>£1.02</td>
</tr>
<tr>
<td>H Block LGH</td>
<td>£2.00</td>
</tr>
<tr>
<td>Vascular Projects – Delivered</td>
<td>£12.02</td>
</tr>
<tr>
<td>Emergency Department - Delivered</td>
<td>£49.52</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>£417.14</strong></td>
</tr>
<tr>
<td>Infrastructure LRI &amp; GH</td>
<td>£26.00</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>£443.14</strong></td>
</tr>
<tr>
<td>Re-provision of support &amp; education space</td>
<td>£10.00</td>
</tr>
<tr>
<td>Welcome Centre at LRI</td>
<td>£1.00</td>
</tr>
<tr>
<td>Demolition (Knighton Street, Immunopathology and HS)</td>
<td>£1.50</td>
</tr>
<tr>
<td>Contribution MPATH</td>
<td>£0.30</td>
</tr>
<tr>
<td><strong>DCP Future Expenditure</strong></td>
<td><strong>£397.59</strong></td>
</tr>
</tbody>
</table>

**Table 13 Reconfiguration programme project costs**
11.2 Specific DCP projects

Below is a description, per site, of the DCPs, and per year how each site will develop from both a structural and a service perspective.

11.2.1 Glenfield Hospital (GH)

Strengths, Weakness, Opportunities and Threats (SWOT) analysis

To support the preparation of the DCP a SWOT analysis was undertaken to inform the prospective design solution. The SWOT analysis assess the site in its current capacity and provides justification for decisions taken with respect to each site:

**Strength**
- Estate condition generally good:
  - Condition B (26350 m2)
  - Condition B/C (7050 m2)
- The mains cold water ring main has 78% spare capacity available.
- The 4No. the Trust managed generator sets are currently running at approximately 42 spare capacity.

**Weakness**
- Site infrastructure – electrical 96% capacity, equipment past economical life expectancy, generators, transformer, switch gear – implications on future development.
- Catering facilities condition D (1730 m2) – improvement required.
- Restrictions to building on existing roof, structure does not have sufficient structural integrity.

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus land to sell for possible third party investment or development</td>
<td>Transport routes around site would require improving to deal with additional traffic to site.</td>
</tr>
<tr>
<td>Development potential to extend within the existing site boundary</td>
<td>New developments affected by planning issues, such as listen building on site and TPO’s reducing development zone and possibility of no LPS/Highways support</td>
</tr>
<tr>
<td>Upgrade areas of the estate with a condition score of C (12800 m2) to B</td>
<td>Local residents may object to development</td>
</tr>
</tbody>
</table>

Glenfield Hospital – 2017

Projects

Relocation of ICU capacity and associated services from the LGH

The Trust’s five year Clinical Strategy includes the need to deliver critical care services through the creation of two ‘super ICUs’ by 2021/22 located at LRI and GH. Triplication of services creates inefficiency and an unsustainable clinical position; the biggest risks are the lack of a suitably qualified workforce to maintain safe Level 3 ICU services across the three sites, and the cancellation of elective cases. The first step is to move Level 3 ICU away from LGH which was first identified in 2014 owing to the increasing risk of clinical sustainability of the service.

Services requiring Level 3 Care are required at an early stage of the programme to move off the LGH site. The programme of works involves:

- **3 New Build wards** – The wards will enable the relocation of Hepatobiliary In-patients (Emergency and Elective) 52 beds and Renal Transplant service 12 beds from the LGH. The wards will be developed on the roof of the existing main hospital and will be provided via a modern method of modular construction – using techniques that will offer a sound robust facility with a 60 year life expectancy. Whilst a roof top position the wards will be central to clinical support services required.
- New lifts and stairwell will ensure avoidance of additional pressure on site circulation and access. To enable the move the following facilities are required:
  - **ICU Extension** – a new build extension to the existing ICU will provide an additional 11 beds to support services relocating to the site. This will be Phase 1 of the ICU works with an additional expansion occurring later on in the Programme.
  - **Interventional Radiology Suite** – a refurbishment of retained estate providing 2 fluoroscopy rooms and 1 mothballed room for future activity relocating to the site. The rooms will be fully supported by waiting areas, changing facilities, recovery area and day-case areas.
  - **Wards LRI** - colorectal services will relocate to the LRI into vacated retained estate. A programme of light refurbishment will be employed to improve patient facilities e.g. creation of ensuites in multiple bed bays, enhanced lighting, decoration and upgrade to services (e.g. medical gasses).
  - **Refurbishment of Mansion House** - administrative accommodation required to support both the service relocations and the release of enabling space required within retained estate will be provided an external facility to the main hospital building - Mansion House. This is a property recently returned to the Trust as part of a land swap agreement. The building will be modified where required and refurbished internally as a compliant space for admin functions.
Cost - £30.8m
Method of funding – STP Capital Application

Relocation of Nephrology (interim)
As a consequence of the Renal Transplant move it became evident that the remaining renal service could not remain at the LGH for any substantial length of time. A case will therefore be developed to relocate the service soon after the Renal Transplant move. The service will occupy space released by the East Midlands Congenital Heart Centre (ward 30 and PICU) as an interim move until later development is undertaken at the GH site.

Cost - £1.5-7m
Method of funding - CRL

Admissions Unit (Phase 1)
The current Clinical Decisions Unit (CDU) the central point for emergency admissions to the GH site. It struggles to cope with the demand in need of expansion and development in order to provide efficient admission pathways for patients. This scheme will see an extension to the current CDU, this will be part refurbishment and part extension – scope yet to be determined.

This will be the first phase in the development of a whole site approach to emergency admissions to the site as more acute services relocate.

Cost - £2.9m
Method of funding – STP Capital Application

Glenfield Expansion Project
This project is by far the largest undertaking across the programme. It comprises of a 35,000m² expansion to the front of the existing main building and will comprise of a Planned Ambulatory Care Hub (PACH) - this facility will provide outpatient and day surgery, with extended recovery (up to 23 hour care) and will incorporate the following:

- Outpatients (including pre-assessment)
- Day cases
- Extended recovery (23 hour care)
- Associated diagnostic and support/therapy services
- 12 Theatres.

The philosophy is to deliver a Planned Ambulatory Care Hub this is Visionary, Vibrant, and Agile.

The key objectives of the project include:

- Delivery of a physical environment which acts as a positive influence on health for patients and staff
- Separation of adult planned care activities from emergency and complex in patient care
- Delivery of seamless pathways of care for adult patients
- Enabling co-location of purpose built out-patient, day case, extended recovery and supporting facilities
- Applying leading edge technology and innovative clinical practice
- Generating efficiencies through new models of service delivery
- Investing in our future workforce
- Encouraging partnerships with Primary Care and Community Services.

The outcome will be space at both LRI and LGH to support decant of services, further rationalisation, and decommissioning at LGH.

- 4 New Build Wards - the wards will accommodate the services needing to relocate from the LGH – Elective Orthopaedics and Urology. They will be repeatable generic clinical facilities. Optimising clinical adjacencies to theatres and ICU.
- Inpatient Theatres - an additional 8 Theatres will be required to support the service moves for in-patients
- Emergency Admissions Unit - further to the CDU expansion, work will be undertaken to understand how best to manage emergency admissions processes for the whole site when acute surgical services are all co-located.
- Models of care are in the process of being developed. There will be an impact on in-patient bed requirements and as a consequence funding released through the new build wards development.

Cost - £159m
Method of funding: STP Capital Application

ICU Expansion Phase 2
The Trust currently falls short of the number of ICU beds required for level 2 and 3 care. Patients visiting our hospitals are getting sicker and the ability to offer acute care is growing. This situation results in patient flow issues which includes cancelled elective surgery.

In addition the ability to close the LGH site is dependent on there being enough Level 2 & 3 capacity available on both the LRI and GH sites. The extension to the existing ICU will provide 49 additional beds.

This facility will be provided within retained estate.

Cost – £3.6m
Method of funding: STP Capital Application

Car parking GH
The GH will increase in size significantly. Much of the development will be across existing car parks which will compound the shortfall in spaces.

It is the intention to enter into a commercial arrangement with a car park service partner to develop a multi storey car park funded by the developer who will get their return on investment through the commercial activity of charging for parking.

Welcome Centre GH
The Trust will partner with an experienced retail developer to create a welcome centre forming a new main entrance within the Expansion at the Glenfield development.

The facility will greatly enhance the patient, public and staff experience, enable better flows through the building and provide an opportunity to separate FM traffic from the majority of the public on the ground floor.

The scheme will be cost neutral to the Trust.

