3Ts
Hospital Redevelopment
Teaching • Trauma • Tertiary care

Brighton and Sussex NHS
University Hospitals

3Ts Hospital Redevelopment Programme

Full Business Case

Management Case

February 2016

brighton and sussex
medical school

NHS
Health Education Kent, Surrey and Sussex

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Introduction

1. The purpose of the Management Case is to demonstrate that the preferred option can be delivered successfully, in accordance with recognised best practice. This includes robust arrangements for change management, contract management, the delivery of benefits, the management and mitigation of risk, and post-project evaluation.

2. Although technically outwith the scope of the 3Ts Programme and therefore the Full Business Case, the chapter also deals with wider Trust management and governance issues as they have an impact upon, and vice versa, the 3Ts Programme and there are some important inter-relationships.

3. The Full Business Case has been developed to align with the Trust Development Authority and NHS England Business Case checklists and supporting documents.

Project Methodology

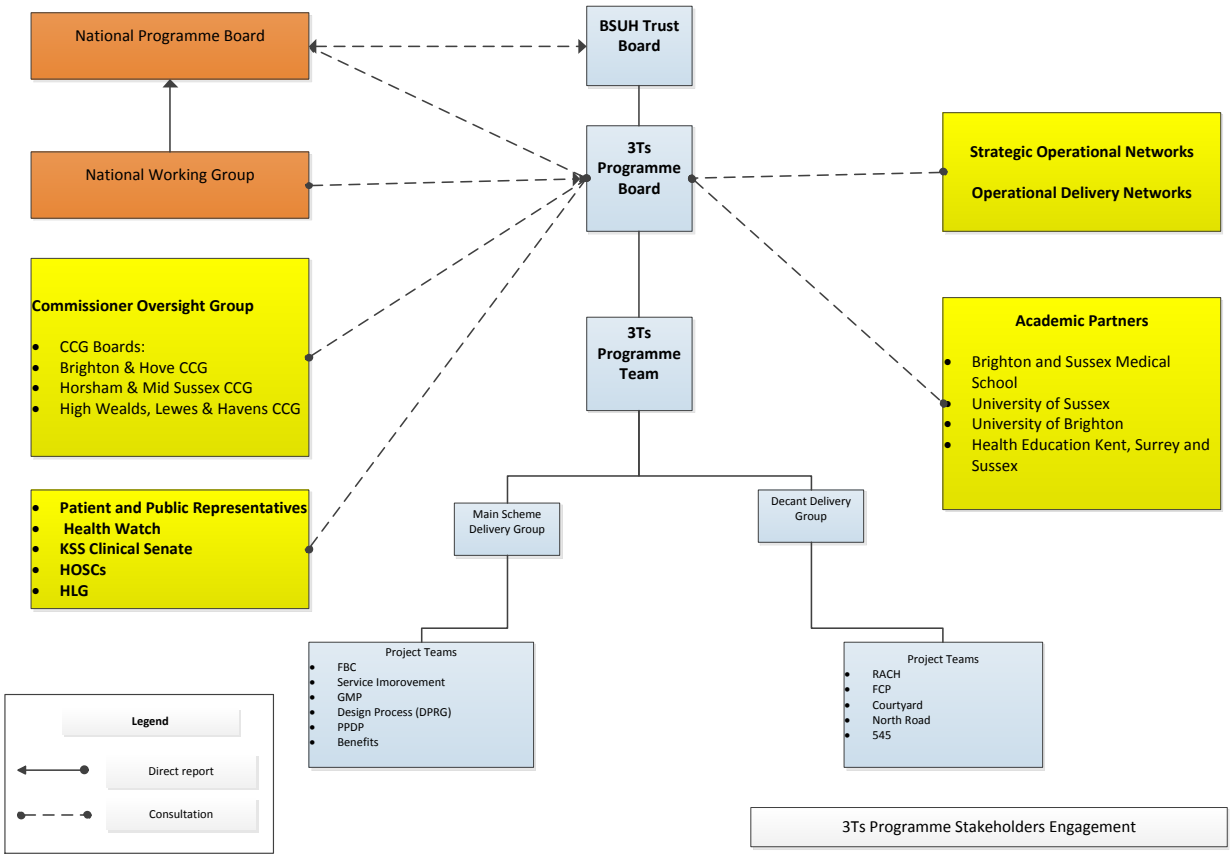
4. The programme's organisation reflects the seven core PRINCE2 principles of project management:

    - continued business justification
    - learn from experience
    - defined roles & responsibilities
    - manage by stages
    - manage by exception
    - focus on products
    - tailored to suit the project environment.

Stakeholders

5. The 3Ts Programme has a range of stakeholders. The stakeholder engagement programme and analysis of issues raised are included in the Strategic Case.

Stakeholder Engagement Diagram



Accountabilities

6. Programme accountabilities are set out in the table below.

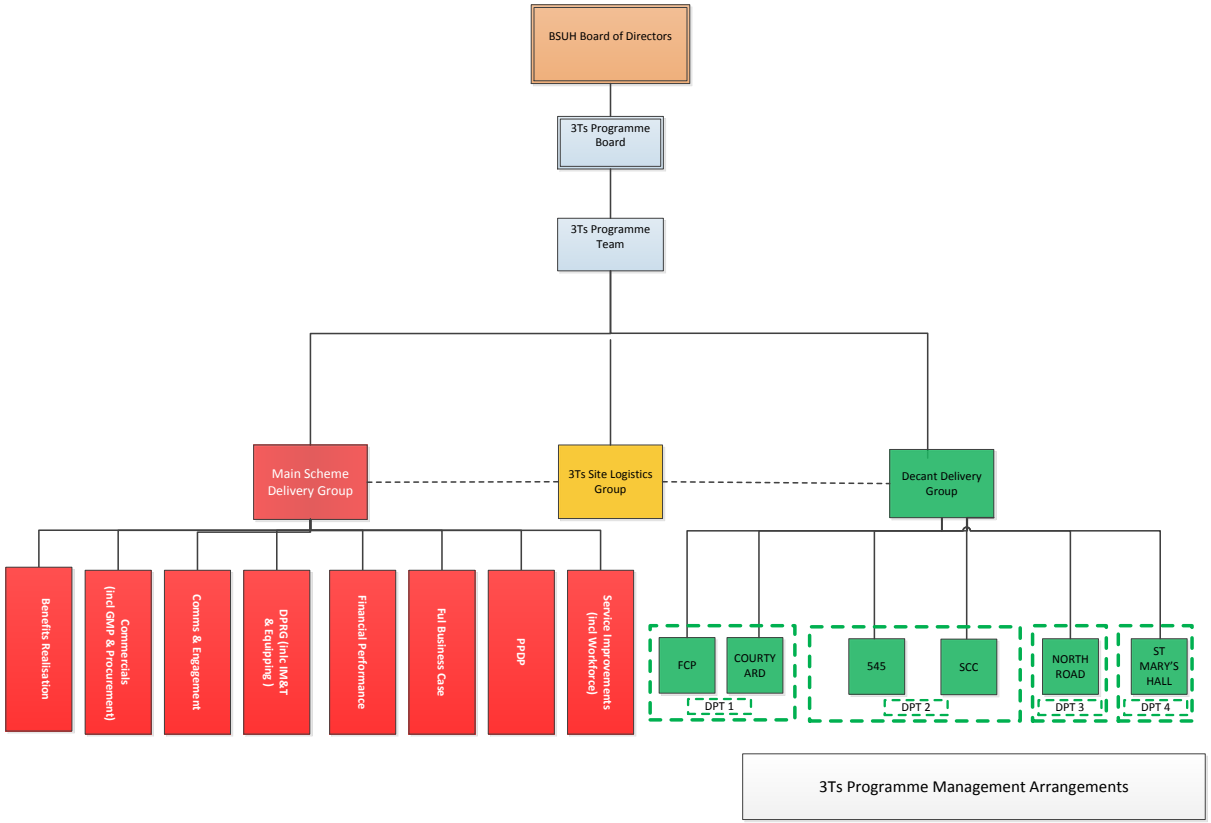
Programme Accountabilities

Role	Description
Investment Decision Maker	• The Trust Board of Directors acts as the Investment Decision Maker, as defined in the NHS Capital Investment Manual. • The 3Ts Programme Director reports to the Trust Board on progress and management of risk at every meeting. The Board also receives a written summary of business transacted at each meeting of the 3Ts Programme Board.
Senior Responsible Owner	• Until 2013 the Trust Chief Executive served as Senior Responsible Owner for the programme. Following an external review of programme governance and assurance by Professor Selim (Cass Business School), the Trust Board approved the transfer of this role to the 3Ts Programme Director.

Role	Description
	• The 3Ts Programme Director/SRO reports to the Director of Strategy and Change. • As the Trust's Accountable Officer, the Chief Executive retains ultimate accountability for the successful delivery of the programme.
3Ts Programme Board	• The 3Ts Programme Board is constituted as a subcommittee of the Trust Board. This is chaired by the Senior Responsible Owner and includes the Trust Chief Financial Officer, Chief Nurse, Medical Director, Director of Corporate Affairs, Director of Health Informatics, Operational Director of HR and Chief Operating Officer; the Principal Supply Chain Partner; and Independent Cost Advisor. • The Programme Board is the decision-making body for the management of the programme, including, on behalf of the Trust Board, oversight of the development of the Full Business Case and progress towards approval. • Terms of Reference were updated following the Selim governance review (appended). These will be reviewed again on FBC approval and as the programme moves from planning into implementation stage. • Programme Board minutes and documents/presentations are posted on the public-facing website, which is also accessible for staff via the internal Trust intranet. Following approval, the FBC will also be published in this manner.
Health Economy Governance	• At OBC stage, the 3Ts Programme Board included the Trust's principal commissioners and representatives from key partner organisations. This helped to ensure that stakeholders' views were fully understood and factored into the planning process. • The Selim governance review recommended establishing a separate forum to engage with commissioners, and to focus the Programme Board on internal management. This reflects the current stage of the programme, and the changes in NHS architecture following the Health & Social Care Act 2012. • The 3Ts Commissioner Oversight Forum has been operating since November 2013, chaired by the Area Director for NHS England's Surrey & Sussex Team. Terms of Reference are included at Appendix 6.2. • Following OBC approval, this was supplemented by a new Stakeholder Board; the 3Ts National Programme Board which includes representation from the Trust and the key approving/assurance organisations (the Trust Development Authority, NHS England, the Clinical Commissioning Groups, the Department of Health and HM Treasury. The work of this Board is also supplemented by a National Working Group with a similar, but smaller membership.

Programme Structure

7. This is a significant and complex programme that intersects with almost all other major Trust programme. The chart below sets out the programme's internal organisational/governance structure. The membership of individual groups is identified in the relevant appendix, but as well as the key representatives of the departmental user groups involved, the Trust Programme team draws from the experience of expertise of other internal advisers within the Trust, particularly in relation to Safety and Quality, Infection Prevention and Control, Risk Management, Fire Safety, Facilities Management and Staffing. This expertise is drawn in in a controlled way through the programme structure to ensure that key inputs are provided at the right time and in a controlled and managed way.


BSUH Board of Directors
3Ts Programme Board
3Ts Programme Team
Main Scheme Delivery Group
3Ts Site Logistics Group
Decant Delivery Group
Benefits Realisation
Commercials (Incl GMP & Procurement)
Comms & Engagement
DPRG (inlc IM&T & Equipping)
Financial Performance
Ful Business Case
PPDP
Service Improvements (incl Workforce)
FCP
COURTYARD
DPT 1
545
SCC
DPT 2
NORTH ROAD
DPT 3
ST MARY'S HALL
DPT 4
3Ts Programme Management Arrangements

8. Terms of Reference for each committee are appended. Of particular note:-

- Main Scheme Delivery Group (MSDG), which is chaired by the Programme Director. This group is tasked with progressing the main scheme.
- Decant Delivery Group (DDG), which is chaired by the Associate Clinical Director of 3Ts. This group is tasked with progressing the decant workstreams.

9. Other sub groups provide the following functions:

- the Design Process Review Group (chaired by the Programme Director/SRO). This considers all proposed amendments to programme scope/design to ensure a rigorous change control process. Scope changes with net cost/space impact are referred to the Programme Team and, as appropriate, 3Ts Programme Board;
- the Patient & Public Design Panel (chaired by the Associate Director, Programme Office). This provides an on-going mechanism for patient/public feedback on design issues, in addition to ad hoc or task-and-finish groups;
- the Benefits Realisation Group (chaired by the Programme Director/SRO). This group is responsible for ensuring robust benefits realisation plan, including ongoing monitoring/reporting and Post-Programme Evaluation.