The capital cost will be paid for by the investor and recovered through rental charges to retailers over the life of the contract. To facilitate this relocation of the Child Development Centre will be the responsibility of the Trust.
The DCP for GH will deliver the following:

- Centre for Planned Care and Tertiary referrals with a significant emergency service – 640 beds
- Increased Level 2/3 provision – 49 beds
- Dedicated whole site admissions facility
- Associated BRU’s/University presence
- Dedicated Outpatient and Day Case (23hr) facility.
### Leicester Royal Infirmary (LRI)

#### Leicester Royal Infirmary Site – 2017

#### Strengths, Weakness, Opportunities and Threats (SWOT) Analysis

To support the preparation of the DCP a SWOT analysis was undertaken to inform the prospective design solution. The SWOT analysis assesses the site in its current capacity and provides justification for decisions taken with respect to each site:

<table>
<thead>
<tr>
<th>Strength</th>
<th>Weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the transformers have been recently replaced and so are in good condition.</td>
<td>Limited parking availability is problematic. Access/Egress to site causes congestion problems on road infrastructure, Havelock street.</td>
</tr>
<tr>
<td>The mains cold water ring main is operating at 63% space capacity. Therefore has ample capacity available</td>
<td>Poor main entrance to A&amp;E and emergency drop off.</td>
</tr>
<tr>
<td>Strong links with University; education facilities provided on LRI site.</td>
<td>Poor way finding signage and no obvious hospital entrance. Long patient journeys between departments</td>
</tr>
<tr>
<td>Hospital location; easily accessible to public with good transport links</td>
<td>Main estate is 76% condition C and requires work.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected buildings could be demolished (condition D) creating new development opportunities and eliminating backlog along with running costs.</td>
<td>Both the firm gas supply and interruptible gas supply are running beyond maximum capacity which could affect future expansion.</td>
</tr>
<tr>
<td>Pathology moving to odd site location – EMPATH, existing pathology space to become available.</td>
<td>Planning restrictions on any surrounding developments due to listen façade.</td>
</tr>
<tr>
<td>Community and population are accustomed to travelling to the LRI site for higher acuity needs.</td>
<td>Lease holder restrictions with third party tenants such as University of Leicester.</td>
</tr>
</tbody>
</table>

#### Areas occupied by the university are a fixed point on site and restrict development potential.

#### Due to congestion on site, ‘Blue Light’ emergency route is often comprised.

### East Midlands Congenital Heart (co-location)

**The East Midlands Congenital Heart Centre (EMCHC) is currently located at the GH.**

It is a quaternary service, providing care for children and adults with congenital heart disease from across the region.

In 2015, NHS England published a new set of standards for Congenital Heart Disease, outlining a minimum level of activity for each centre, and requiring paediatric congenital heart services to be co-located with other paediatric services.

Through the EMCHC Co-Location Project, we will move all paediatric cardiac services from the GH to the LRI, and ensure sufficient capacity is available in order to achieve the required level of surgical activity.

The scope of this project includes:

- 24 bed Paediatric Cardiac Ward, 12 bed Cardiac PICU, Outpatient and Diagnostic, Department, Theatres, MRI scanner, Parents Accommodation, Administration space, On-call facility
- The EMCHC will move into the Kensington Building, utilising existing gynaecology outpatients, GAU and SCBU which will be relocated as part of the enabling works into Balmoral and Windsor. Theatres and MRI facilities will be new build.

**Cost - £10.0m**  
**Method of funding – CRL £8.0m and Charity £2.0m**

### Adult Intensive Care Extension

The Trust currently falls short of the number of ICU beds required for level 2 and 3 care. Patients visiting our hospitals are getting sicker and the ability to offer acute care is growing. This situation results in patient flow issues which includes cancelled elective surgery. In addition the ability to close the LGH site is dependent on there being enough Level 2 & 3 capacity available on both the LRI and GH sites. The extension to the existing ICU will provide 43 additional beds.

The project will adopt a part retained estate part new build approach. The refurbishment of the existing unit, refurbishment of the current day case ward and a new build extension over the newly build Emergency Floor.

**Cost - £16m STP**  
**Method of Funding - STP Capital Application**

### New Build Maternity Hospital

The Trust currently supports the majority of births and maternity care across LLR with an annual birth rate of circa 10,000. The LGH provides currently 4,000 births which will need to be relocated.
A new build maternity Unit is proposed to be developed on the Knighton Street campus area of the LRI. The umbilical link into the main hospital building would be via the new adult ICU area above the Emergency Floor. This will result in the demolition of estate which is subject to much back-log maintenance and compliance issues. Both elements of the project therefore provide wins for the Estates Department and the Maternity Service.

As part of the public consultation process it may become necessary to provide a stand-alone Birthing Unit – this would be provided at the LGH if required.

**Cost - £96m**  
**Method of payment – STP Capital Application**

**Children's Hospital**
With the exception of the EMCHC, all paediatric services are located at the LRI. The majority of services are in the Balmoral and Windsor Buildings, however there are pockets of paediatric space all over the LRI, many within predominately adult areas.

The scope of the Children's Hospital Project is to bring together all children’s services into one area of the LRI site, to create a consolidated Children’s Hospital. This will improve adjacencies, split paediatric and adult flows, ease our ability to provide age appropriate facilities and create a defined identity for the Children’s Hospital. Through the Children’s Hospital Project, we will also increase the upper age limit of Leicester Children’s Hospital, from a patient’s 16th birthday to a patient’s 19th birthday.

As part of Reconfiguration, Children’s Services will be moved into the Kensington Building, to sit alongside the paediatric EMCHC.

**Cost - £22m**  
**Method of funding: £12m STP funding £10m Charitable**

**Ward Refurbishments**
Only wards affected by service moves will be refurbished as part of the Reconfiguration Programme. These are primarily within both the Balmoral and Windsor Buildings - as a result of Gynaecology services relocating as part of the EMCH enabling works and activity relocation from the LGH – Gynaecology and Brain Injury Unit. There will be growth within ‘Care of the Elderly’ activity which will result in the need for previously paediatric accommodation being converted to adult facilities.

This forms part of the Trust’s Golden Appeal.

**Cost - £6.4m**  
**Method of funding – STP Capital Application and Charity**

**Car-park**
Additional parking will be required as a consequence of the overall programme. Finer detail is subject to further on-going work with regards to capacity impact. Potential sites for this have been identified as part of the DCP: additional 2 storeys to the new multi storey car-park and a single decked area on the current Havelock Street Carpark.

**Welcome Centre**
The Trust will partner with an experienced retail developer to create a welcome centre forming a new main entrance at the Winsor building. This landmark development will comprise of new reception facilities, PALS office, Pharmacy and public toilets as well as retail food and shopping outlets.

The facility will greatly enhance the patient, public and staff experience, enable better flows through the building and provide an opportunity to separate FM traffic from the majority of the public on the ground floor.

The scheme will be cost neutral to the Trust. The capital cost will be paid for by the investor and recovered through rental charges to retailers over the life of the contract. To facilitate this relocation of the Child Development Centre will be the responsibility of the Trust.
Phased Delivery
Leicester Royal Infirmary - 2018/19

Leicester Royal Infirmary - 2019/20

Leicester Royal Infirmary - 2020/21

Leicester Royal Infirmary - 2021/22

Leicester Royal Infirmary - 2022/23
Leicester Royal Infirmary - Future configuration outcomes:

- 1194 in-patient beds
- Primary site for Emergency care
- Significant Elective service provision
- Increased Level 2/3 provision – 43 beds
- Stand-alone Children’s and Maternity Hospital
- Predicated on positive EMCH outcome & £397m
Strengths, Weakness, Opportunities and Threats (SWOT) analysis

To support the preparation of the DCP a SWOT analysis was undertaken to inform the prospective design solution. The SWOT analysis assess the site in its current capacity and provides justification for decisions taken with respect to each site:

<table>
<thead>
<tr>
<th>Strength</th>
<th>Weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly refurbished H block housing diabetes care.</td>
<td>Poor condition of buildings across the site, 67% condition C 25% condition D</td>
</tr>
<tr>
<td>Newly refurbished Theatres in condition B (1650m2).</td>
<td>Possible isolation of H block if it’s the only retained building by the Trust on site.</td>
</tr>
<tr>
<td>Adequate parking for current level of service.</td>
<td>Transport links to site are infrequent, especially if travelling from West of the city.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus land to sell for possible third party investment or development</td>
<td>Local residents may object to development</td>
</tr>
<tr>
<td>Vacant buildings such as Brandon could possibly be used for nurse training &amp; development if refurbished.</td>
<td>Lease holder restrictions with third party tenants</td>
</tr>
<tr>
<td>Potential for use by wider LLR health community.</td>
<td>Strategic planning constraints</td>
</tr>
</tbody>
</table>

The Reconfiguration Projects will sequentially over the 5year programme vacate areas across the LGH site. The detail and impact of each project has not yet been identified and is subject to on-going work.

The pictures overleaf demonstrates the areas where the projects impact the site but in parallel to this each project will have additional supporting services that will vacate at the same time. These areas are not depicted at this point.

Facilities/Buildings that will remain on the LGH site are:

- **The Diabetes Centre of Excellence**: Situated within an area known as the H-Bloc k it provides outpatient facilities, training and administrative services for the Diabetic community across LLR and will continue to expand to become the pre-eminent diabetes research institute in the UK.
- **Haemodialysis Daycentre**: Outpatient facilities for patients requiring dialysing in the East of the Leicester and Leicestershire.
In addition, we may provide a stand-alone Birth Centre at the LGH dependant on the outcome of consultation; and will provide a Stroke and Neuro Rehab Unit at the Evington Centre (run by LPT) on the LGH site. All of the above would be facilities would be technically isolated to enable them to function as standalone premises on the site.

**Leicester General Hospital - Rationalisation Outcomes**

Below we have listed the planned rationalisation outcomes for the LGH site:

- Rationalisation work stream will manage the programme safely and efficiently
- Comprises of three defined stages:
  - Stage I - Planning Stage
  - Stage II - Mobilisation Stage
  - Stage III – Future site use Stage
- Ability to support remaining facilities
- Potential to house approx. 608 residential units across 44 acres
- Land receipt potential £19.8m.

**Cost Model**

Every built area across the Trust has been surveyed in terms of in-patient capacity measured and plotted to ensure m2 rates can be accurately applied. The following m2 rates have been generated to be applied to each type of development that is planned as part of the Reconfiguration Programme:

<table>
<thead>
<tr>
<th>Refurb Type</th>
<th>£/m2</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Build</td>
<td>£5,200</td>
</tr>
<tr>
<td>High Refurb</td>
<td>£3,200</td>
</tr>
<tr>
<td>Medium Refurb</td>
<td>£2,200</td>
</tr>
<tr>
<td>Low Refurb</td>
<td>£1,600</td>
</tr>
<tr>
<td>Minor Work</td>
<td>£800</td>
</tr>
</tbody>
</table>

These rates form the basis of the cost modelling employed to each of the reconfiguration projects at this point in time.