Clinician Involvement

10. Clinician engagement (in its broadest sense – not just medical staff) is critical and this has been designed into the programme across the range of activities and at every level of governance – from the Programme Board through to each individual user group. Frontline staff/clinicians and key Trust leads (eg. the Infection Prevention & Control team) are involved in the individual design groups. The list of clinical staff who have been involved to date is included as an appendix to the part of the Full Business Case:-

- To date, 198 users have been formally engaged in the 1:200 and 1:50 design process in almost 100 separate design meetings;
- Where possible, the same staff members are being engaged in the next stage of the design process. Where staff have moved on, retired or changed roles, appropriate staff (clinical and non-clinical) are being recruited to the process.

11. In addition, the programme has a Clinical Chief and Deputy resourced to provide regular input as well as at key critical periods. The Deputy Clinical Chief of 3Ts also chairs the Decant Delivery Group to ensure that there is a clinical oversight of these activities.

3Ts Programme Team

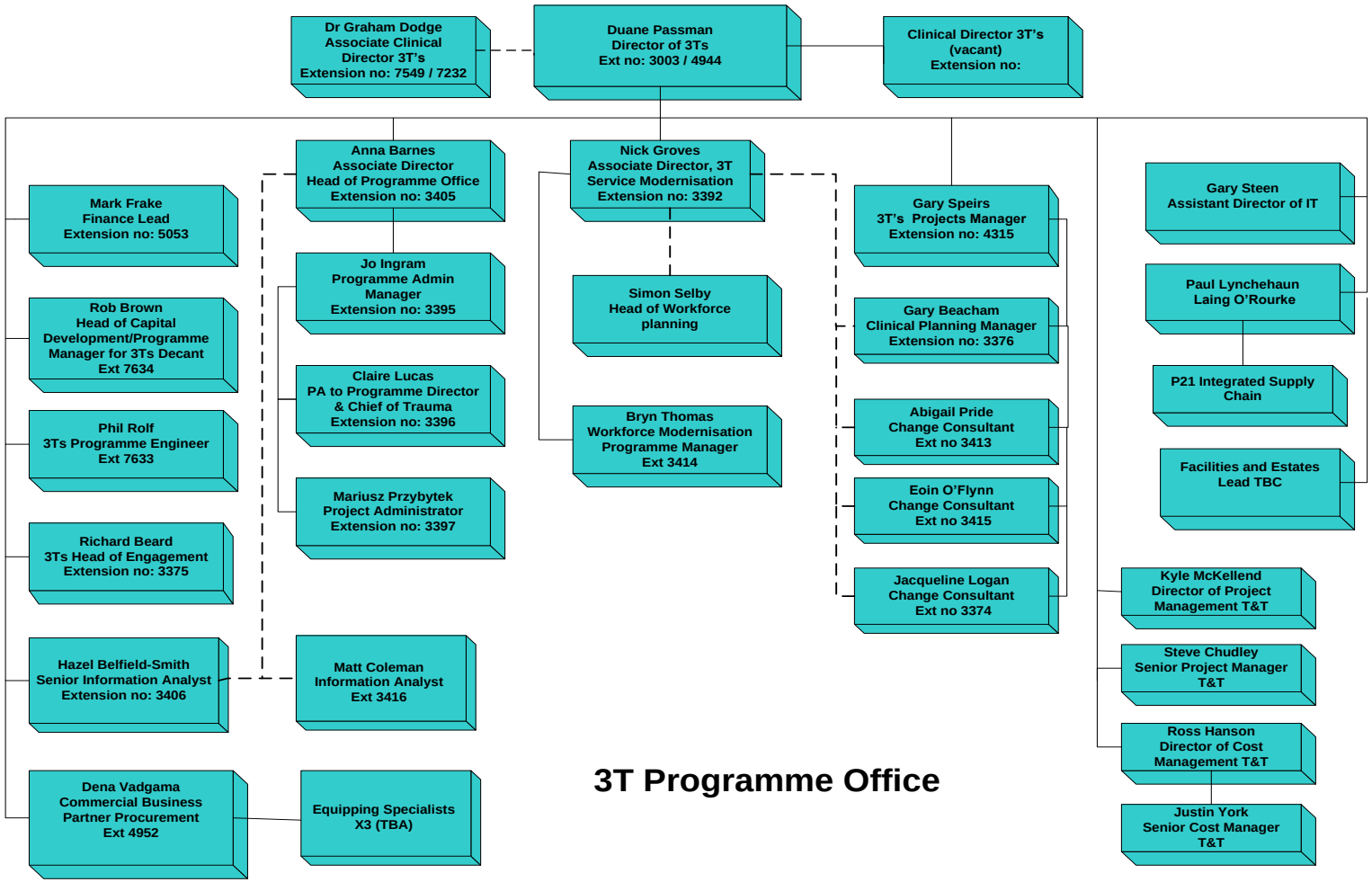
12. The programme team supports/advises the Programme Director in undertaking the activities and responsibilities delegated by the Programme Board and Chief Executive. The team structure is set out below.

13. Key activities include:

- managing the external input from the ProCure21 PSCP and other external advisors to develop the preferred option and associated decant plan;
- Inputting to the design and Schedule of Accommodation at key, programmed intervals throughout the programme;
- developing activity projections and models of care on a specialty basis through engagement with internal and stakeholders, including patient representatives;
- financial modelling of the preferred option;
- discussing and agreeing new models of care which may be required;
- co-ordinating the production of the FBC within budget and to the timetable agreed by the Programme Board; and
- communicating effectively with and engaging the Trust's strategic partners and key stakeholders, including local residents, patients and their representatives.

14. Summary biographies of project team members and skillset analysis are included at the end of this chapter.

3Ts Programme Office Management Structure



Use of Internal Advisors

15. In addition to the dedicated 3Ts team, the programme has drawn on specialist expertise from within the Trust, including staff formally seconded on a part-time basis. These staff attend design meetings as and when required and play a key role in the governance and assurance process prior to formal sign off.

Key Internal Advisers

Advisor	Name	Title
Infection Control[1]	Suzanne Morris	Nurse Consultant and Deputy Director Infection Prevention & Control
Facilities & Estates	Dale Vaughan	Operational Director Estates and Facilities
Procurement & Equipping	Dena Vadgama	Commercial Business Partner- Procurement
Medical Physics	Andrew Hince	Deputy Head of Radiation Safety
Health Informatics	Gary Steen	Associate Director of IT
HR	Lorissa Page	Assistant Director of HR
Workforce Planning	Simon Selby	Trust Head of Workforce Planning

16. The Trust has appointed Laing O'Rourke as its Principal Supply Chain Partner under the ProCure 21 (P21) framework. Under this arrangement, the PSCP appoints most of the programme's external advisors, drawing on its approved supply chain. The advisers will vary over time in accord with the stage of the programme. The following have been used to develop the OBC to FBC:

External Advisors (OBC to FBC) BSUH

[1] The 3Ts project team have been working closely with the Deputy Director of Infection and Control (DIPC) and the IPC team who are members of the Trusts Infection Prevention and Control Action Group (IPAG). IPC have been members of the 3Ts Design Process Review Group which now reports into the Main Scheme Delivery Group. The IPAG is an operational forum which has delegated authority to provide a trust wide response to the management of infection prevention. The group members include the director and deputy director of Infection prevention and control, the IPC team, estates, risk management, occupational health and specialist IPC staff including a named consultant microbiologist (The Infection Control Doctor, primarily Dr Marc Cubban, Consultant Microbiologist) and antimicrobial pharmacist.

Role	Company
Public Arts advice and supply chain management	Willis Newson
Independent Cost consultants (QS)	Turner & Townsend
Health planners and risk management services	Sweett Group
FM	EC Harris
CDM Coordinator	Turner & Townsend
Firecode	Tenos

External Advisors (OBC to FBC) PSCP

Role	Company
Equipping	MTS Consulting
Mechanical and Electrical	BDP
Structural engineers and travel planning	WSP
Energy Efficiency	Conclude Consultancy
Architects	Building Design Partnership (BDP)
Town Planning	BDP planning

Budget & Contract Management

17. The Programme Director/SRO is the accountable budget-holder for the 3Ts programme, supported by the 3Ts Programme Accountant.

18. Project fees associated with the P21 contract and its deliverables have been agreed as part of the formal P21 Phase 3 Contract. These are invoiced by Laing O'Rourke monthly in arrears. Invoices are supported by timesheets, and Earned Value Analysis is assessed by the Trust's Independent Cost Advisor (Turner & Townsend).

19. External advisers appointed by the Trust invoice the Programme Director/SRO directly and are required to comply with Trust Standing Financial Instructions for the provision of services.

20. The design development programme with external consultants is being managed through the ProCure 21 (P21) contract framework and Engineering and Construction Contract. Changes to the scope of the contract and any associated fee and programme implications are notified to the Trust by the P21 PSCP, initially as Early Warning Notices and then as Contract Compensation Event notices, in accordance with the P21 framework procedures.

21. Compensation Events are audited and signed off by the Trust's independent Quantity Surveyor for the programme (Turner & Townsend) prior to agreement and payment by the Trust via the monthly valuation process. The forecast contract outturn and any variations are reported to the Programme Director on a monthly basis, and to the Programme Board via monthly report.

22. Contracts and fees for other external consultants supporting the 3Ts programme outside the P21 framework are competitively tendered and appointed in accordance with the Trust's Standing Financial Instructions. Variations to contracts are agreed with the Programme Director on a case by case basis.

Risk Management

23. This section describes how programme risks are identified, managed and mitigated, and arrangements for risk management as the programme progresses to completion. It identifies the current top risks (the full Risk Register is appended).

24. The approach to Risk Management draws on the PRINCE2 methodology, which encourages risks to be identified, owned and managed at the lowest possible level, with suitable mechanisms for escalation when required.

Risk Management Processes

25. The 3Ts programme maintains an integrated Risk Register, including both Trust and contractor/construction risks, which is managed in collaboration with the PSCP under P21 procedures[2]. Risks are identified by individual team members and by each subcommittee (as a core element of its role).

[2] Department of Health (2007) *The ProCure21 Guide: Achieving Excellence in Construction*

26. The programme uses the standard OGC risk scoring system[3].

		Likelihood				
		Highly likely (5)	Likely (4)	Fairly likely (3)	Unlikely (2)	Very/ extremely unlikely (1)
		Over 95%	50-95%	21-49%	2-20%	Up to 2%
Impact	Disastrous (5)	H	H	H	M	H
	Severe (4)	H	H	M	M	H
	Large (3)	H	M	M	L	L
	Marginal (2)	M	M	L	L	L
	Negligible (1)	L	L	L	L	L

Impact Description	Scenario	Guide Cost % of Project	Guide Time % of Programme
Disastrous (5)	Business investment could not be sustained, project at risk	> 2	> 5
Severe (4)	Serious threat to project	1 – 2	2 – 5
Large (3)	Reduces viability significantly	0.5-1	1 – 2
Marginal (2)	Small effect on viability	0.1-0.5	0.5-1
Negligible (1)	Trivial effect on viability	< 0.1	< 0.5

[3] Office of Government Commerce (2002) *Management of Risk: Guidance for Practitioners*

Score	
Low Risk	1-6
Medium Risk	7-14
High Risk	15-25

27. The programme team updates its assessment of pre- and post-mitigation risk and this is reviewed formally on a monthly basis with the Trust's risk advisor and(until recently) a representative from TIAA (formerly South Coast Audit). The 3Ts Programme Board receives monthly reports and formally approves changes to the Risk Register, including new and closed risks. Top risks and associated mitigations are also included as a standing element of the 3Ts Programme Director/SRO's monthly report to the Programme Board.

28. For additional assurance, the risks which threaten Trust business continuity are added to the Trust-wide Risk Register (DATIX), reviewed with the Trust Head of Risk Management, and additionally reported through the Finance and Workforce Committee of the Board of Directors.

29. External assurance to this process was provided by TIAA and Audit Commission. Grant Thornton now undertakes this function. This informs the Trust's Annual Governance Statement, signed by the Chief Executive.

Current Risk Position

30. The Risk Register currently comprises 246 risks, of which 73 relate to the decant programme. Costings at OBC and FBC stage are summarised below – this is discussed in detail in the Economic Case.

Stage	Costed Contingency	%
OBC (2011)	£17.65m	8.5%
FBC (2015)	£15.3m excl. decant	5.26%

31. The top programme risks (assessed as likelihood x severity) and principal mitigations are set out in the table below.

Key Programme Risk areas (as at December 2015)

No. of Risks	Type	Risk	Mitigations
54	Construction	**Capital Costs / Equipment** • Changes to management structure/ responsibilities and shortage of staff to participate in design process. • Changed governmental or local health economy priorities leading to abortive design costs. • Construction delays caused by requirements from statutory authorities outside BSUH control such gas/water/fire. • Legal warrantees with the adjacent SPV for the children's' hospital causing delay to GMP. • Wildlife impacts on construction and surveys, eg. relocation of Peregrine Falcon which could lead to delay. • Planning requirements leading to increased cost such as soundproofing of helipad and increased provision of cycle spaces (part of S106 agreement). • The highest rated construction risks concern the helipad. • The Trust also carries the risk of uncertainty regarding the time required to approve the design making it difficult to release the clinical staff needed to contribute to the design.	• Appropriate mitigations include outsourcing some of this work to contractors with expertise in the field.
28	Performance (of PSCP)	• Key risks identified in the joint risks workshops with the PSCP: - Failure to meet BREEAM standards - Failure to design to brief - Failure to achieve AEDET - Failure to design to specification e.g. infection control • The main reason for continuing to carry these risks relates to changes in the brief because of external requirements from DH, changes to HBNs or changes in clinical practice.	• To a great extend the NEC framework contract minimises these risks and has a good public record for schemes being delivered to time and within the GMP (84% as of 2010). This is partly due to the “Open Book” nature of the contract, and the shared financial incentives for performing well. • The mitigations include robust budget and a well-managed design control process, which can accommodate any necessary changes and incur minimal additional design costs.
18	Functioning of the hospital	• The highest scoring risk concerns the construction and operation of the helipad. This is appropriately flagged as it ensures that the design challenges associated with the construction of the helipad on TKT are given sufficient focus. • The additional challenges of running a hospital whilst developing 40% of the site are risks associated with vibration, noise, dust, apergillus, construction traffic and	• The mitigations are chiefly those which have been successfully used in other hospitals during construction, such as acoustic screening, dust dampening and, when absolutely necessary, providing additional capacity (e.g. MRI) in temporary locations. • Additional parking provision is also being actively sought in the local area.

No. of Risks	Type	Risk	Mitigations
		excavation, the effects on clinical activities, patient comfort and air quality. • These risks also cover the potential effects on staff who may have anxieties about the problems in providing clinical services during noisy construction periods. • The loss of parking during the decant period is also included here, as is the specific risks around ICT.	
23	Income, transitional costs and commissioning	Examples include: • Short term - Lack of support for the redevelopment. - Lack of support for relocation of staff from HWP. - Loss of income during construction phase as services are not able to operate as normal. • Long term (ie. post construction) - Estimated income from income generating schemes is incorrect Volume and case mix of activity estimated incorrectly to support services.	• The mitigations associated with the short term income risks include increased liaison with CCGs within the health economy regarding transitional costs and a communication strategy for staff affected by the move. Some provision has been made for an estimates £.05m loss if income. • The longer term mitigations have been a focus of intense scrutiny both during the approval process and within the FT application process. The requirement to make further efficiencies of circa £20 billion across the entire NHS in 2013/2014 has been considered in more detail and is described in the Economic Case. Further information is appended. • These risks require a whole health economy approach to ensure that support for the 3Ts development across Sussex is on-going and affordable. This requires clarity regarding the risk exposure through obtaining detailed cash flows and by sharing these together with commissioners. The QIA attached to the risk register contains further detail regarding these risks. • In summary assurance on the mitigation of these risks is provided by the detail within the long term financial plan, coupled with support from our commissioners who are actively engaging in supporting 3Ts whilst simultaneously reducing excess capacity across the health economy.

4	Trust expenditure	• This risk area concerns inaccurate calculations of maintenance costs and the requirement to use BSUH operational capital for some of the equipment which needs to be procured.	• The mitigation is to include contingency within the cost allowances and to ensure that equipment costs are benchmarked against peers.
12	Affordability and access to capital	• These score very highly compared to some of the others described above. The main risks are: - Market conditions - Exchange rates - P21 rates - Availability of Public Dividend Capital • The main risks to the capital development, the risks to the Trust's ongoing clinical operation during construction and potential adverse impacts on the Trust's longer term income streams have been explained above.	• These short term risks have been worked through and appropriate contingency included within the GMP and will require minimal mitigation thenceforward.

Top Risks, by Score as at December 2015

Project	ID	Title	Mitigation	Progress	Owner	Control	Probability	Impact	Cost	Score	Total
12 Main Scheme Capital	24	Trust do not vacate all of site in a timely manner as part of the decant leads to delay to start of construction, cost of inflation, increased duration of decant and associated costs. (Main issue is nuclear med). Additional transition costs (Revenue) (Note closed on Trust PPT - now an issue, remains here for contingency)	Joint risk mitigation meetings. Liaison with Trust Ops.	Site Logistics Group set up to manage and mitigate these risks. Partial site hand over being implemented.	DP	Programme Board	5	5	5	25	1
10 Design Process 1	33	Risk of aspergillus to immuno compromised patients exacerbated by the impact of construction on the RSCH site. Impact on decant programme caused by delay whilst mitigations are identified.	Review of evidence from other construction sites and further testing as work on site progresses.	Liaison with Infection Control for appropriate mitigation measures. Also include a joint (Trust/PSCP) review of all associated construction risks, reviewing all potential hazards with agreed mitigations, for sign-off by all parties. Policy awaiting ratification in November 2015.Risk reduced following discussions. Joint Statement included in contract between LOR and BSUH re mitigations.	DP	Programme Board	4	5	5	20	1
14 Design Process Main Scheme 2	55	There is a risk that stakeholders within the Trust are unsatisfied with the construction, demolition, excavation and any other method statements applicable causing significant delay to construction.	Identify and manage key stakeholders - clear authorisation Mitigation includes early identification of key stakeholders and formal sign off of method statements.	Various meetings held with clinical ops staff to identify and progress mitigation strategies. Clear authorisation for works on site, or any requests to cease work on site is also imperative. Preparatory work is underway on the identification of these issues and detailed work is about to start in the development of the risk and method statements; Site Logistics Group has been set up to work through these issues in more detail.	DP	MSDG	4	5	5	20	1
16 P21+ GThps	8	Stage 3 Approvals and Contracts not implemented in time leading to delayed design deliverables	P21 Stage 3 contracts to be finalised asap and design team instructions issued. Trust to formally confirm budget in writing whilst paperwork is put in place	Portacabins to be provided at SMH to mitigate delays.	Trust	DDG	4	5	5	20	1
11 Trust Business Continuity	4	Affordability- capital	Path to GMP approval is being discussed with TDA at the National Programme Board. FBC submitted to TDA at the end of October 2014 .	The Outline Business Case has been approved by HMT . FBC has been approved by PB and Trust Board. HMT approval letter received on 02/12/15. However capital still not drawn down	DP	Trust Board	4	4	4	16	1

Project	ID	Title	Mitigation	Progress	Owner	Control	Probability	Impact	Cost	Score	Total
11 Trust Business Continuity	19	Site electrical Infra-structure is inadequate	Infrastructure requirements now identified and replacement timescales. NRB will provide additional capacity for electrical loads.	Allowance made in the Trust's Operational Capital programme for 2014/15 which was approved by TBoD on 31/03/14 with additional monies coming from 3Ts to cover off the Courtyard electrical loading requirements. Plans for a revised British Gas solution for energy provisions is being brought into line with 3Ts Energy Centre plans to ensure a smooth transition through the work phases.	DP	Programme Board	4	4	4	16	1
12 Main Scheme Capital	6	Failure to sign up partner Trusts / Medical School /CCG to the brief	Work with Partners - Medical School and CCGs	Negotiations with BSMS close to fruition re financial settlement for the cost of this space.	DP	Research & Education Group	4	4	4	16	1
12 Main Scheme Capital	30	Prudential Borrowings used as procurement route instead of Public Dividend Capital could add £15.6m to CIPs programme over next 10 years and have an adverse effect on Trust's liquidity position e.g. loan with 40 year repayment term would create an overdraft of £44m by 2022/23	Ensure borrowing is under best possible terms for BSUH	Discussions with DH have focused on the availability of Public Dividend Capital as a preference. Final mix of PDC/PBL will be a key aspect of FBC approval. Conditions of approval letter describe this in more detail.	DP	Programme Board	4	4	4	16	1
14 Design Process Main Scheme 2	53	Interfaces/impacts from other projects on site during Decant - Trust/PFI/utilities contractors / capital works (LOR, Willmott Dixon infrastructure, Children's hospital, audiology) - Leads to delay. (piling and ground anchors, leads to interference on other projects and start claims)	Interface planning tool required to track complexities across the site.	Initial meeting held with Estates team across BSUH to begin to track interdependencies. Development control plan in existence and regulary updated.Site Logistics Group also now in existence.	DP	MSDG	4	4	4	16	1
21 ICT	28	Continuing alignment with Trust IM&T developments	Accept stage D+ design to avoid FBC approval delay	Process being managed as part of market testing. Stage D design accepted	G Steen	Programme Team	4	4	4	16	1
04 Decant - all	6	Failure to implement agreed decant plan	Regular update to 3T's Programme Board. Regular meeting to update operations team, Executives and Chief's. Ongoing discussions with individual divisions and services.	Operational staff now engaged and a range of solutions are being worked through for the "orphans" although some double decanting will now be necessary. Site Logistics Group also now in existence.	DP	DDG	3	5	5	15	1

Project	ID	Title	Mitigation	Progress	Owner	Control	Probability	Impact	Cost	Score	Total
11 Trust Business Continuity	22	Commissioners cannot afford scheme (changes in the size and allocation of resources for health care) which undermines FBC	Mitigating this risk would include a regular updates/commissioning interface to confirm costs and affordability as the scheme progresses. There is also a need to ensure that the scheme kept to its brief and that there are robust plans in place to ensure that BSUH's efficiency programme delivers its savings and to see if more savings can be delivered above those already identified.	Commissioning support requires further discussions and negotiations via Commissioner Oversight Forum and National Programme Board. Downside scenarios have been outlined within FBC and now require further modelling.	DP	Programme Board, Project Team, Local Health Economy Board LHE attendance	3	5	5	15	1
12 Main Scheme Capital	1	Support with transitional costs is withdrawn	Transitional costs have been agreed with commissioners to be funded by 2% top slice. Invoice has been raised for 2014/2015 and monies received	Ongoing support with transitional costs requires confirmation as part of FBC approval process	DP/SP	Oversight Forum and National Programme	3	5	5	15	1
											13

Future Risk Management

32. As the programme moves into phase 4 the risks will be increasingly concerned with construction and maintaining business as usual during construction. The programme management arrangements outlined in section 6 will be crucial in maintaining grip and focus on risks and issues.

Issues Log

33. As outlined above the various programme workstreams also maintain an Issues Log. Strictly, this is for known issues rather than potential risks, however issues that cannot be resolved within a reasonably short timescale are transferred to the Risk Register to reflect the risk to delivery of non-resolution.

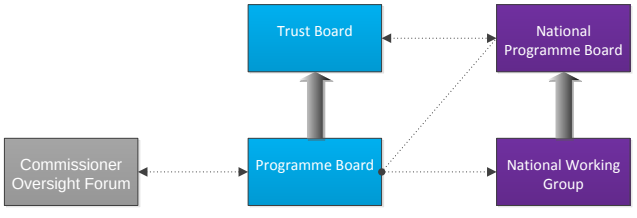
34. The Issues Log is updated monthly and exception reports made to the Programme Team as required. Issues are reported to the Programme Board on a quarterly basis.

Programme Assurance

35. Programme assurance is provided through a number of external bodies/processes, including:

- BSUH internal audit;
- OGC Gateway Reviews;
- Major Projects Authority (MPA); and
- 3Ts Commissioner Oversight Forum / National Programme Board.