Throughout the process build rates have been applied to projects to reflect the nature of the scheme based on the Estates & Facilities team.
11.3 Site Rationalisation

A significant element of developing the Trust’s Estates Strategy has been focused on our capital investment plans, however it is equally important to review and identify opportunities for dis-investment through the identification of future potential land and property disposals.

The benefits of such an exercise will be to:

- Produce capital receipts of land and property sales to reinvest in the reconfiguration of the estate.
- Improve space utilisation of the estates.
- Improve clinical to non-clinical ratio of occupancy.
- Disposal of aging estates and significantly reduction of backlog maintenance.
- Contribute to the DoH targets of provide public sector land for housing.
- Support Leicester City Council’s development plans with the allocation of land for local housing and key worker accommodation.

The Estates Strategy has identified three areas where land may be released either as a consequence of the intended reconfiguration of two acute sites from the existing three or where surplus land has already been identified.

The delivery of the reconfiguration programme once complete will see our acute sites from the existing three or where surplus land has already been identified.

The majority of the identified value results from the reconfiguration of the three acute sites to two, releasing up to 44 acres of land at the General Hospital, with the full list and estimated values as follow:

<table>
<thead>
<tr>
<th>Site</th>
<th>Area</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leicester General Hospital</td>
<td>44 acres of land</td>
<td>£19.8m</td>
</tr>
<tr>
<td>Glenfield Hospital</td>
<td>12 acres of pasture land</td>
<td>£6m</td>
</tr>
<tr>
<td>Glenfield Hospital</td>
<td>6 acres of residences</td>
<td>£2.2m</td>
</tr>
</tbody>
</table>

Government Spending Review

In parallel with this, the Government’s Spending Review in November 2015 committed the NHS to finding £2bn from NHS land sales by 2020-21 and releasing land for 26,000 houses.

The Annual Surplus Land Collection required by the Department of Health (DoH) of each Trust, seeks to identify opportunities for the future. As a result of this the Trust has received several visits by the DoH to ascertain how reduced running costs can be accelerated and free up land for sale where applicable.

As the Trust does not hold Foundation Trust status, all transactions are subject to compliance with HBN 008 Estate Code, Section 7 Disposal of Freehold Land and Property.

Leicester General Hospital (LGH)

The LGH overall site is formed by freehold land and property from Leicester Partnership NHS Trust (LPT), East Midlands Ambulance Service NHS Trust (EMAS) and the Trust. Under the STP, LPT and EMAS land and property remains unchanged and fully utilised.

LGH sits on a total site area of 26.5 Hectares (65 acres of which 44 acres are deemed developable) with a potential to house approx. 608 residential units, spread across private sale, affordable rent and shared ownership tenure profiles.

In October 2015 the Trust commissioned property agents, GVA Bilfinger, to provide strategic advice on potential disposal options, future uses, an overview of planning restrictions, development viability and delivery options of the sites surplus to requirement at the LGH.

Delivery

To realise the disposal opportunities at LGH a rationalisation work stream was formed as part of the wider the Trust rationalisation programme to specifically manage the required at the LGH site. The LGH rationalisation programme comprises of three defined stages:

- Stage I - Planning Stage
- Stage II - Mobilisation Stage
- Stage III – Future site use Stage.

Whilst the focus at present relates to Stage I - the detailed planning of service moves to identify the locations and sequencing of moves which will be set out within the Development Control Plan (DCP). The outcome of this exercise will drive the direction of stage III.

At the time of writing, The Trust’s current plans were to retain some services on the site leaving the potential opportunity for re-use of any surplus site.

The release of any land at the site would be subject to rigorous internal scrutiny through the rationalisation work stream, reconfiguration programme, public engagement process and planning consent.

It is assumed, based upon current plans set out within the STP that the ‘H’ block, used as a Diabetes Centre of Excellence in partnership with the University of Leicester would remain in situ, with the necessary service and access connections reserved for its continued use. Consideration is being given as to whether other buildings should remain on site and the optimum phasing for release of parcels of land for housing development.

Through discussions with our Local Authority partners, our future plans will seek to align with the Local Plan for Leicester and support our common goals for our community.

Glenfield Hospital (GH) – Aerial Shot illustrating Paddock Land
This site adjoins the GH sitting alongside Hallgate Drive and Glenfrith Way and comprises 5.29 Hectares (12 acres) of pasture land and is presently used for horse grazing on an informal arrangement. The land has the potential to house approx. 150 residential units.

The land, which is surplus to the Trust requirements, has been the subject of frequent discussions with the Local Planning Authority, with regard to its use for residential development and latterly the DoH, who have recently introduced a new statutory transfer model.

The Trust is therefore pursuing numerous options for the sale and disposal of land and property through traditional routes and newer models such as those offered by the Homes England partnership.

Mones pass to the Trust at the point of transfer prior to detailed consent being sought with any uplift in value post planning permission being shared 70/30 with Homes England (HE) in favour of the Trust (traditionally developer uplift values equate to 50/50).

The contract is pre-approved by the Treasury, so the legal process is fast tracked and no Stamp Duty is applied giving further savings.

The DoH has already undertaken a number of similar transactions which have the effect of de-risking the process to the Trust and bringing cash forward earlier.

**Progress to date**

Initial meetings have taken place between the Estates Property Team and the DoH to explore the above benefits process and to set out appropriate and realistic timescales. The DoH act as advisors for the Trust in this process not for HE and it is their view that the terms of this Statutory Transfer model are the best available for delivery of receipts at the point of transfer, with the risks being passed to HE. The DoH has now undertaken a number of schemes regionally and has no hesitation in recommending this approach.

These discussions have now lead to the Instruction on a joint basis by the Trust and HE of the District Valuer, to produce a valuation of the site based upon the outcome of his undertaking a wider comparable analysis to prepare a draft residual appraisal. This valuation approach will also be informed by discussing development principles with the Local Authority. Land searches, have already been requested to start to undertake a technical assessment with the initial focus on planning, highways/access, drainage and will continue to build up understanding as searches are returned. It is expected that the initial abnormal overview and draft high level valuation will be provided before the Christmas break. This will then be refined and finalised early in the New Year with a target to finalise and agree value for transfer mid – end January.

The transfer will take place, prior to a detailed scheme and planning consent being sought, and based upon the valuation figure that the District Valuer

produces having taken into account all of his findings. This gives the twin benefit of speeding up the delivery of a capital receipt and ‘de-risking’ the possible uncertainty of the design development and planning process. Once the land has transferred, a detailed scheme will be prepared by HE and the land marketed. Any uplift in the land value having obtained a detailed consent, will be divided between the Trust and HE in the ratio of 70/30, once HE’s costs have been deducted.

Whilst all efforts are being made by the Estates & Facilities team to ensure receipt of a capital sum during the financial year 2017/18, there can be no guarantees in this regard as much is dependent upon the Local Authority’s Planning and Highways teams and their positive feedback.

It should be recognised, that the valuation figure that will be produced by the District Valuer prior to transfer, will be informed by the discussions that take place with the Local Authority in advance of a formal planning application, so is unlikely to give full market value at this stage. The full market value will however be realised once a full development scheme has been prepared and approved by the Local Authority and split between the Trust and HE in the ratio described above.

**Overall Disposal Process**

In-line with HBN 00-08, to achieve maximum value from a surplus site a comprehensive analysis of the disposal options available should be undertaken before any decisions are made, as well as an assessment of the benefits of undertaking pre-disposal work such as demolition / masterplanning / reclamations.

As a minimum, for any surplus accommodation or land, the following activities as a minimum will be undertaken:

- A comprehensive review of the potential disposal options
- Open Market disposal
- Private Treaty disposal
- Joint Development.

**A comprehensive review of the future uses of the site and market viability**

- A review of planning restrictions
- A review of delivery options
- Review of options to maximise the value of the surplus land / accommodation pre disposal, and quantify the return on investment / benefits.
- An options appraisal should be undertaken to agree a way forward that best meets the estate drivers.
- A disposal plan should be prepared that summarises the findings and presents an agreed way forward. This should be approved before any work is undertaken.

**Glenfield Hospital - Residencies**

There are 52 residential units varying in size, giving 237 rooms overall on a total site area of approximately 6 acres (plan at appendix 3). The residencies are in varying states of condition, but could all benefit from refurbishment.

Whilst identified as a potential disposal for generation of a capital receipt in the STP, this is dependent upon the identification of alternative solutions for the provision of stakeholder and staff accommodation, the demand for which is likely to intensify when the LGH, including its residencies close and clinical activity and staff numbers increase at the GH. Opportunities are being explored to either refurbish or re-provide this accommodation, potentially in partnership with third parties.
11.4 Town & Country Planning Issues

Leicester City Council is currently developing a new local plan "It's your City" that sets out a vision and objectives for Leicester's growth over the next 15 years. It is expected to be adopted mid 2019.

The Trust together with other health providers have contributed to the consultation exercise on the draft new Local Plan which will replace the 2006 Local Plan and the 2014 Core Strategy. The new plan is currently being prepared based on new evidence. It involves significant public engagement at all stages.

All future planning decisions - from deciding whether to build a new shopping centre, to whether to approve a new housing development will be assessed against this framework, helping to make sure the city is developed in the right way, including building the right number and types of houses, developing the right kind of shopping and recreation facilities, getting the right office and industrial spaces, creating opportunities for local jobs to be nurtured and protecting our wildlife, landscapes and heritage.