3Ts Programme External Assurance



National Programme Board:	Chair Dr Stephen Dunn (TDA). BSUH (CEO, CFO, D3Ts) DH, TDA, NHS England
National Working Group:	Chair Jim Lusby (TDA). BSUH (CFO, D3Ts) DH, TDA, NHS England

3Ts Programme External Assurance

TIAA

36. TIAA (previously known as South Coast Audit) was also tasked with providing an Internal Audit appraisal of the 3T Programme's processes and adherence to established guidance. South Coast Audit identified no recommendations for improvement to the programme's controls and has provided 'substantial' assurance to the Trust Board that the programme is being managed appropriately (appended).

OGC Gateway

37. Gateway reviews are undertaken at key points in the project lifecycle and action plans are being progressed/are completed (appended).

Project Milestones

Milestones December 2015	Date
SOC approved by SE Coast SHA	Complete July 2008
OBC to Trust Board for approval	Complete 30 June 2009
Submit OBC to NHS SE Coast for approval	Complete July 2009
OGC Gateway 1 assessment	Complete August 2009
OBC approval period	Complete July – October 2009
OBC approved by NHS South East Coast	Complete November 2009
Submission of OBC to DH	Complete November 2009
Refreshed OBC to NHS South East Coast and DH	Complete May 2011
Refreshed OBC approved by South East Coast SHA and resubmitted to DH	Complete July 2011
Application for Full Planning Consent submitted to Brighton & Hove City Council	September 2011
Full Planning Consent granted by Brighton & Hove City Council (subject to completion of Section 106 legal agreement)	Complete January 2012
Full Planning Consent released by Brighton & Hove City Council	Complete Mar 2012
Refreshed OBC re-approved by NHS South of England	Complete March 2012
Statutory planning submission for decant temporary buildings	Complete January 2013
OBC passed to DH	Complete March 2012
OBC passed to HMT	Complete July 2012
OBC supplementary submission to TDA	Complete May 2013
OBC approval announced by DH and HMT	Complete May 2014
Decant construction works period (5 sites – phased completion)	September 2013-June 2016
Confirm target cost for main construction works	September 2014
Gateway Review	Gate 3 – November 2014
Agree GMP	July 2015
FBC approved	December 2015
Commence Stage 1	Winter 2015

Milestones December 2015	Date
Gateway Review	Gate 5 (Stage 1) – October 2020
Stage 1 Complete and Fully Operational	Spring 2020
Commence Stage 2 enabling works, demolitions and man build	Summer 2020
Gateway Review	Gate 4 (Stage 2) – July 2022
Complete Stage 2	Spring 2023
Stage 2 Fully Operational	Summer 2023
Gateway Review	Gate 5 (Stage 2) –October 2023
Gateway Review	Gate 0 (Final) – December 2023
Overall Development Complete and Operational	Summer 2024

Major Projects Authority (MPA)

38. MPA guidance has been followed since its establishment in April 2011. For all major projects an Integrated Assurance and Approval Plan (IAAP) is now mandatory. At the first assessment (2009), the Risk Potential Assessment (RPA) was assessed as high with a score of 49 (appended). The following assessment in 2011 (appended) assessed it as MEDIUM. The most recent assessment of the RPA in July 2014 maintained the MEDIUM risk rating (appended). The IAAP has been taken to the 3Ts Programme Board on several occasions. This has been formally integrated into the PID which is refreshed at each key stage of the programme (appended).

39. A self-assessment against the OCG Gateway *Common Causes of Project Failure* was also undertaken in November 2013 and June 2014 (appended). This now informs the RAG rating in the bi-monthly MPA return and formed the basis of our first stage Post Project Evaluation (appended).

3Ts Commissioner Oversight Forum

40. The 3Ts Commissioner Oversight Forum undertakes the following duties via accountable officers:-

- Monitors progress in resolving Specialised Commissioning Contract Derogation issues (Major Trauma, Neurosciences, Vascular and others).
- Enables commissioners to share the total demand implications of their commissioning intentions so as to ensure that workforce and infrastructure change demands on BSUH are realistic and achievable, aligned to the 3Ts programme.

- Reviews impact on commissioning intentions for other providers resulting from the temporary and end state capacity changes arising from 3Ts.

41. For the meeting to be quorate there must be representation from:

- NHS England Surrey & Sussex Area Team
- Brighton & Sussex University Hospitals NHS Trust
- Two Clinical Commissioning Groups

42. This has been supplemented by a National Programme Board. Membership includes NHS TDA (Programme Board Chair), NHS England, Department of Health and the Trust. This provides monitoring and assurance on the development of the 3Ts project to support the approval of the FBC by the Department of Health and HM Treasury. Its Terms of Reference are to:

- ensure the project is managed to the time and budget;
- receive reports from the Trust project team and monitor progress against programme;
- advise on analysis, options development and recommendations;
- assess and advise on the wider impacts of the 3Ts programme and appropriate mitigations;
- engage stakeholders appropriately and to support the approvals process; and
- escalate any issues that arise, as appropriate.

Design Quality

43. A Design Quality Indicator (in this case ASPECT) was used to inform the signed off design.

44. The Design Review Panel for East Sussex, reviewed this scheme in June 2009, followed by the Council for the Built Environment (CABE now part of the Design Council) in July 2011. This resulted in changes to the design which was broadly accepted to have improved it. The final report in July 2011 concluded as follows (appended in Commercial Case):

> Thank you for submitting this scheme to us; we reviewed the proposal on 25 July 2011. This demanding brief reveals a genuine desire on the part of the client to put the experience of the patient first; the stipulation that all patient rooms should have a sea view is particularly welcomed. We appreciate the client's readiness to amend the scheme in light of our previous comments. We think the resulting design is stronger for this, responding more sensitively to the Brighton context while creating an improved visitor experience. We think the proposed site diagram is sound and will significantly improve wayfinding. We also appreciate the further thought given to possible future phasing of hospital development. The revised approach to the Eastern Road frontage, coupled with the new proposals for the helipad, has produced a calmer, more contextually appropriate design. However, we continue to think the relationship of the 'spine block' to the Children's Hospital could be improved. The new designs for the public realm at ground and upper level are welcomed.

Management Control Plan

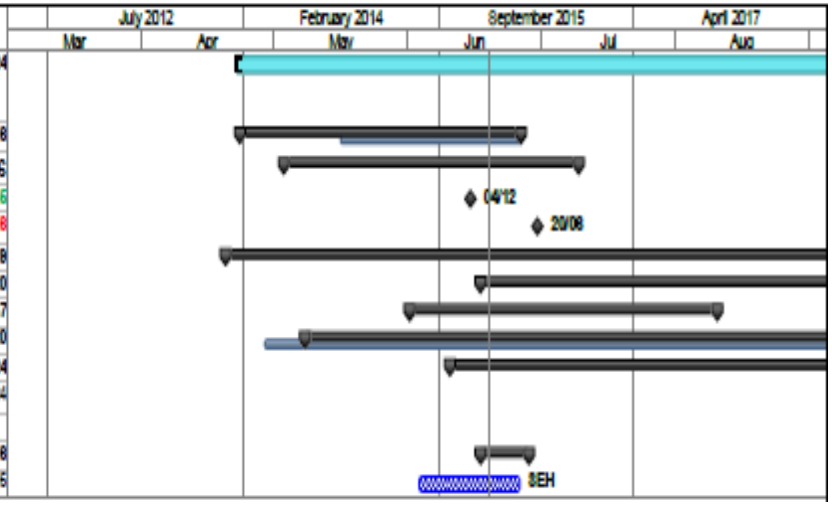
45. The Management Control Plan (MCP) is set out and appended as a comprehensive project plan. The associated Project Initiation Document (PID) outlines the methodology for executing the MCP. The latest version covers the period from OBC approval to the signing of the Stage Four contract. The PID will continue to be refreshed prior to commencement of each key stage of the project. The MCP includes a detailed programme for the development, inclding the PSCP construction programme (summarised below).

46. The 3Ts decant and redevelopment present the additional challenge of maintaining business continuity ('business as usual') during the contruction period, which is much more easily achieved with a greenfield development. The Trust aims to maintain services during the redevelopment period, with only minimal loss ofactivity/income anticipated. This has been factored into the financial plan/Transition Planning. Services transferred out of the construction site ('decant') will continue to operate from temporary alternative accomodation, pending completion of the relevant Stage of the 3Ts development. The PID/MCP includes the decant programme.

47. The scale and complexity of the decant programme is reflected in the 3Ts Risk Register, which therefore includes a formal risk assessment and mitigation strategies.

3Ts Programme

ID	Task Name	Duration	Start	Finish
1	December 2015 RSCH SITE MAJOR DEVELOPMENTS MANAGEMENT CONTROL PROGRAMME	607.4 wks	Mon 06/01/14	Tue 23/04/24
2	MACILLIAN CANCER SUPPORT INFORMATION CENTRE	113.2 wks	Mon 20/01/14	Mon 02/06/16
5	STAGE 1 DECANT PROGRAMME	119.9 wks	Fri 30/05/14	Thu 20/10/16
64	PARTIAL SITE POSSESSION	0 wks	Fri 04/12/15	Fri 04/12/15
65	3TS STAGE 1 FULL SITE POSSESSION	0 days	Mon 20/08/18	Mon 20/08/18
66	ENGINEERING/ ENABLING INFRASTRUCTURE DIVERSIONS	281.88 wks	Mon 09/12/13	Thu 28/08/18
101	ENERGY CENTRE INSTALLATION	200.18 wks	Mon 04/01/16	Fri 24/01/20
104	HELIDECK - ENDO-SKELETON	124.78 wks	Mon 08/06/15	Tue 05/12/17
107	SERVICE DEVELOPMENT /WORKFORCE MODERNISATION	284.4 wks	Fri 01/08/14	Mon 20/07/20
135	MAIN SCHEME PROGRAMME	433.8 wks	Mon 05/10/15	Tue 30/07/24
195	Scheme completion date	0 wks	Tue 30/07/24	Tue 30/07/24
196				
197	H - OTHER SITES	20 wks	Mon 04/01/18	Fri 27/06/18
200	SUSSEX EYE HOSPITAL REFURBISHMENT	40 wks	Mon 05/07/15	Thu 28/04/16



Trust-Wide Transformation and Service Change

48. Although not directly within the scope of the 3Ts Programme and therefore this Full Business Case, it is of importance to reference the work which is going on elsewhere in the Trust and the Trust's capacity/capability for successfully managing transformation programmes, including:

- initiatives described in the Trust *Clinical Strategy 2014-19*;
- the Site Reconfiguration programme, which includes the interim transfer of neurosurgery from Hurstwood Park (Princess Royal Hospital) to the Royal Sussex County Hospital to support the Major Trauma Centre;
- the Action Plan arising from the Care Quality Commission (CQC) inspection (August 2014);
- the variety of change programmes that will be prioritised for 2015-17 through the Business Planning process currently underway; and
- 3Ts hospital redevelopment.

49. This is put in the context of the Trust's wider governance and management structures which have been amended and updated over the last 18 months to reflect the changing nature of the organisation and to promote the overall development of the Trust, and its staff, in meeting the challenges ahead.

50. It is also instructive to consider, as context, the Trust's track record in safely and successful managing transformational change, often at scale, since its establishment in 2002:

Year	Site (s)	Service Change/Development
2002	Trust-wide	Brighton & Sussex Medical School established.
2004/5	RSCH	Opening of new Sussex Kidney Centre
2004/5	Trust-wide	Elective orthopaedics transferred from RSCH to PRH (as part of Best Care, Best Place)
2004/5	Trust-wide	Trauma activity centralised at RSCH (as part of Best Care, Best Place)
2004/5	RSCH	Acute elderly care inpatient wards from Brighton General transferred to RSCH (as part of Best Care, Best Place)
2004/5	Trust-wide	Emergency surgery centralised at RSCH (as part of Best Care, Best Place)
2004/5	Trust-wide	Implementation of Best Care, Best Place establishes PRH as the DGH for Mid-

Year	Site (s)	Service Change/Development
		Sussex and the elective care centre for the Trust as a whole, whilst RSCH becomes the DGH for Brighton & Hove and the emergency care centre for the Trust. RSCH is the tertiary/specialist care hospital for the Region.
2005/6	RSCH	Opening of the Audrey Emerton Education Centre
2005/6	PRH	Opening of the Euan Keat Education Centre
2005/6	RSCH	New interventional radiology suite opened
2005/6	RSCH	New Clinical Investigations & Research Unit (CIRU) opened
2005/6	RSCH	Elton John Centre transfers from Brighton General Hospital (including inpatient beds for patients with HIV)
2005/6	RSCH	New Urgent Care Centre opened
2005/6	RSCH	Major upgrade of the Barry Building completed.
April 2006	Trust-wide	40X bus service established to assist patients and staff moving between PRH and RSCH
Spring 2007	RSCH	New Chemotherapy Suite opened
2007	RSCH	All operating theatres upgraded and 7th theatre added.
June 2007	RSCH	Royal Alexandra Children's Hospital completed and services transfer from the old RACH.
Oct 2007	PRH	New 10-bedded rehabilitation unit opens
2007	RSCH	Third Cardiac Catheter lab opened
Jan 2008	RSCH	Establishment of dedicated isolation ward for patients with HAIs
August 2008	RSCH	Expansion of the Trevor Mann Baby Unit
Nov 2008	RSCH	New Breast Care Centre opens at 177 Preston Road
Jan 2009	PRH	Sussex Rehabilitation Centre transfers from Southlands Hospital
March 2009	PRH/HWP	Replacement Interventional Angiography Room for neurosurgery
May 2009	RSCH	Relocation of Fracture Clinic from Level 5 for ED/AMU/HDU Development
May 2009	Trust-wide	Introduction of WHO Surgical Checklist
Jan 2010	RSCH	Establishment of 36 bed Acute Medical Unit(AMU)

Year	Site (s)	Service Change/Development
April 2011	Trust-wide	Introduction of Comfort Rounds on all inpatient wards
May 2011	Trust-wide	Introduction of telemedicine facilities to assess stroke patients
June 2011	RSCH	Establishment of Gynaecology Assessment Unit
July 2011	Trust-wide	Confirmed as an Experimental Cancer Medicine Centre in collaboration with Barts and Queen Mary's Medical School.
Nov 2011	PRH	Establishment of dementia service in Poynings Unit
Dec 2011	PRH	SOTC transferred to BSUH
Dec 2011	RSCH	12 Bed High Dependency Unit completed adjacent to ED
Jan 2012	RSCH	Establishment of dedicated paediatric A & E in the Children's Hospital
April 2012	Trust-wide	Trust established as the Major Trauma Centre for the Region.
April 2012	Trust-wide	Screening assessment introduced to improve care of patients with dementia
April 2012	Trust-wide	Contract signed to introduce new Electronic Patient Record across the Trust.
Oct 2012	PRH	Opening of a new Day Surgery Unit for the majority of day surgery in the Trust
Oct 2012	RSCH	New CT Scanner at the front door of ED opens to support Major Trauma and Stroke patients.
April 2013	RSCH	Emerald Centre for patients with dementia opened.
April 2013	RSCH	New dedicated Polytrauma Theatre completed.
June 2013	Trust-wide	"Butterfly" scheme established so that patients with dementia can be clearly identified and their particular needs addressed.
Jan 2014	RSCH	Opening of third hybrid cardiac theatre: first in the country of its type
Jan 2014	RSCH	St. Mary's Hall redevelopment completed (as first stage of the 3Ts decant and ongoing estates rationalisation programme)
Feb 2014	RSCH	Establishment of new Outpatient Pharmacy "Pharm@Sea"
Oct 2014	RSCH	Opening of new Hybrid Interventional Radiology Theatre to allow centralisation of vascular surgery in Sussex
May 2015	RSCH	Neurosurgery moves to RSCH site from PRH

Transformation Capacity & Capability

51. The Trust has been pursuing a systematic and phased programme of Organisational Development (OD) since the arrival of the new Chief Executive, Matthew Kershaw, in April 2013, and Director of Strategy & Change/Deputy Chief Executive, Amanda Fadero, in September 2014. This encompasses:

- infrastructure for managing clinical services;
- clinical service strategy;
- organisational ways of working (values & behaviours, empowerment and accountability);
- corporate planning processes and priorities;
- transformational change infrastructure.

52. It is important to recognise, as reported in the recent (December 2014) *Mixed-Methods Evaluation of Transformational Change in NHS North East*[4], that 'transformational change in a complex system takes time and demands consistency, constancy of purpose and organisational stability.' This programme of work is therefore not a quick-fix and will take consistent and sustained investment of organisational time, energy and resource.

Foundations for Success

53. The *Foundations for Success* (FfS) programme was launched in August 2013 and included three principal strands:-

- Development of the *Clinical Strategy 2014-17* (see also 3Ts FBC Strategic Case – Strategic Context, para. 144-145, and update included at **Appendix A**). This was approved by the Board of Directors in March 2014 and includes:
  - a number of key service developments for 2014-17;
  - activity/capacity assumptions to 2019 (ie. the year before 3Ts Stage 1 is expected to open), which has enabled the development of a seamless capacity model from 2014 to 2028 (five years after 3Ts Stage 3 is expected to complete), including the impact of demand management and the Better Care Fund; and

[4] http://kingsfund.blogs.com/health_management/2014/12/a-mixed-methods-evaluation-of-transformational-change-in-nhs-north-east.html

- a strategic direction for each of the Trust's principal sites for the five year planning period and beyond.

- A Values & Behaviours Programme, which encompasses an approach to empowerment and accountability (see also 3Ts FBC Strategic Case – Strategic Context para. 146-147, The Behavioural Blueprint was developed following a wide programme of staff engagement (involving 700+ staff), with five core domains:

- Organisational restructure, which was completed in September 2014 and replaced four Clinical Divisions with 12 Clinical Directorates. The purpose was to:
  - reduce spans of control;
  - bring the role of clinical services to the fore in the Trust's governance arrangements, with corporate services aligned and providing appropriate 'back of house' support;
  - refresh the cadre of senior leaders, supported through the *Leading the Way* leadership development programme for the c. 70 Directors and direct reports (aligned with the Behavioural Blueprint).

Organisational Development Programme

54. The next phase of OD work has been led by the new Director of Strategy & Change/Deputy Chief Executive. This has focused on:-

- redesigning the Trust's governance/committee structures, again to ensure a consistency of purpose in supporting the 12 Clinical Directorates and wider transformation agenda;

- refreshing the Trust's approach to business planning, to ensure a clarity in progressing the Trust's strategic vision, alignment of planning elements (activity, income, capacity, workforce, financials), and match organisational change capacity;
- establishing a Directorate of Strategy & Change, to ensure alignment of/exploit synergies between key corporate services (eg. HR, Corporate Communications, 3Ts) and ensure a consistency of purpose in supporting the 12 Clinical Directorates.

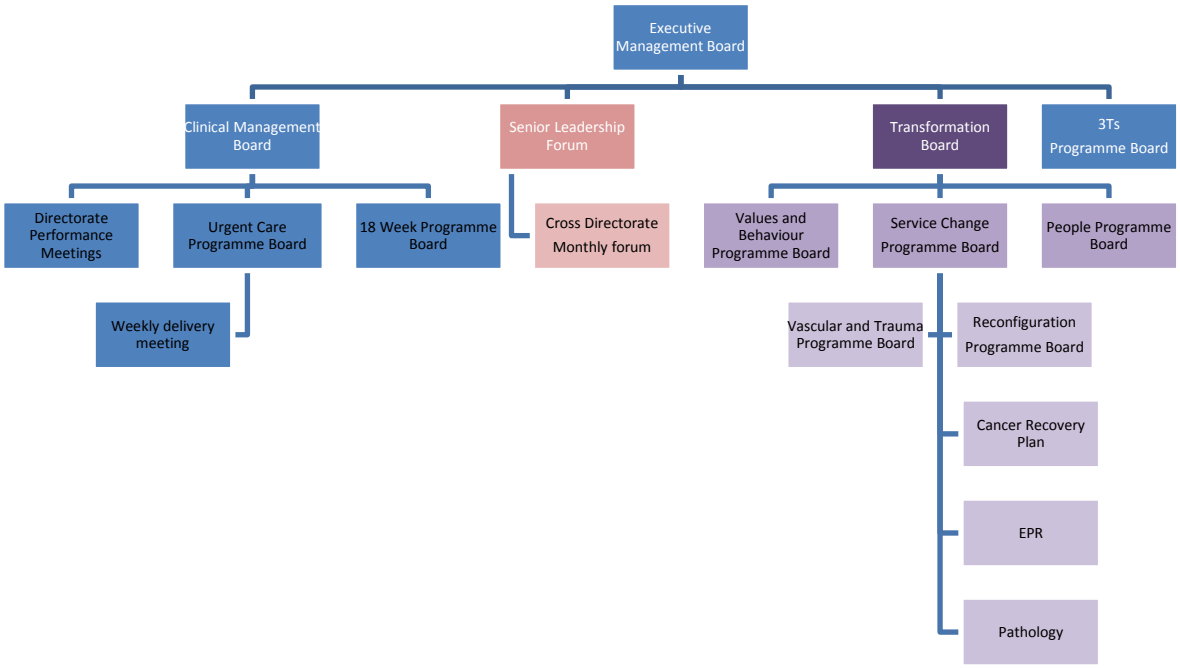
55. This programme is underpinned by a number of key principles:

- the new Clinical Directorates need to be empowered and supported to deliver real change;
- Corporate Directorates need to reshape and respond differently, eg. integrating their functions and engagement/delivery mechanisms to avoid duplication, and creating virtual teams to support planning and transformation agenda;
- Directorate Business Planning and Delivery needs to represent all aspects of the *Foundations for Success* programme and build on it with explicit steps of improvement;
- There will be one annual planning round that includes CIPs , developments and targets. This will reduce the need for individual business cases since Directorates will manage their budgets, performance and transformation agenda;
- the monthly Performance Meetings currently in place need to have a different focus and tone while ensuring that delivery is secured;
- the 'performance escalation' process will provide more freedom/autonomy and ;lighter touch' scrutiny to Directorates that are performing well, and enhanced support and 'shepherding' to Directorates that are more challenged; and
- committee structures and reporting must be streamlined/simplified, and some committees will be eliminated.

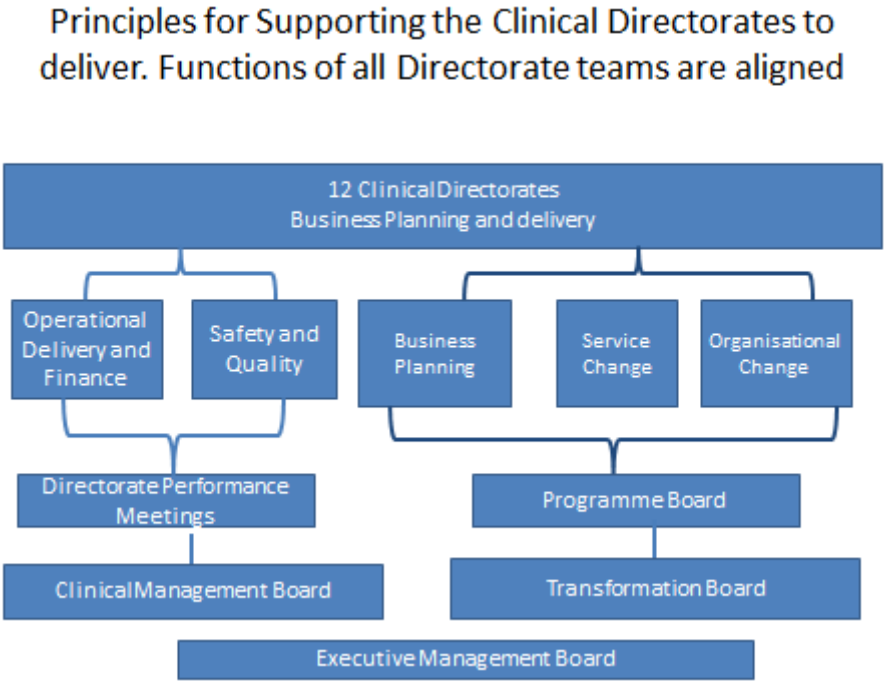
Executive Committee Arrangements

56. To support the 12 Clinical Directorates, new Executive Committee arrangements (illustrated below) have been introduced to streamline decision making and to ensure transparency of service and people change at Trust Board level.