The local plan will cover a wide range of subjects and look at a number of different issues including:

- Housing
- Employment
- Transport
- City centre and regeneration
- Shopping and retail
- Waste and minerals
- Environmental issues
- Community facilities.

The current iteration of the Local Plan is currently out to consultation.

The Trust has reviewed and made comment with reference to local health needs, the LLR STP and the reconfiguration programme, and have established a dialogue with the council to ensure the health infrastructure needs are fully referenced, and an appropriate planning framework is articulated within the plan to meet the needs of both the Trust and wider community.

To inform the identification of the potential for land release, the Trust Estates and Facilities team have been working closely with Leicester City Council over the past two years to ensure that the wider health strategic planning dovetails into the Trusts Local Plan.

It will set out how the Trust will respond to local priorities and how it will meet the social, economic and environmental challenges and opportunities that face the city. It will identify broad locations, scale and type of development and supporting infrastructure that will be required in the city.

Timescales for adoption of 'It's your city'

Below is a brief outline of the process and timescales:

- Pre- Issues and Options (Consultation Completed - October to Jan 2015)
- The pre issues and options stage or initial evidence gathering including initial searches for potential sites for development
- Emerging Options and Development Management policies (Current Consultation July - October 2017)
- This is first key stage of the Local Plan process and outlines the key issues 3. Draft Local Plan stage (preferred options). (Spring/Summer 2018)
- The plan will be subject to extensive external consultation.
- Submission stage (Consultation Autumn 2018)

- By submission stage the local authority will have prepared a final plan which it is confident is 'sound' (compliant with planning legalisation).
- The plan as well as its extensive evidence base is submitted to the secretary of state for communities and local government for examination in public (EIP).
- Examination in Public (EIP) (End of 2018 – Start of 2019)
- Adoption Stage (2019)

The challenge of cross agency strategic planning is to ensure that individual strategies align recognising that in many cases are at different stages in their development and progressing at differing pace.

The Estates & Facilities team is also working with Leicester County Council and Rutland County Council to support their local planning process.
11.5 Supporting Initiatives

Below we have listed a number of initiatives that will need to be further developed and will support and add value to both the Reconfiguration Programme and Estate Strategy:

Interior Design Strategy
Building on from the successful wayfinding initiative at LRI, a Trust Interior Design Strategy will bring together the interior environment, in a consistent, compatible and safe manner. These aspects include:

- Light, colour, texture, surfaces, materials and sound
- Furnishings and fittings
- Arts in healthcare
- Wayfinding and signage
- Privacy, safety and security
- Access to nature, both internal and external.

Embedding a consistent set of interior principles will not only help to achieve savings in procurement, but will also standardised and enhance the Trust’s brand throughout the estate.

Trust Arts Programme
Having a Trust’s arts programme would help to plan, develop and manage arts throughout the Trust for the benefit and support of:

- Patients, their families and visitors
- Staff at the Trust
- The local community

It will also encourage, promote and influence the incorporate of the arts into the planning and delivery of quality patient care and services. An arts programme would also add considerable value to the reconfiguration programme by:

- Widen peoples understanding and appreciate of the role of the arts and artists in healthcare and the community
- Create a greater awareness of the diversity of arts forms and professional practices appropriate with healthcare
- Establish partnerships with local, regional, and national groups/organisation with the intention of stimulating new opportunities
- In turn, this helps to establish the needs of patients, staff and communities and assists in creating environments and services influences by, and responsive to the users.

Landscape Strategy
The reconfiguration programme and wider Estate Strategy creates a wide set of opportunities to enhance the external environment across our hospital sites, and to consider pedestrian, and vehicle circulation but also the broader external environment including the pedestrian street scene, character, sense of place, views and scale.

On this basis an integral element in establishing the reconfiguration programme, is the creation of a landscape masterplan, which should be seen as a fundamental in allowing future development opportunities to be accommodated within a well-considered, structured environment.

A landscape masterplan can be broken down into three core elements:

- Perimeter landscape
- Intermediate landscape
- High profile landscape.

In meeting the demands and unique pressures imposed by a hospital environment the landscape should seek to embrace the following aspirations:

- Develop a robust, flexible landscape framework able to accommodate existing and proposed development opportunities
- Reflect the Trust’s essentially urban character
- Create a safe and attractive working environment
- Strengthen the staff and visitor experience
- Reinforce the visual relationship with adjoining land use, reflecting scale and character
- Provide initial impact with due consideration for the long term management issues.

Equality Act
It is recognised that under the Equality Act all reasonable effort needs to be made to make information and facilities accessible to disabled users. These principles are built into everything that the Estates & Facilities team do, and is an integral part of the Reconfiguration Programme.

Safety and Security
The principles of the Trust’s Security Policy are based on the ‘deny, deter and defer’.

The Trust looks for a coordinated approach to its security problems involving its partners in the Police and City Council.

There are comprehensive security systems in place across the Trust estate.
**Accessibility and Movement**

Many patients and visitors accessing our hospitals do not have any viable alternatives to travelling by car. This may be because they are elderly, infirm, and ill or are travelling from a location where there is no reasonable alternative mode of transport.

There are also many members of staff who either need to use their cars as part of their job or do not have any viable alternative way of accessing the site.

Police need to ensure that people who need to access the site by car are able to do so. At the same time, it is necessary to ensure that the majority of people who could use alternate methods do so.

**Travel Plan**

In 2014 the Trust commissioned the completion of a new Travel Plan (TP) as an update to the previous one devised in 2001. The new plan confirmed that the targets set in the 2001 plan had been successfully achieved and developed a new strategy that can build upon this success.

The updated TP document sets out new targets and an action plan for achieving the new targets over the short, medium, and long-term; there are issues relating to the need for improvements to access and egress arrangements to/from sites.

The TP has been prepared to demonstrate The Trust’s commitment to sustainable travel, and to inform Highways Officers at Leicester City Trust of how the Trust’s will promote the use of alternative sustainable modes of travel and discourage single vehicle occupancy, including targets and methods for management and monitoring of measures.

The new TP supersedes the existing TP for the Trust’s which was adopted in 2001. Since then there have been a number of measures implemented as part of the TP, which include, and will need to be embedded into the delivery of the reconfiguration programme:

- Improved cycle and pedestrian infrastructure
- A car parking strategy
- The introduction of a the Trust’s bus service
- Discount schemes for staff travelling sustainably; and
- Various events to encourage healthier transport modes.

**Car Parking**

During the development of the new TP a detailed review of existing parking policy, supply, and usage at the three the Trust’s sites, and in light of government guidance on hospital car parking was undertaken.

The TP recommends further development/implementation of a Car Parking Management Strategy (CPMS) that is could be updated at intermediate points as part of, or alongside, the TP to ensure that car park management is maximised as a key opportunity for encouraging modal shift away from the car and towards healthier, more sustainable modes of travel, all of which will be considered when further developing the reconfiguration programme.

The following car park measures were recommended as considerations for future implementation:

- Increasing patient/visitor parking charges, with a focus on shorter-stay parking.
- Increasing staff car parking charges, potentially combined with a decremental charging system
- Adjusting the assessment criteria for staff permits to account for actual distances
- Providing barrier control at all car parks, potentially combined with a “pay on exit” system at patient/visitor car parks
- Reducing staff parking supply, particularly in locations where occupancy is already low
- Offering incentives such as a preferential, guaranteed or reduced cost parking space to car sharers
- Promoting an up-to-date car sharing database.
11.6 Reconfiguration Governance Arrangements

Below is a summary of the governance arrangements that have been established to support the delivery of the reconfiguration programme.

Summary

The Trust has a reconfiguration programme team with dedicated and skilled programme and project management resources, supported by subject matter experts in estates project management, finance, workforce, organisational development and procurement.

Backfill for clinical colleagues to confirm and challenge proposals and provide sign-off for plans is an integral component of each project. It is envisaged that the only external resource required will be for professional services – e.g. architects; cost advisors; Mechanical & Electrical and structural engineers etc.

Experience

The Estates team managing design and construction is led by a Director with over 20 years of NHS reconfiguration experience including the delivery of significant new build estate across Leeds Teaching Hospitals NHS Trust

Programme management, in conjunction with the Trust programme management, will be governed by the OGC methodologies:

- PRINCE2 – For project management.
- Managing Successful Programmes (MSP) – For programme management.

All estates developments are managed using the project and programme management principles identified which can be summarised as:

- New developments must be supported by a business case that is signed off by the appropriate steering group/programme Board.
- Projects must have a senior responsible officer who is accountable for the delivery of the project to the executive.
- Projects must have a Business Change Manager (project lead or clinical lead) responsible for delivering the necessary change within their business or clinical area.
- Projects must have an estates Project Manager who leads the planning, delivery, monitoring and post implementation review of the project.
- The Project Manager and Business Change Manager will ensure benefits are identified, monitored and realised.

Where more than one project requires managing together, a suitable Programme Manager must be identified to ensure interdependencies are appropriately coordinated.

All Projects are required to report progress, against the aims, objectives, benefits, budgets and plans set out in the Project Initiation Document, to the steering group / programme Board.

Governance

Project Governance arrangements have been established to reflect national best practice guidance and the Trust’s own Capital Governance Framework, as shown in the figure 14 below:

Reconfiguration Programme Board
Executive Strategy Board
Capital Monitoring & Investment Committee
Project Board(s)

Finance
workforce
Estate & FM
IMAT
Clinical

Communication & Engagement

Regular progress reports are submitted to the Trust Reconfiguration Board for review and then onward reporting and management to the Trust Executive Strategy Board.