Executive Committee Arrangements

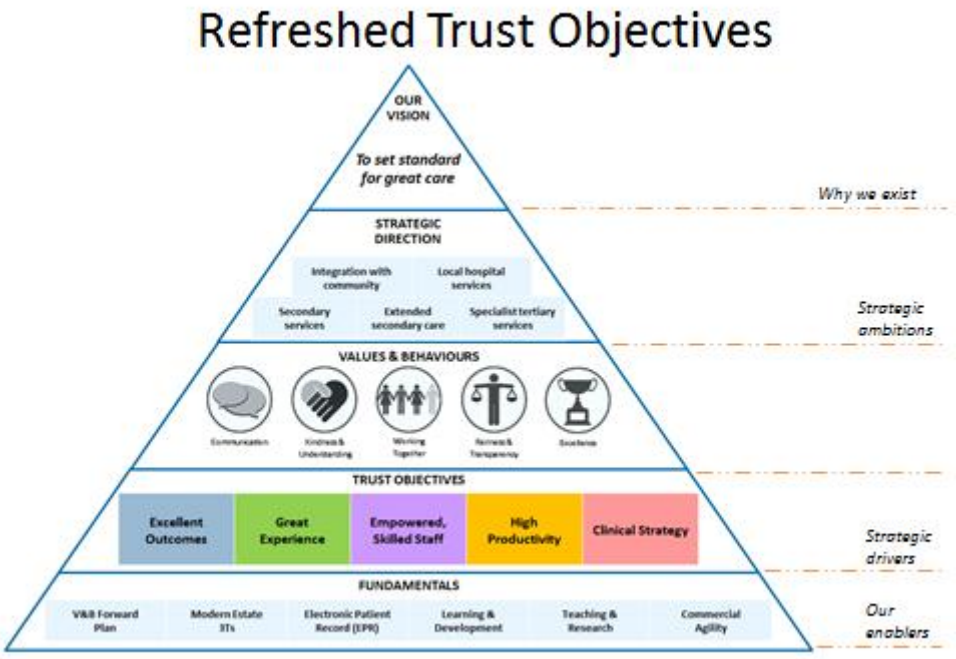


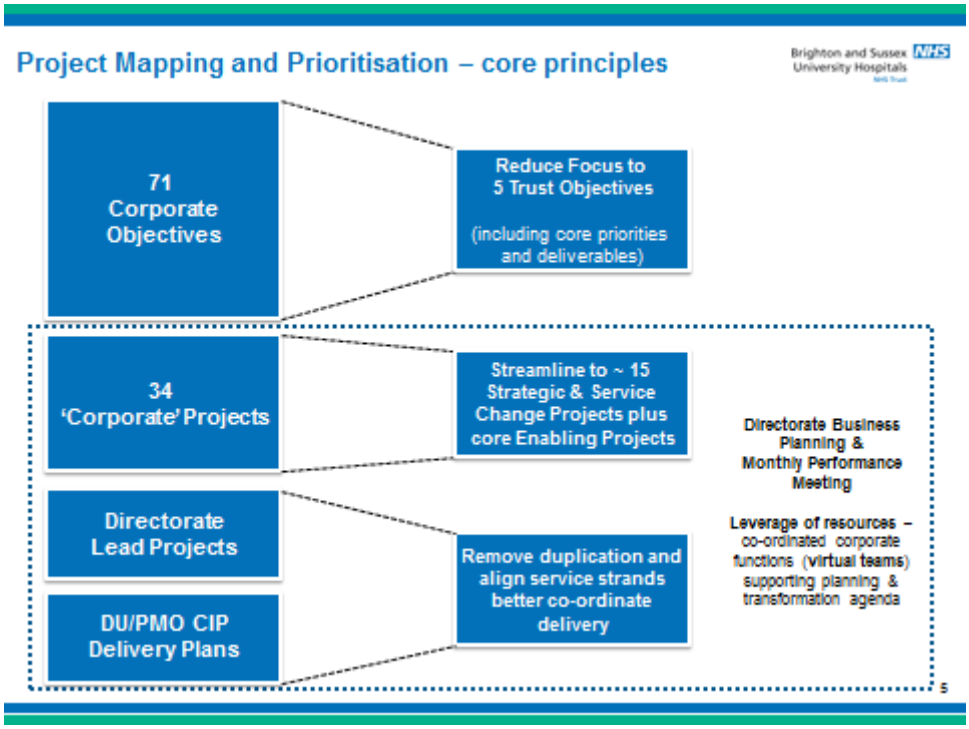
57. These changes are part of a wider programme of 'organisational rewiring' to ensure consistency and efficiency of approach in the Trust's strategic planning and delivery processes (illustrated below).



Business Planning

58. Work is underway to develop a two-year Trust Business Plan (2015-17) to refresh the Trust's objectives, focus and prioritise activities, and ensure an appropriate 'fit' between commitments and the organisational resource to deliver them. (The framework and initial, high-level programme mapping are illustrated below).





59. Integrated planning processes will ensure that:

- activity, income, capacity (eg. inpatient beds), workforce and financials (including Cost Improvement Plans) are aligned;
- interdependencies between major Trust programmes are understood, opportunities for synergy exploited, and potential overlaps/publications (eg. in benefits realisation) are avoided – through a 'virtual support team' and the extended role of the Trust Delivery Unit (which previously only focused on CIPs-related programmes);
- organisational capacity to support transformational change is aligned with the identified priorities/demand;
- a 'balanced scorecard' of Key Performance Indicators (KPIs) is developed, to ensure clear 'line of sight' from the Trust Board of Directors;
- there is clarity of Responsibility, Accountability and Consultation/Engagement ('RACI') across the Trust's programmes; and
- the key strategic risks (for programmes individually *and collectively*) are appropriately understood, quantified, mitigated/managed.

Strategy & Change

60. The realignment of Executive Director portfolios and creation of an integrated Directorate of Strategy & Change is building organisational capacity/capability to implement transformational change:

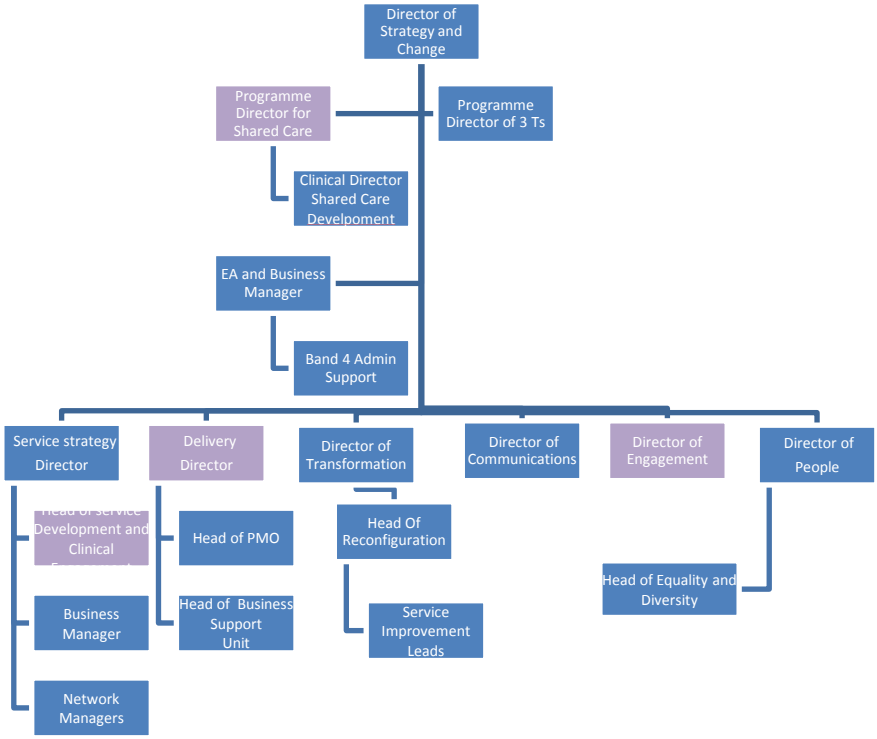
- aligning key corporate services (eg. HR, Corporate Communications, 3Ts);
- exploiting opportunities for synergy; and
- ensuring a consistency of purpose in supporting the 12 Clinical Directorates to deliver the Trust strategic vision.

61. The new Directorate is leading implementation of the Site Reconfiguration programme (see 3Ts FBC – Strategic Case – Strategic Context, para. 169-172). This includes the transfer of neurosurgery from Hurstwood Park (the Trust's Princess Royal Hospital site) to the Royal Sussex County Hospital, to support the Major Trauma Centre and meet NHS England specialist commissioning standards.

62. The Directorate also plays a critical 'outward-facing' role in supporting/leading the Strategic, Operational Delivery and other clinical networks of which the Trust is a member (see also 3Ts FBC Strategic Case – Strategic Context, para. 36 ff.). Examples include:

- the pathology network joint venture between the Trust and Surrey & Sussex Healthcare NHS Trust;
- significant changes in the 'fragility' patient pathway, in partnership with neighbouring NHS Trusts, Clinical Commissioning Groups and the Local Authorities (under the auspices of the Better Care Fund – see separate supplementary briefing note, and the 3Ts FBC Strategic Context, para. 86 ff.)

Directorate of Strategy & Change



Next Phase of Work

63. The next phase of OD work will focus on:-

- Embedding the Values & behaviours/Behavioural Blueprint in all Trust systems and processes;
- Development of a *People Strategy* (due to be submitted in outline to the Trust Board on 26th January 2015) to refresh the current *10-Year HR Strategy* (see also 3Ts FBC – Strategic Case, Strategic Context para. 148 ff.; strategy also appended to the FBC).

- Continuing to streamline Trust business processes. As part of the Values & Behaviours Programme, work is underway to redesign a number of key processes directly linked to organisational performance/efficiency, including:
  - end-to-end recruitment process;
  - Booking Hub (Schedule Care) processes;
  - Emergency Department (ED) referrals to specialties (linked to ED performance/4-hour standard).

- Progressing an 18-24 month Workforce Modernisation programme, which was initiated in December 2014 and aims to implement a rigorous and systematic process to align the healthcare workforce with the work to be undertaken (in effect, to ensure _'the right staff, with the right skills, in the right place, at the right time.')[5].

- Continuing to strengthen Operational Delivery, Strategic and other clinical networks across Sussex, including:
  - Cancer, including the development of satellite/linked radiotherapy units at St Richard's Hospital in Chichester (Western Sussex Hospital NHS Foundation Trust) and Eastbourne District General Hospital (East Sussex Healthcare NHS Trust);
  - Vascular and Cardiovascular;
  - Major Trauma;
  - Musculoskeletal (MSK), as part of the Any Qualified Provider (AQP) initiative.

[5] NHS England (2013). *How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: a Guide to Nursing, Midwifery and Care Staffing Capacity and Capability*

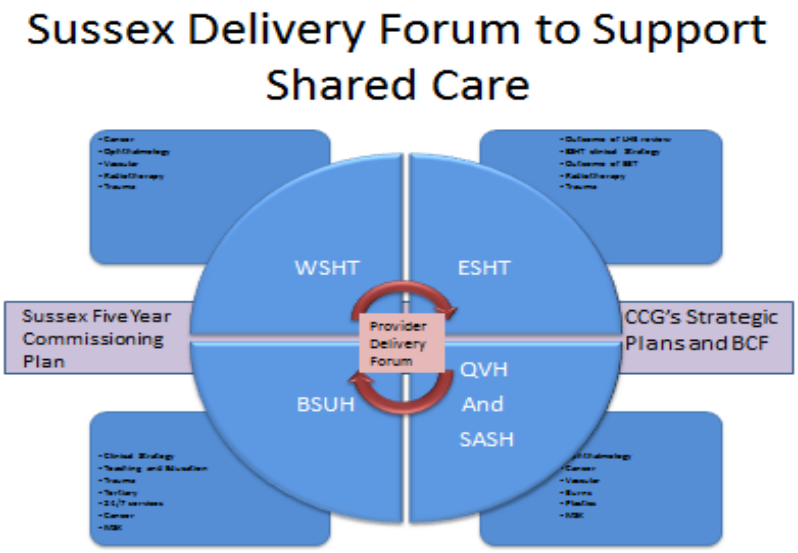


Diagram 1

64. As consistently reported in the literature, Organisational Development is a long-term programme requiring consistent and simultaneous action at individual, team and corporate (process, culture) level.