The reconfiguration projects will subsequently move towards the creation of an operational commissioning team or teams. This will be constructed of suitable management and clinical representatives to allow the production of detailed implementation plan to operationally deliver the reconfiguration projects. The team/s will operate within the existing governance of the project.

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

The Trust Reconfiguration Programme Board

This group is a designated committee appointed by the Executive Strategy Board (ESB) to which it reports. The Reconfiguration Programme Board’s responsibilities include:

- Overall responsibility for the delivery of the Trust’s Reconfiguration Programme
- Ensuring that developments are consistent with the Trust’s strategic direction and Better Care Together / STP plans.

The Executive Strategy Board (ESB)

This group is a designated committee appointed by The Trust Board to which it reports. ESB’s responsibilities include:

- Advising the Trust Board on formulating strategy for the organisation
- Ensuring accountability by holding Board members to account for the delivery of the strategy and through seeking assurance that all systems of control are robust and reliable
- To lead the Trust executively, in accordance with its values, to deliver its vision and, in doing so, help shape a positive culture for the Trust.

The Finance and Investment Committee (FIC)

This group is a designated committee appointed by the Trust Board, with responsibilities which include:

- Ensuring that strong financial governance and control is adhered to in business case preparation
- Ensuring that capital and revenue implications of all business cases are fully understood
- Ensuring that business cases represent best value for the Trust.

Project / Programme Workstreams

A number of work-streams have been set up to take responsibility for driving the key objectives and to report back to the Project Board on a regular basis. Key roles and responsibilities will include:

- Day to day responsibility for the delivery of the project to meet the parameters described within the business case
- Provision of appropriate reports on status to the Project Manager;
- Management of risks and issues, and escalation of appropriate matters for executive direction/ approval
• Providing working groups with detailed briefs
• Monitoring, co-ordinating and controlling the work of the working groups
• Drawing together the outputs of the working groups
• Ensure continuing commitment of stakeholders, both internal and external.

**Project Plan**
The project will be managed in accordance with the principles of PRINCE2 methodology. The project manager will be supported by the Trust’s capital projects team and external specialist consultants as required.

**Project Management**
Effective project management offers many benefits to an organisation.

Estates & Facilities commitment to robust programme and project management is reflected within its Reconfiguration Programme Office; a dedicated resource that takes responsibility for managing the vast programme of project work that Estates & Facilities is expected to deliver.

All the capital projects undertaken by the Trust are managed by the Estates and Facilities Department.

The organisational structure for each major project broadly follows NHS Capital Investment Manual and project management best practice principles.

Within the Trust a Project Board is responsible for the delivery of a project. The Board will report to the Reconfiguration Programme Board and the Capital Monitoring and Investment Committee. The Project Board, will determine local strategy and policy and provide the terms of reference for the Project Team.

The Project Team manages the planning and co-ordination of the service and capital briefs and is responsible for producing the Business Cases at the various stages. It is responsible for the delivery of all of the aspects of the project, including any moves and enabling schemes.

The Project Team will set the terms of reference for each Subgroups to be appointed to take forward individual elements of the scheme. Each of these Subgroups will be responsible for developing the detailed service requirements for their part of the scheme and to carry them forward through planning, design, construction and commissioning, for the particular scheme.

Where construction work is required, designers will be appointed to provide the necessary architectural and engineering inputs within Design Teams. This construction work will be carried out by Building Contractors appointed through tender, negotiation or partnering agreements according to the particular project parameters.

Generally, User Commissioning Teams will be set up to bring into use the facilities or manage the moves associated with each scheme under the direction of the Estates Commissioning Manager.

The Project Director for all major schemes is the Director of Estates and Facilities. Most of the Project Manager appointments are held by Estates and Facilities professional and technical staff.

Weekly resource meetings are held to ensure that resources are allocated to projects and managed effectively and efficiently.
11.7 Risks to delivery

Overall risks will be mitigated by the inherent incremental and flexible approach of the Estate Strategy. This is strengthened by the focus of the reconfiguration programme and the reduction of the estate, subject to consultation, from 3 to 2 sites, which is not only less expensive in capital terms, but also contributes to the reduction of the backlog maintenance.

New build is mainly limited to continuing to infill by building on top of existing buildings to achieve excellent clinical adjacencies. This avoids the ground take and car parking losses, and reduces infrastructure duplication.

The above approach will ensure that, where appropriate, schemes can be modified or halted as the need changes or if the anticipated capital, revenue or workforce do not become available.

Whilst the initial prioritisation of schemes has been based on capacity requirements, and then adjusted to reflect physical estate factors, the Reconfiguration Programme is driven by the availability of capital. The incremental factors noted above will enable development to follow the available funding. If it reduces, the Plan slows down, and maybe also adjusts priorities: if funding improves, the Plan can speed up, since the range of independent schemes can be progressed in parallel.

All schemes are subject of individual business cases and approval by the Reconfiguration Programme Board.

New build is minimised and refurbishment remodelling maximised to make best use of existing space and to minimise capital costs and additional revenue capital charges and rates.

Wherever possible, charitable funds will be raised for specific projects, such as the Golden Thread Appeal, where the upgrading of the existing ward will be the objective.

Where quality improvements could lead to reduced space efficiency, other compensating productivity gains will be maximised (through, for example, the optimisation of the size of the ward units).

Everything is underpinned and controlled by the Reconfiguration Programme, which is tasked with controlling annual capital expenditure against sources of income, together with the monitoring and prioritisation roles of the Capital Investment Board will ensure financial risks are mitigated.

Below we have summarised the risks that require mitigation:

- **Political** – ensuring that there is appropriate political approval is essential to the success of the Plan
- **Managerial** – it is vital to the success of the Estate Strategy that high level managerial support is in place across the Trust.
- **Budgetary** – in dealing with construction projects and maintenance there is considerable expenditure on items where the price is influenced by external factors. These include fuel costs, material costs and professional fees. Unforeseen increases in these could lead to the full implementation of this plan being compromised.
- **Funding** – Availability of capital for the reconfiguration programme and other core estate investments and backlog reduction. If some degree of reliance is made for reconfiguration via the private finance route then the affordability will require testing robustly.
- **Legislative** – changes in Statutory Compliance regulation may mean that certain properties are no longer compliant for use. This would mean unplanned increased costs to make them compliant, or the potential closure of buildings. There could also be changes that affect construction standards thereby increasing costs.
- **Reconfiguration Programme Office Resources** – to progress the various activity themes and projects within the scope of the reconfiguration programme, the appropriate staff and availability of skills, succession planning, resources require to be available.
- **Estates & Facilities Resource** – it is vital that the estates & facilities team is fully resourced and funded with the individuals who have the rights skills and experience. From a revenue perspective it is essential that appropriate funds are allocated on an annual basis to ensure that the estates and facilities function can operate effectively and professionally to ensure that estate environment is fit for clinicians, patients and the wider workforce needs.
- **Buildability** – is the reconfiguration programme deliverable. Given that the site is currently used to its capacity how can all the schemes be delivered without impact of clinical services and patient safety.

In terms of scale, each of these risks would have a significant effect on the successful implementation of the Estate Strategy. Each has been considered and there are appropriate controls in place to mitigate risks. Whilst it is recognised that there will be instances where each of these will have some impact, whether on specific projects or activity themes, these are not considered to be highly likely, or insurmountable to the overall implementation and success of the plan.
11.8 Funding Options

Consideration has been made as to whether there is potential for alternative funding for the reconfiguration programme and individual estates & facilities projects, with the following outcomes:

- The Trust has been discussing the options for the use of PF2 with the DoH PFI and Capital Unit and HM Treasury. These discussions are on-going and revolve around the suitability of these schemes for PF2, attractiveness to market, procurement timescales and the relative cost of capital. For the purposes of this submission it has therefore been assumed that the programme will be financed through public capital but PF2 may be an alternative for some elements if the key issues noted above can be resolved.

- LIFT – this is not appropriate as this is an acute scheme.

- We understand that access will be available to Regional Health Investment Companies (RHIC) which would provide an off-balance sheet solution.

- Local Government sources – this is not an appropriate source of funding as the Trust would still require the CRL cover through this funding route.

- Internally generated capital - considered viable, however progress would be limited within each year without external resource, leading to an elongated programme and loss of key benefits. Possible in conjunction with external borrowing also.

- Charitable donations or Trust appeals.

- Fund through the existing PFI Project Agreement - considered viable, although expensive. Would lead to increased unitary charge and life cycle payments, estimated at £6.2m per annum.

- Create a Strategic Estates Partnership (SEP) Joint Venture - whilst having several advantages, not considered viable in conjunction with the existing PFI Project Agreement due to significantly increased complexity and risk, and a service profile that would be unattractive to the majority of potential partners.

- Transformational Capital Grant form DoH - in light of current position of the Trust, consideration should be given to applying for transformational support to the Trust / local health community in order to achieve the required performance improvements within the required timescale.

Please note that the Trust does not have any existing PFI (or similar) schemes.

There are risks associated with various funding routes mentioned above, and include:

- Potential revenue saving opportunities will be lost, with high quality accommodation mothballed and old estate continuing to be used.

- A growing mismatch between the need of redesigned clinical services and the estate needed to deliver those services, in terms of space, quality, location and operational effectiveness.

- Significant risks will continue due to life expired assets not being replaced, which could have serious operational, reputational or financial risks to the Trust.

- Construction is a rising market, and the potential to lock in to beneficial rates.

- There is a significant risk of the trust being left with stranded estates costs as a result of decreasing acute activity.

- Investment will be needed in facilities that are not considered to have an on-going useful life as part of the overall estates plan.

- The range of potential funding routes, and the terms of those agreements may not be as beneficial or affordable as those currently available, and are unlikely to be improved upon in the foreseeable future.

Conventional Procurements

In addition to the above, other conventional procurement methods open to the Trust include:

- Competitive Tendering, any suitable project if either of the above is not appropriate.

- Negotiated Contracts: If any of the above are not appropriate due to timescale/workload.

- Measured Term Contract where none of the is suitable for Minor Works of a small and repetitive nature, where previously (tendered) agreed rates can apply for up to (say) 3 years, with agreed inflation increases.

- ProCure22 (P22) is a Construction Procurement Framework administered by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England. It is consistent with the requirements of Government Policy including the Productivity and Efficiency agenda; the Government Construction Strategy; the Public Contracts Regulations 2015; the National Audit Office guidance on use of centralised frameworks; and the Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector.

These will be considered on a project by project basis by the Reconfiguration Programme Board.
11.9 Benefits

Reconfiguration programme benefits

**Estate Strategy benefits**
Delivering the estate strategy will allow the Trust to benefit from a range of factors including:

- **Quality of Estate** – the Trust premises will be fit for purpose and functionally suitable with appropriate and effective maintenance arrangements to meet the required standards.
- **Enhanced patient experience** – we will provide state of the art facilities that enable clinicians to deliver treatment in a comfortable, caring, safe and uplifting environment, which enhances patient experience.
- **Effectiveness** – the estate will be fully utilised and will have appropriate measures in place to ensure business resilience and continuity.
- **Equality and Diversity** – the estate will provide facilities that are appropriate and respect the values of equality and diversity to patients, staff, visitors and all others likely to use or visit Trust premises.
- **Health & Safety** – the estates will provide a safe environment to high standards of Health & Safety and statutory compliance.
- **Environmental** – the sustainability agenda will be embedded into the core values of the Estates & Facilities team and new developments and refurbishment employ sustainable methods and techniques, making use of low and renewable energy sources and improving the energy efficiency of the existing building stock where feasible.
- **Value for Money** – the estate will offer the NHS value for money.

**Benefits**

- Improving the quality of the patient environment
- Addressing the long standing mismatch between demand and capacity by making sure there is the right number of beds in medicine and the two new ‘super ICUs’. This will have a knock on improvement for operating theatres as well as improving ability to deliver against the 62 and 31 day cancer performance metrics and the 18 week referral to treatment standards.
- The provision of a single site Maternity Hospital (subject to public consultation) which allows the creation of a comprehensive, safe, sustainable and effective service for the future through workforce changes and improved training, teaching, education and research.
- Providing services which are quicker, easier to navigate and of a higher quality; largely as a result of being able to focus on specialisms, improve processes and streamlining, and because staff will no longer be spread across three main sites.

- **Reducing unnecessary patient journeys**
- **Improving clinical adjacencies so that support and diagnostic services are close to where they are needed, promoting closer team working and providing a better patient experience**
- **Reducing delays to care by streamlining care pathways**
- **Reduce cancellations by protecting our elective beds by separating out emergency and planned care. This will be done by creating a planned ambulatory care hub at the GH as well as re-distributing some of our services into the counties’ community hospitals**
- **Partnerships and stakeholders** – we work with our public sector partners and key stakeholders to deliver a cohesive approach to strategic estate management through our investment and disinvestment programmes.
- **Staff Welfare** – we provide, in all its estate provision, fit for purpose and cost-effective facilities and amenities for staff.
- **Capital Receipts** – capital receipts are achieved through the timely execution of the disposal plan.
- **Capital Investment** – improved functionality for service delivery with better co adjacencies which generate better efficiencies, improved access and enhanced support facilities, response to privacy and dignity, disability discrimination legislation and security and safety.
- **Backlog Maintenance** – a reduction in the Trust’s overall estates backlog with improved mitigation of critical service infrastructure risk.
- **Space Utilisation** – maximising clinical/non clinical ratios enhancing the target performance of the Lord Carter recommendations.
- **Sustainable Development** – we will continue to recognise the importance of the sustainable development agenda within the design and build process. Ensuring standards continue to improve we will fully reinforce this through HTM 07-07 sustainable health and social care buildings, BREEM and achieving sustainability in Construction procurement.
- **Social & Corporate Citizenship** - we will provide significant benefits to our local communities through the development of a local supply chain partner network and local labour giving improvements to reducing carbon, reduction in unemployment, opportunities to education and apprenticeship programmes and overall enhancements in value for money.
- **Disinvestment** – our disinvestment strategy will significantly contribute to the NHS Surplus land targets set out under the “Accelerating the release of public sector land for development”. Working closely with our local authority partners we have identified opportunities to support housing and community development which dovetail with the local planning timescales.
- **Housing** – releasing land for the development of housing in alignment with the local need, e.g. the release of land at LGH to develop up 604 dwellings.

Through the Trust’s Reconfiguration Programme, there will be a focus on emergency and specialist care at LRI and GH, whilst ensuring that appropriate clinical services are provided in the county’s community hospitals, to offer care as close to home as possible.

The patient is at the heart of reconfiguration, and through consolidation, improved patient experience and quality will be delivered by:

- Reducing unnecessary patient journeys
- Improving clinical adjacencies so that support and diagnostic services are close to where they are needed, promoting closer team working and providing a better patient experience
- Reducing delays to care by streamlining care pathways
- Reduce cancellations by protecting our elective beds by separating out emergency and planned care. This will be done by creating a planned ambulatory care hub at the GH as well as re-distributing some of our services into the counties’ community hospitals.

**Return on Investment Payback**

**Estate Deliverables:**
Carter and Naylor Metrics

**Timescales:** 2022/23

**Reconfiguration Programme:** £397.5m capital

**Delivers 3 to 2 acute sites**

- **Value for Money**
- **Staff Welfare**
- **Capital Receipts**
- **Capital Investment**
- **Backlog Maintenance**
- **Space Utilisation**
- **Sustainable Development**
- **Social & Corporate Citizenship**
- **Disinvestment**
- **Housing**

We will fully reinforce this through HTM 07-07 sustainable health and social care buildings, BREEM and achieving sustainability in Construction procurement.

We will aim to conserve and enhance the estate will be fully utilised and will have appropriate measures in place to ensure business resilience and continuity.

Enhanced patient experience – we will provide state of the art facilities that enable clinicians to deliver treatment in a comfortable, caring, safe and uplifting environment, which enhances patient experience.

- **Quality of Estate**
- **Enhanced patient experience**
- **Effectiveness**
- **Equality and Diversity**
- **Health & Safety**
- **Environmental**
- **Value for Money**
Operational Efficiencies

Ensuring the best use of resources is key to delivering financial sustainability across the system. Many of the plans set out how services can be redesigned and the reconfiguration of acute and community hospitals makes the best use of resources.

Lord Carter’s 2015 report, Operational productivity and performance is English NHS acute Hospitals, found that there is significant unwarranted variation across all main resource areas. Through the Reconfiguration Programme the Trust’s has plans to implement as many of the Carter and the 2017 Naylor Review recommendations as possible.

The Trust Cost Improvement Programme delivery includes plans that are based on benchmarking, analytics and opportunities from national best practice such as Getting It Right First Time.

We are committed to recruiting, retaining and supporting our staff to ensure they have productive, healthy and happy working lives, as well as recognising that our staff work best when there is a healthy work life balance. It is also important that consider other barriers to the recruitment and retention and how our approach to estates planning should address these.

Each member of our staff is unique and requires different things from the Trust to ensure we can achieve working arrangements that support the needs of the organisation and our patients, as well as fitting around the needs of each member of staff. This is committed to supporting flexible working and to making this a win-win-win for our patients, our staff and the Trust.

How we develop and deploy our estate has the potential to make a marked impact on our success no only on recruitment and retention but on staff morale and well-being.

5 Year Estates Investment Programme impact on backlog

The Trust estate comprises of a large range of properties of varying age and condition. The overall performance of the estate is directly affected by the level of capital investment and operational resources available.

Historically the Trust has not invested significantly in the estate and as such there are high levels of backlog maintenance prevalent across the Trusts three acute sites. The overall backlog value of backlog recorded and reported via our 2016/7 Estates and Facilities Returns Information Collection (ERIC) is circa £87m.

The reconfiguration programme will not only redesign services to meet future models of care but also reconfigure the physical estate to enable this to be implemented. The investment planned over the next five years will have a positive effect on the estate performance in terms of condition and compliance and the details within this paper provide a high level summary of these benefits on the overall backlog maintenance.

An exercise has been conducted to review the estates element of the five year investment programme. Many of these are project specific which have been reviewed based on the area (sq. m.) of the scheme and apportioned that against the total identified backlog value (£) to that location. Where investment schemes relate site wide issues, such as infrastructure, these have been apportioned accordingly to the backlog element. To mirror the investment programme the backlog reduction has been phased over the life of the programme.

There are a number of assumptions and qualifications which have been made in carrying out this exercise due to the level of detailed information available at this time which are summarised below:

- Not all schemes have been detailed in the five year plan as the business cases and briefs are still to be developed (therefore not included in the backlog reduction)
- Backlog based on 16/17 ERIC returns
- No uplift of backlog costs have been applied for further deterioration of the estate, but this can be applied and an annual basis when the estate and facilities team carry out a desk top review of the 6 facet survey.
- The backlog at LGH fall significantly in year 6 when we dispose of the surplus estate. This is based on the retention of some building on the LGH site (current assumptions are H Block, Maternity Block and the Brandon Unit) which are subject to the outcome of the public consultation and potential future use of the site.