65. The Trust considers, that it is continuing to refine its corporate objectives to deliver the strategic vision, its organisational structures and processes, the capacity and capability, and its *modus operandi* (Values & Behaviours) to deliver a major programme of transformational change – including, but not only, the 3Ts hospital redevelopment programme.

Capacity to Undertake the Programme of Work

66. The Trust already has in place a significant resource to draw from in order to deliver safely and successfully the programme of work which was been set out above, and that implied for the 3Ts programme for which there is also a dedicated team, which is undertaking significant clinical engagement, as set out elsewhere in this chapter of the FBC.

67. 'The transformation team' is a broad term, all staff (per new Values & Behaviours 'behavioural blueprint') have a responsibility for transformation/innovation, including those whose roles are largely or exclusively 'transformation'. For the purposes of this briefing therefore, the focus is on the three corporate teams with principal transformation responsibilities: 3Ts, Delivery Unit/Programme Management Office and Site Reconfiguration/Clinical Networks. However the approach will be true for the range of other teams with transformation responsibilities, as shown in the organisational structure for the Strategy & Change Directorate (separate briefing note).

68. The briefing note describes the core posts in these three teams. However this significantly under-represents clinical involvement and engagement in transformation activities, eg. (i) the specialist clinical staff seconded part-time into the 3Ts team (Nuclear Medicine, Imaging) to lead relevant strands of the design work, and (ii) the ongoing programme of clinical engagement (detailed in the 3Ts Full Business Case Strategic Case – Consultation & Engagement, para. 33-44,).

69. It is important to recognise that while some posts will require clinical experience and/or current professional registration, clinicians will also fill other posts that do not. So, again, 'clinical' posts will under-represent clinicians in post.

Clinicians in Post

70. The table below sets out the core posts in the Trust's three principal transformation teams, and which postholders are clinicians (ie. current or recent professional registration). (The structure of the 3Ts Programme Office is included above, CVs and core skills are included at the end of this chapter).

Team	Post/Postholder (Headcount)	Clinician?
Site Reconfiguration	Simon Maurice, MTC & Site Reconfiguration Programme Director	
	Dr Jo Andrews, Consultant Anaesthetist, Clinical Lead for Site Reconfiguration Programme	Doctor
	Jonathan Harris, Site Reconfiguration Programme Manager (seconded from Delivery Unit)	
	Catherine Purdie, Snr HR Relationship Manager	
	Kevin Nederpel, Asst Director of Finance (Financial Planning)	
	Bridget McGee, Capital Project Manager	
	Emma Tee, Support Change Consultant, Delivery Unit	
Networks	Barbara Rayner, Network Manager (Sussex Trauma and Vascular Operational Delivery Networks)	
	Dr Jo Andrews, Consultant Anaesthetist & Network Director (Major Trauma)	Doctor
	Mr Mike Brooks, Consultant Vascular Surgeon & Network Director (Vascular)	Doctor
Delivery	Beverley Thorp, Programme Director	Nurse

Team	Post/Postholder (Headcount)	Clinician?
Unit/PMO	James Weller, Senior Project Delivery Manager	
	Sharon Howes – 1 wte 8b Change Consultant - previous HR manager	
	Sarah Mackmin, Change Consultant	
	Katy Ma, Change Consultant (on secondment to Neurosciences & Stroke DMT)	
	Erin Burns, Change Consultant	
	Emma Tee, Change Consultant	
	Ruth Haffenden (on secondment to Abdominal Surgery DMT)	
	Venessa Neylen, Change Consultant (on secondment to the DU)	
	Lisa Jeffries, Rosterpro Consultant	Midwife
	Helen Davies (KPMG Consultant)	
3Ts	Duane Passman, Programme Director	
	Mr Peter Hale, Clinical Director	Doctor
	Dr Graham Dodge, Associate Clinical Director	Doctor
	Nick Groves, Associate Director (3Ts Service Modernisation)	
	Anna Barnes, Associate Director (Governance & 3Ts Programme Office)	
	Abigail Pride, 3Ts Change Consultant	
	Eoin O'Flynn, 3Ts Change Consultant	Radiographer
	Jaqueline Logan	Nurse
	Phil Rolf, Programme Engineer	
	Richard Beard, 3Ts Head of Engagement & Communications	
	Hazel Belfield-Smith, Senior Information Analyst	
	Matt Coleman, Information Analyst	
	Gary Speirs, Capital Projects Manager	
	Gary Beacham, Clinical Planning Manager	

Team	Post/Postholder (Headcount)	Clinician?
	Mark Frake, 3Ts Programme Finance Manager	
	Jo Ingram, Programme Administration Manager	
	Claire Lucas, PA to Programme Director	
	Mariusz Przybytek, Project Administrator	

Service Improvement Training

71. For example, as part of the 'Leading the Way' leadership development programme, the Trust's 70 Directors and direct reports are receiving 5.5 days (plus Action Learning Sets) of training, aligned with the Values & behaviours Behavioural Blueprint (described in the supplementary briefing note on Trust transformation capacity/capability: *Foundations for Success*/Values & Behaviours). This is critical for effective transformation/Organisational Development, but is not directly 'service improvement'.

72. Similarly, in preparation for the 3Ts design programme, 81 staff were trained, a significant proportion of whom were clinicians – again, not directly 'service improvement', but a critical precursor in the context of the 3Ts service modernisation/design programme. A further programme of refresher training is being planned for clinical/departmental leads in preparation for the completion of the 1:50 design programme on remobilisation.

73. Other training aligned to service improvement of particular note:

- As part of the Values & Behaviours programme, key Trust processes (incl. end-to-end recruitment, ED referrals to specialty doctors, Booking Hub) are being redesigned as part of a 'process amnesty'. This is being supported by external consultants (Innermost Consulting), however the process redesign workshops include development/training for frontline clinical and non-clinical staff in redesign – to ensure both effective engagement in the workshop(s), and to build capacity for future activities. This work is currently underway and is due to conclude at the end of January 2015.

- Also as part of the Values & behaviours programme, a team of 15-20 internal Team Coaches is being recruited (ie. staff who have other substantive posts but who can be released 1-2 days/month to support team development activity). These staff will be supported by a Learning & Development Coach, and training will include service improvement skills in addition to team development and related learning.

74. Work currently underway within the Trust (eg. to enhance the uptake and quality of appraisals, and as part of the pilot, funded/supported by Health Education Kent, Surrey & Sussex (HEKSS) to establish a multidisciplinary Education & Knowledge Directorate) will also strengthen the Trust's Training Needs Analysis (TNA) processes – to assess the need for further, structured/accredited learning and development in 'service improvement' techniques, in addition to current informal/'on the job' learning.

3Ts Service/Workforce Modernisation Programme

Background

75. In discussing the 3Ts high-level service/workforce modernisation and governance plan, the November 2013 3Ts Programme Board agreed the following key principles:-

- 3Ts is not solely a major capital/building scheme – as highlighted by the Selim review[6] of programme governance.
- In addition, a programme of service/workforce modernisation will be required to realise the underpinning benefits, e.g. to implement the new models of care/patient pathways and achieve workforce efficiencies. This will need to be detailed in the 3Ts Full Business Case.
- In order to provide the necessary assurance to the Board of Directors, the 3Ts Programme Board will need oversight of the planning and delivery of the modernisation programme.
- In addition, projects that are cash-releasing/income-generating will be overseen by the Trust Delivery Unit / Efficiency Steering Group as part of the three-year rolling CIPs programme.
- The role of the 3Ts team includes provision of change management support[7], however this does not affect existing accountabilities (eg. workforce).

Modernisation Programme

76. The modernisation programme comprises six strands of activity:

Workforce
- Operational recruitment
- Workforce modernisation

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6 Prof. Georges M. Selim (2013) *Review of the Governance and Assurance of Major Programmes: Report of a Diagnostic Investigation Commissioned by Brighton & Sussex University Hospitals NHS Trust*

7 This will need to be programmed alongside the team's design responsibilities/contracted deadlines.

	• Education & Learning (Simulation)
Service	• New models of care/pathways
	• Repatriation of activity
Other	• Travel planning

77. These elements have been prioritised to reflect:

- legal obligations (eg. planning conditions);
- operational delivery of 3Ts (eg. staffing);
- income/efficiency benefits (eg. repatriation of additional activity); and
- education and research (cf. the Trust's wider role as Regional Teaching Hospital).

78. Detailed planning, and the approach to change management, will also need to reflect the Trust Values & Behaviours, which are being developed as part of the *Foundations for Success* programme. In addition, the Trust will be establishing a Transformation Board (under the leadership of the Trust's Deputy Chief Executive/Executive Director of Strategy and Change) to ensure that all programmes and projects across the Trust are co-ordinated and that there is a consistent and well planned approach to all modernisation initiatives, including workforce. This will have an overarching responsibility to the Trust Board, but will work alongside the governance of the 3Ts Programme.

Project Scope & Outcomes

Project	**Operational Recruitment**
Rationale	To minimise the number of staff vacancies when each Stage of 3Ts opens without: • recourse to agency staffing (additional cost); or • denuding neighbouring NHS Trusts (in a way that is detrimental to BSUH).
Context	Most recruitment for services in 3Ts can be undertaken as 'business as usual'. Support will be provided by the 3Ts team for 'hard to recruit' staff groups, ie. where: • there is a significant increase in activity/capacity in 3Ts; • existing vacancy and/or wastage rates are high; and • the staff group is recognised (locally or nationally) as hard to recruit.
Scope	In discussion with 3Ts service leads and the Trust Workforce Planning Manager, the following staff groups have been identified as hard to recruit: • Critical Care nursing (general and Neurosurgery) • Radiotherapy (Therapeutic Radiography, Medical Physics) • Chemotherapy nursing • Imaging (Diagnostic Radiographers, Sonographers, IR nursing) • Theatres nursing/ODPs (general and neuro) • Medical staff (Oncology Consultants; juniors in Neurosciences, Trauma & Orthopaedics, Anaesthetics).
Risks	Without enhanced support, the risks are: • 3Ts will not open to full capacity (potential loss of income and operational pressure); or • will rely on agency staff (who are more expensive, and will be less well inducted) to do so.

Project	Operational Recruitment
Work involved	The 3Ts Change Consultants, working closely with the Trust Head of Recruitment and Workforce Planning Lead, will support services in: • planning recruitment (eg. Open Days, recruitment materials, developing education/learning and benefits packages); • as part of this, planning best use of 3Ts Transitional Funds; • assessing/addressing any retention issues within the service; • in the immediate lead-in to 3Ts, implementing operational recruitment.
Products	• Recruitment and retention plan/programme for each of the above services/staff groups. • Business case(s) where enhanced recruitment/retention suggests the need for investment (eg. Cost of Living Supplement).
Benefits (incl. financial)	• Avoided agency staff costs. • Avoided lost income (where 3Ts assumes repatriated activity). • Reduced delivery risk to 3Ts. • More stable workforce (indirectly, improved patient care/outcomes).
Early Benefits	• If this initiative started sooner, it could reduce existing vacancy rates. This would potentially: - reduce agency spend; - create a more stable workforce (indirectly, improve patient care/outcomes); - reduce the staffing/operational risk to 3Ts; - enable any learning to be shared/applied more widely sooner.

Project	Operational Recruitment
Governance	• 3Ts change support would be on an 'internal consultancy' basis, ie. - the respective Division/service would 'commission' the consultancy and manage the programme of work; - depending on the size/scope of the project, it may be appropriate to establish a separate Steering Group; - the consultancy brief would include the responsibilities of the Division/service, eg. to enable and support the change management process; - the expectation is that any resourcing required (over and above the 3Ts Change Consultant support) would be provided by the Division, which may require a separate business case; - the 3Ts Programme Director/SRO would have overall accountability for the quality of the consultancy. • Overall accountability for recruitment/staffing for services in the 3Ts building would be as for the rest of the Trust, ie. shared between the Director of HR, Divisional Management Teams and Heads of Profession.