It is planned that as the investment programme is refreshed the Backlog prediction are also refreshed on a regular bases (half yearly).

Chart 12 'Theoretical Diagram' on investment versus backlog reduction

The graph below illustrates the positive impact of the reconfiguration programme on the levels of outstanding backlog across the Trust’s portfolio.
11.10 Financial Estates & Facilities
Revenue Benefits

The Trust is required to clearly articulate its financial strategy for a number of purposes including:

- Summarising the financial impact of the Integrated Business Plan (IBP), or ‘the strategy’
- Demonstration of timing in which the Trust will execute its financial recovery plan and will return to making a surplus or in the very least breakeven
- To inform the cash application process for the Trust to seek cash support whilst operating in financial deficit and for external loans to fund the major capital investments not possible from within Trust internally generated resources
- Aligning internal financial and strategic planning to the Better Care Together (BCT) programme and the LLR Sustainability and Transformation Plan (STP).

A large component of the Trust’s financial strategy is focused on the estate reconfiguration programme. Key milestones to note include:

- On April 28th, an initial bid of £30.8m for capital against the £325m announced in the 2017 spring budget was made in order to progress the interim ICU scheme.
- On May 24th, a second capital bid for £397.5m was submitted reflecting the capital required to deliver the whole reconfiguration programme (this includes the £30.8m capital reflected in the first bid).
- On 17th August 2017, the Trust was given the opportunity to update the original capital bid document to ensure complete alignment with the newly released assessment criteria. There was also a compulsory requirement for all capital bids to complete an additional value for money template. The updated bid documents were submitted by the deadline of Wednesday 6th September 2017.
- Our original bid reflected the STP, which was the delivery of a five year Reconfiguration programme first described in the 2014 LLR Better Care Together Strategic Outline Case (SOC); completing by 2020/21.
- The impact of the STP process and lack of availability of capital has delayed the commencement of this programme, making delivery in this timescale impossible. The timescales for delivery were revised within our bid to reflect the delays that have been experienced and to ensure that the programme is realistic and deliverable. The capital programme will now conclude in 2022/23, with the Trust returning to a surplus financial position in 2023/24.

Reconfiguration Programme Savings
The savings in 2023/24 associated with reconfiguration of the sites have been summarised in the table below:

<table>
<thead>
<tr>
<th>Costs</th>
<th>Savings £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Rates *</td>
<td>847</td>
</tr>
<tr>
<td>Catering *</td>
<td>2,687</td>
</tr>
<tr>
<td>Cleaning *</td>
<td>2,030</td>
</tr>
<tr>
<td>Contract Management *</td>
<td>-</td>
</tr>
<tr>
<td>Electricity *</td>
<td>1,199</td>
</tr>
<tr>
<td>Estates Management &amp; Maintenance *</td>
<td>1,802</td>
</tr>
<tr>
<td>Gas *</td>
<td>1,144</td>
</tr>
<tr>
<td>Laundry Contract *</td>
<td>541</td>
</tr>
<tr>
<td>Other *</td>
<td>589</td>
</tr>
<tr>
<td>Portering *</td>
<td>917</td>
</tr>
<tr>
<td>Security *</td>
<td>283</td>
</tr>
<tr>
<td>Switchboard *</td>
<td>-</td>
</tr>
<tr>
<td>Water &amp; Sewerage – Charges *</td>
<td>321</td>
</tr>
<tr>
<td>**Gross Estates &amp; Facilities Costs *</td>
<td>12,359</td>
</tr>
<tr>
<td>Income from Car Parking &amp; Catering</td>
<td>2,052</td>
</tr>
<tr>
<td>Net Estates &amp; Facilities Costs</td>
<td>10,307</td>
</tr>
<tr>
<td>Depreciation **</td>
<td>2,420</td>
</tr>
<tr>
<td>Return on Asset **</td>
<td>2,527</td>
</tr>
<tr>
<td>Capital Charges **</td>
<td>4,947</td>
</tr>
<tr>
<td>Direct Costs &amp; Overheads ***</td>
<td>9,272</td>
</tr>
<tr>
<td>Total Costs</td>
<td>24,526</td>
</tr>
</tbody>
</table>

Table 14 Reconfiguration programme savings

*Data is from the 15 – 16 Budget
**Data is from the 16 – 17 Asset Register
***Data is from the 14 – 15 costing breakdown

Please note that the data has not materially changed since the 2015 version of the Financial Strategy and are therefore those reviewed independently by Ernst and Young in 2015.

The specific assumptions contained within these savings are as follows:

- Baseline costs not inflated
- Buildings & land capital charges saved, no change to IT & equipment
- Full saving assumed on majority of estates and facilities costs with zero on some others, reality is likely to be somewhere in between.

The direct costs and overheads included contain the following assumptions and calculations:

- Non clinical/management staff reduced as a result of reducing from 3 sites to 2 based on 50% of site share of costs, £4.8m
- Nursing saving based on 33% of theatres pay budget (£1.7m) with other nursing (£0.2m), total £1.9m
- Medical staff savings based on 1 consultant per specialty (£1.3m) with junior doctor savings (£0.4m) in the same proportion, total £1.7m
- CNST saving based on reduction of doctors and activity which drive the cost, total £0.3m
- Pharmacy & imaging savings as a result of reduced site presence based on 50% of site share of costs, total £0.6m.
- Each discrete business case can begin to deliver savings prior to the full estate solution being in place.
- The phasing of estate related cost savings and whether the cost savings shown in table 13 can be delivered, in part, any earlier than 2023/24.
12 Conclusion

In summary, the Estate Strategy demonstrates that the consolidation of acute clinical services onto two sites provides a feasible option for the Trust; however detailed planning is required to further develop the proposed design solutions.

There is a clear vision for the future of the Trust and the goals to be obtained, over a realistic time period with a commitment through the STP for additional funding.

This vision can only be realised through reform and more innovative ways of working, not only within the Trust but also across the wider healthcare economy of LLR.

The resources needed to carry out this transformation are not only financial, but include the people with the necessary skills and commitment at all stages of the change process.

The outputs

The proposed design solution allows the Trust to reduce their GIFA (m²) by 18% with further land identified across the three sites which could potentially be sold for development. Any potential receipts generated from the sale of this land could directly cross-subsidise the new hospital development.

The strategy articulates a plan for detailed delivery of the Trust’s strategic objectives. The key conclusions from this Estate Strategy are:

- The Trust’s Clinical Strategy and future model of care is the key driver for change and there will continue to be full engagement with this dynamic process.
- The Trust needs to improve the efficiency and cost effectiveness of its estate, to provide clinical facilities which are affordable and cost effective, and therefore make a positive contribution to the Trust’s financial position.
- There are a number of clinical, estate and financial drivers for change and an overriding need to rationalise the estate and reconfigure services to improve the patient experience and make the Trust more efficient.
- The Estate Strategy will continue to focus on making the most effective and efficient use of the Trusts hospital sites, to enable clinical staff to work in the right place, to provide the best, safest and most seamless care.
- The Trust faces a significant challenge to deliver this strategy, however, as long as there remains an appetite to make the inevitable difficult choices, operating within the flexible framework, as articulated within this strategy, then significant improvements to the management and delivery of the Trust estate will be realised.
- The proposed investments and phasing will be continually and individually assessed as part of the capital planning process.
- Outputs of service changes and reconfiguration will lead to opportunities for disinvestment and associated capital receipts.

12.1 Closing Statement by Director of Estates & Facilities

“The principal purpose of this version of the Estate Strategy is to inform the delivery of the wider health economy Estate Strategy and provide a transformational platform based on the current versions of our site development control plans.

It addresses the main strategic drivers for change as they relate to our estate. Further iterations will address the wider contextual issues such as our plans for education, teaching and research.

We will continue our journey of improvement and reflect these changes in future updates including the production of a fully integrated Clinical and Estate Strategy.

Watch This Space!”

Darryn Kerr, Director of Estates & Facilities
12.2 Next steps

These are the future actions required to develop the Estate Strategy:

- NHS Improvement and NHS England to confirm LLR STP funding position.
- Confirmation of planning assumptions and service model (detail development) which will lead to refinements in the proposed design solutions.
- Agree appropriate level of upgrade works; to be informed by the latest condition survey information.
- Review operational parameters including the number of outpatient/theatre sessions per week and the impact the Trusts 'hot desk' policy would have on space requirements.
- Consultation with the Children’s Board to develop proposals for the reconfiguration of children’s services on the LRI site to create a unified centre (excluding children’s cardiac which will remain at GH).
- Ensure all key projects are taken through a rigorous business case process to ensure they deliver benefits based on the situation at the time of their development.
- Detailed build-up of capital costs to provide an overall 5 year capital programme to ensure appropriate finances are allocated to implement the changes required.
- Site infrastructure plans to be developed for the changes the Trust wish to make on each site.
- Agree a clear communications message promoting estate changes to the public, commissioners and other stakeholders.
- Identify a plan for those changes which require public consultation.
- Review opportunities for further site rationalisation and a detailed masterplanning exercise for the future of LGH.
12.3 Evaluation & Review

Review and Challenge
Proper and effective challenge of the performance of the estate provides the cornerstone of effective estate management. Every property asset should be subject to full scrutiny in accordance with the Estate Strategy and supporting reconfiguration delivery programme. Additional challenge may result from the need to review discrete groups of property assets either on a geographical or service basis.

Anticipated outcomes of the Estate Strategy are summarised below.

- Release of capital for re-investment or debt reduction
- Release of surplus land for housing development
- Improved running costs
- Better public service provision by improved property and co-location of services
- Property assets in an improved condition
- Improved property utilisation and bringing together similar uses into the same property, rather than providing them separately
- Improved productivity, changes in corporate culture and facilitation of corporate change
- Innovative strategic procurement.

The Estates & Facilities department are experiencing pressures on both revenue budgets and capital programme, therefore effective review and challenge will help to ease these financial pressures as well as providing the opportunity to support the Trust’s corporate and service objectives.

Measuring success
In order to measure success and identify areas for improvement, Estates & Facilities will need to regularly review performance of the estate.

Outlined below is what successful delivery of this Estate Strategy will look like:

- Increased occupancy levels within the Trusts commercial estate and increased economic growth
- Reduction in Trust operational floor space
- Improved estates and property asset management
- Increased proportion of buildings suitable for their current use
- Increased income generation from the Trust’s commercial estate
- A fully implemented property disposal programme
- Improved capital governance of construction projects
- Projects delivered on time, on budget and to required specification
- High level of customer satisfaction
- Improved customer and service user experience
- Improved change control procedures.

Property review/challenge process
Based on best practice property asset management, going forward Estates & facilities will need to continue to review all Trust assets on an ongoing basis. Part of this process relates to setting, monitoring and reporting against performance targets.

For this Estate Strategy to achieve its objectives, its ambition needs to be accompanied by year on year delivery of significant, meaningful and measurable benefits to the Trust and the wider LLR footprint.

The Trust needs to be capable of demonstrating these benefits through its own performance measures and to satisfy both external scrutiny and comparison against external benchmarks. The performance challenge for the Trust in terms of property asset management is captured in the following chart.

It embraces external assessment, to meet statutory performance obligations and internal challenge in terms of a performance measurement framework. Put simply, the approach is to assess how well the Trust against a clear set of performance criteria which reflect the Trust priorities in terms of efficiency, effectiveness and added value.

Estates & Facilities will need to ensure that the structure for and disciplines around corporate property management are maintained and refreshed annually.

Post Project Evaluation
To learn from experience, all major projects will be evaluated. In accordance with current guidance and good practice, the Project will be evaluated in 3 stages:

1. Monitor progress and evaluate the project outputs on completion of the new facilities. This will take place at each stage as new facilities are completed
2. Initial post-project evaluation of the service outcomes six to 12 months after all the relevant facilities have been commissioned
3. Follow-up post-project evaluation to assess longer-term service outcomes two years after the facilities have been commissioned.

The evaluation process will be overseen by the relevant Project Board. At each stage of the evaluation, a formal report will be issued. At each stage, the project evaluation on completion will determine what went well during the procurement of the new facilities, what went less well and what lessons may be learnt from the process, and will be addressed by reviewing:

- To what extent relevant project objectives have been achieved
- To what extent the project went as planned
- Where the plan was not followed, why this happened
- What learning may be transferred to other projects, internally or externally.
## Glossary of Terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AICU</td>
<td>Adult Intensive Care Unit</td>
</tr>
<tr>
<td>ALOS</td>
<td>Average Length Of Stay</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>CAAS</td>
<td>Compliance Assessment and Analysis System</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CDM</td>
<td>Construction Design Management</td>
</tr>
<tr>
<td>CHUGGs</td>
<td>Cancer, Haematology, Urology, Gastroenterology and General Surgery</td>
</tr>
<tr>
<td>CIL</td>
<td>Compliance Improvement Loop</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CMG</td>
<td>Clinical Management Group</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CRL</td>
<td>Capital Resource Limit</td>
</tr>
<tr>
<td>CSI</td>
<td>Clinical Support and Imaging</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>DCCM</td>
<td>Department of Critical Care Medicine</td>
</tr>
<tr>
<td>DCP</td>
<td>Development Control Plan</td>
</tr>
<tr>
<td>DNO</td>
<td>Distribution Network Operator</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EAC</td>
<td>Equivalent Annual Cost</td>
</tr>
<tr>
<td>ECMO</td>
<td>Extracorporeal membrane oxygenation</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EDS</td>
<td>Electrodiagnostics</td>
</tr>
<tr>
<td>E&amp;F</td>
<td>Estates &amp; Facilities</td>
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<tr>
<td>EFL</td>
<td>External Financing Limit</td>
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<tr>
<td>EMAS</td>
<td>East Midlands Ambulance Service</td>
</tr>
<tr>
<td>EMHCIC</td>
<td>East Midlands Congenital Heart Centre</td>
</tr>
<tr>
<td>ERCP</td>
<td>Endoscopic Retrograde Cholangio-pancreatography</td>
</tr>
<tr>
<td>ERIC</td>
<td>Estates Return Information Collection</td>
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<tr>
<td>ESB</td>
<td>Executive Strategy Board</td>
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<tr>
<td>ESM</td>
<td>Emergency and Specialist Medicine</td>
</tr>
<tr>
<td>EUS</td>
<td>Endoscopic Ultrasound</td>
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</table>

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>FBC</td>
<td>Full Business Case</td>
</tr>
<tr>
<td>FM</td>
<td>Facilities Management</td>
</tr>
<tr>
<td>FYFV</td>
<td>Five Year Forward View</td>
</tr>
<tr>
<td>GEM</td>
<td>Generic Economic Model (Dept of Health)</td>
</tr>
<tr>
<td>GH</td>
<td>Glenfield Hospital</td>
</tr>
<tr>
<td>HBN</td>
<td>Health Building Notes</td>
</tr>
<tr>
<td>HE</td>
<td>Homes England</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>HPB</td>
<td>Hepato-Pancreato-Biliary</td>
</tr>
<tr>
<td>HPPT</td>
<td>Hospital Pharmacy Transformation Plan</td>
</tr>
<tr>
<td>HTM</td>
<td>Health Technical Memorandum</td>
</tr>
<tr>
<td>I&amp;E</td>
<td>Income and Expenditure</td>
</tr>
<tr>
<td>IBD</td>
<td>Interest Bearing Debt</td>
</tr>
<tr>
<td>ICNARC</td>
<td>Intensive Care National Audit and Research Centre</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IFPIC</td>
<td>Integrated Finance and Performance Investment Committee</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>Information Management and Technology</td>
</tr>
<tr>
<td>ITAPS</td>
<td>Intensive Care, Theatres, Anaesthetics, Pain and Sleep</td>
</tr>
<tr>
<td>ITFF</td>
<td>Independent Trust Financing Authority</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>LGH</td>
<td>Leicester General Hospital</td>
</tr>
<tr>
<td>LLR</td>
<td>Leicester, Leicestershire and Rutland</td>
</tr>
<tr>
<td>LPT</td>
<td>Leicester Partnership NHS Trust</td>
</tr>
<tr>
<td>LRI</td>
<td>Leicester Royal Infirmary</td>
</tr>
<tr>
<td>LTFF</td>
<td>Long Term Financial Model</td>
</tr>
<tr>
<td>MRSA</td>
<td>Meticillin-resistant Staphylococcus aureus</td>
</tr>
<tr>
<td>MSS</td>
<td>Musculoskeletal and Specialist Surgery</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
</tr>
<tr>
<td>NPC</td>
<td>Net Present Cost</td>
</tr>
<tr>
<td>NSSG</td>
<td>Network Site Specific Groups</td>
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</table>

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>NTDA</td>
<td>National Trust Development Authority</td>
</tr>
<tr>
<td>PA</td>
<td>Planned Activity</td>
</tr>
<tr>
<td>PACH</td>
<td>Planned Ambulatory Care Hub</td>
</tr>
<tr>
<td>PAM</td>
<td>Premises Assurance Model</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PDC</td>
<td>Public Dividend Capital</td>
</tr>
<tr>
<td>PEAT</td>
<td>Patient Environment Action Team</td>
</tr>
<tr>
<td>PFI</td>
<td>Private Finance Initiative</td>
</tr>
<tr>
<td>PF2</td>
<td>Private Finance 2</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
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<tr>
<td>PLACE</td>
<td>Patient Led Assessment of the Care Environment</td>
</tr>
<tr>
<td>PVE</td>
<td>Portal Vein Embolisation</td>
</tr>
<tr>
<td>PYE</td>
<td>Post year end</td>
</tr>
<tr>
<td>RCV</td>
<td>Renal, Respiratory, Cardiac and Vascular</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to Treatment Time</td>
</tr>
<tr>
<td>SARF</td>
<td>Severe acute respiratory failure</td>
</tr>
<tr>
<td>SDMP</td>
<td>Sustainability Development Management Plan</td>
</tr>
<tr>
<td>SFI</td>
<td>Trust Standing Financial Instructions</td>
</tr>
<tr>
<td>SIRT</td>
<td>Selective Internal Radiation Therapy</td>
</tr>
<tr>
<td>SMART</td>
<td>Specific Measurable Achievable Realistic Time related.</td>
</tr>
<tr>
<td>SO</td>
<td>Standing Order</td>
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<tr>
<td>SRO</td>
<td>Senior Responsible Officer</td>
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<td>STP</td>
<td>Sustainability and Transformation Plan</td>
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<td>TACE</td>
<td>Transcatheter Chemo Embolisation</td>
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<td>TAVI</td>
<td>Trans-Catheter Aortic Valve Insertion</td>
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<td>Travel Plan</td>
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<td>University Hospitals of Leicester</td>
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<td>Value Added Tax</td>
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<tr>
<td>VFM</td>
<td>Value for Money</td>
</tr>
<tr>
<td>W&amp;C</td>
<td>Women’s and Children’s</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
<tr>
<td>YDU</td>
<td>Young Disability Unit</td>
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</table>