Project	Workforce Modernisation
Rationale	Reprofiling the workforce (eg. introducing new roles, extended/multi-skilled roles, non-professionally registered roles), where it is clinically safe and appropriate to do so and meets relevant national guidance, aims to: • reduce the number/proportion of the hardest to recruit staff; • reduce wastage (which avoids agency spend and recruitment costs); • improve staff satisfaction (which in turn has been shown to improve patient outcomes/satisfaction); • improve workforce efficiency.
Context	Staffing levels/structures, and the way in which staff (in particular non-professionally registered staff) are prepared for/assessed as competent in their roles, is particularly topical (eg. Francis[8], Berwick[9], Cavendish[10]). In 2012, the Delivery Unit commissioned external professional advice on the legal, professional, regulatory and governance implications of workforce reprofiling, and in particular the use of non-professionally registered staff. The current Trust Long-Term Financial Model (LTFM) assumes 24% cumulative workforce efficiencies/reductions between 2013/14 and 2018/19. Work in this area is underway, however this is largely focused on nurses and Healthcare Assistants.

8 Department of Health and The Rt Hon Jeremy Hunt MP (2013) Francis report on Mid Staffs: Government accepts Recommendations

9 National Advisory Group on the Safety of Patients in England (2013) *A Promise to Learn – a Commitment to Act. Improving the Safety of Patients in England*

10 Department of Health (2013) *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*

Project	**Workforce Modernisation**
Scope	The identified 'hard to recruit' staff groups in 3Ts: • Critical Care nursing (general and neuro) • Radiotherapy (Therapeutic Radiography, Medical Physics) • Chemotherapy nursing • Imaging (Diagnostic Radiographers, Sonographers, IR nursing) • Theatres nursing/ODPs (general and neuro)
Risks	Without considering any further opportunities for workforce reprofiling, the risk is: • the recruitment challenge will be exacerbated (see above); • opportunities for enhanced workforce efficiency (eg. larger ward templates) will be missed.
Work involved	The 3Ts Change Consultants, working closely with the Chief Nurse and other Heads of Profession, will: • work with services to assess any potential (cost/benefit) for workforce reprofiling *that is not already being addressed*; • develop an implementation plan/business case, identifying any issues with Trust-wide implications or requiring Trust-wide policy; • support the refresh of the Trust-wide Workforce Plan; and • as agreed, support services in implementing their plan.
Products	• Assessment for each service/staff group of the potential (cost/benefit) for any further workforce reprofiling. • Where appropriate, implementation plan/business case, identifying any issues with Trust-wide implications or requiring Trust-wide policy.

Project	Workforce Modernisation
Benefits (incl. financial)	• Reduced staffing risk to 3Ts. • More stable workforce (indirectly, improved patient care/outcomes). • Increased workforce efficiency. • Supports the benefits identified for Operational Recruitment project.
Early Benefits	• If this initiative started sooner, it could reduce existing vacancy rates, reduce wastage and improve staff satisfaction. This would potentially: - reduce agency spend; - create a more stable, engaged workforce (indirectly, improve patient care/outcomes; reducing staff sickness absence); - reduce the staffing risk to 3Ts; - enable any learning to be shared/applied more widely sooner.
Governance	• 3Ts change support would be on an 'internal consultancy' basis, ie. - the respective Division/service would 'commission' the consultancy and manage the programme of work; - depending on the size/scope of the project, it may be appropriate to establish a separate Steering Group; - the consultancy brief would include the responsibilities of the Division/service, eg. to enable and support the change management process; - the expectation is that any resourcing required (over and above the 3Ts Change Consultant support) would be provided by the Division, which may require a separate business case; - the 3Ts Programme Director/SRO would have overall accountability for the quality of the consultancy. • Overall accountability for workforce/bandmix for services in the 3Ts building would be as for the rest of the Trust, ie. shared between the Director of HR, Divisional Management Teams and Heads of Profession.

Project	**New Models of Care/Pathways**
Rationale	To ensure that benefits of 3Ts building layout/design (eg. staffing/efficiency and clinical outcomes benefits, as described in the Benefits Realisation Plan) are fully realised.
Context	Opportunities arise from: • co-location of services (eg. integration of HIV and Infectious Diseases inpatient wards to create a Clinical Infection Service); • new facilities (eg. Air Ambulance helipad, negatively pressured inpatient rooms); • departmental design (eg. design of Fracture Clinic, where the patient remains in situ and staff rotate).

Project	Workforce Modernisation
Scope	In discussion with 3Ts User Groups, the following new models of care/patient pathways enabled by 3Ts design have been identified: **Stage 1 Services** • Acute Brain Injury Centre (Stroke, Neurology, Rehabilitation) • Clinical Infection Service (HIV, Infectious Diseases) • Medical Day Unit (all medical specialties)* • Greater use of Interventional Radiology • Split between 'hot' and 'cold' Imaging/Nuclear Medicine • Fracture Clinic model of care • Integration of general/neuro Critical Care* • Integration of Neurosciences (eg. with the Sussex Cancer Centre)[11]* • Air Ambulance helipad (major trauma pathway) **Stage 2 Services** • Integrated chemotherapy daycase unit • Early repatriation of transplant patients from London. • Merger of the acute leukaemia service with Worthing Hospital's.
Risks	Without appropriate preparation, the risk is that the benefits associated with the new models of care will not be realised. (Worse, the design of the new building will not be appropriate for current models of care, which may impact negatively on patient care).

[11] May be fully/partly achieved in advance through Site Reconfiguration or other interim plans.

Project	Workforce Modernisation
Work involved	The 3Ts Change Consultants will support the above services in: • articulating the new models of care, ensuring that they reflect best evidence-based practice, NICE guidance etc.; • refreshing the associated benefits/benefit quantification; • detailing the new patient pathways; • developing associated Operational Policies; • identifying educational issues/requirements and ensuring these are fed into the Trust-wide Workforce Planning process and Education & Learning Strategy; • identifying research opportunities and ensuring these are fed into the Trust R&D Strategy; • to develop patient information materials/models (working with the Trust Head of Library Services/Chief Knowledge Officer); • implementing new patient pathways on moving into the new building; and • evaluating and refining the new patient pathways.
Products	• Described models of care and refreshed benefits/benefit quantification (for the FBC). • Detailed new patient pathways. • Associated Operational Policies. • Identification of educational issues/requirements. • Patient information materials/models. • Evaluation of the new patient pathways.
Benefits (incl. financial)	• Each model of care has different benefits (financial and non-financial). These are set out in the 3Ts Benefits Realisation Plan and will be refreshed in preparation for the 3Ts FBC.
Early Benefits	• Except where otherwise stated, benefits associated with co-location, new facilities and/or building design will not be realised in advance of opening each stage of 3Ts.

Project	Workforce Modernisation
Governance	• 3Ts change support would be on an 'internal consultancy' basis, ie. - the respective Division/service would 'commission' the consultancy and manage the programme of work; - depending on the size/scope of the project, it may be appropriate to establish a separate Steering Group; - the consultancy brief would include the responsibilities of the Division/service, eg. to enable and support the change management process; - the expectation is that any resourcing required (over and above the 3Ts Change Consultant support) would be provided by the Division, which may require a separate business case; - the 3Ts Programme Director/SRO would have overall accountability for the quality of the consultancy. • Overall accountability for quality and efficiency/cost-effectiveness of services in the 3Ts building would be as for the rest of the Trust, ie. shared between the Director of HR, Divisional Management Teams and Heads of Profession.

Project	Repatriation of Activity
Rationale	The 3Ts FBC assumes some additional/repatriated activity. This will not be achieved solely by building additional capacity but will also require some management support to implement (eg. change of GP referral pathways).
Context	The Site Reconfiguration project (which will transfer neurosurgery to RSCH in advance of 3Ts) is underway, and the Trust Clinical Strategy is in development. These may realise some of the additional activity in advance of 3Ts. The 3Ts FBC assumes that additional staffing will be proportionate to additional activity/capacity but costed at marginal rates, ie. an increase in efficiency.
Scope	3Ts FBC assumes additional activity (other than general growth), including: **Stage 1** • Head Injury service/NICE compliance (additional neurosurgery and neuro-Critical Care beds) • Neurology inpatients (transfer of activity from DGHs as part of networked care, repatriation from London). • Neurosurgery (repatriation from London, expansion into S. Surrey/NW. Kent) • HIV inpatients (transfer of activity from DGHs as part of networked care). **Stage 2** • Early repatriation of transplant patients from London. • Merger of the acute leukaemia service with Worthing Hospital's • Satellite Bone Marrow Transplant unit • Private Patients Unit.

Project	Repatriation of Activity
Risks	Without management support, the risk is that: • additional activity (repatriation) assumptions will not be realised (lost income); • assumed workforce efficiencies will not be realised (increased cost).
Work involved	The 3Ts Change Consultants will support services and commissioners in: • where required, developing internal (commissioner) business cases, likely in advance of, or as part of, 3Ts FBC approval; • developing the new models of care/pathways (as for New Models of Care/Pathways above); • developing a change management plan for repatriation (eg. referral pathways from GPs/CCGs and neighbouring NHS Trusts); • agreeing the financials (eg. remuneration for split pathways) and contractual model (eg. where BSUH is a subcontractor of a larger centre); • implementing the plan; • evaluation (ie. monitor changes in referral pathway/market share and associated income).
Products	• As appropriate, input to commissioner business cases. • Description of new models of care/pathways (as for New Models of Care/Pathways above). • Implementation plan, including financials. • Evaluation report.
Benefits (incl. financial)	• Additional income. • Increased workforce efficiency.
Early Benefits	• Except where otherwise stated, benefits associated with expanded facilities will not be realised in advance of opening of each stage of 3Ts.

Project	Repatriation of Activity
Governance	• 3Ts change support would be on an 'internal consultancy' basis, ie. - the respective Division/service would 'commission' the consultancy and manage the programme of work; - depending on the size/scope of the project, it may be appropriate to establish a separate Steering Group; - the consultancy brief would include the responsibilities of the Division/service, eg. to enable and support the change management process; - the expectation is that any resourcing required (over and above the 3Ts Change Consultant support) would be provided by the Division, which may require a separate business case; - the 3Ts Programme Director/SRO would have overall accountability for the quality of the consultancy. • Overall accountability for repatriation of activity to services in the 3Ts building would be as for the rest of the Trust, ie. shared between the Divisional Management Teams and Director of Finance.

Project	Simulation
Rationale	3Ts Stage 1 includes a dedicated Simulation Suite[12] and Imaging Simulation Suite. (Equipment and staffing are subject to separate business cases). Work will need to be undertaken to ensure the opportunities for simulation are appropriately reflected in the pre- and post-registration education curricula.
Context	The 3Ts team drafted the business case to the (then) KSS Deanery for simulation equipment and a Simulation Project Manager, which was approved in 2009.
Scope	Trust-wide education and learning (through the new Education & Knowledge Division).
Risks	The risk is that the simulation facilities will not be fully used.
Work involved	The 3Ts Change Consultants will, as required, support the Education & Knowledge Board in: • developing business cases for staffing and equipment for the Simulation Centre; • refreshing the Trust Education & Learning Strategy and pre- and post-registration education curricula to reflect the opportunities for simulation-based learning; • evaluating the effectiveness of the Simulation Centre.
Products	• Business cases for staffing and equipment for the Simulation Centre. • Refreshed Trust Education & Learning Strategy. • Refreshed pre- and post-registration education curricula.
Benefits (incl. financial)	• Enhanced education and learning (and, therefore, enhanced clinical outcomes).
Early	• Benefits associated with the new facilities will not be realised in advance of opening 3Ts Stage 1. However there continue to be opportunities for incorporating simulation as a

[12] 'Simulation is a technique for practice and learning that can be applied to many different disciplines and types of trainees. It is a technique (not a technology) to replace and amplify real experiences with guided ones, often 'immersive' in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion. 'Immersive' implies that participants are immersed in a task or setting as if it were the real world.' (Jha AK, Duncan BW, Bates DW, 2001; Gaba D, 1999).

Project	Simulation
Benefits	technique in pre- and post-registration education (where this does not require a dedicated Simulation Suite).
Governance	• The Director of Education & Knowledge has overall responsibility for the design of the Simulation facilities in 3Ts, the development of associated business cases (eg. for faculty) and the integration of simulation facilities/practice into education curricula. • The 3Ts team is providing ad hoc support to the Education & Knowledge Board, eg. development of an interim Education & Learning Strategy. • The 3Ts Programme Director/SRO has overall accountability for the quality of the team's input/support.

Project	Travel Planning
Rationale	3Ts provides additional motorbike and cycle spaces and better facilities for pedestrians. The use of these facilities will need to be promoted through a refreshed Travel Plan.
Context	The legal agreement between Brighton & Hove City Council and the Trust under *inter alia* Section 106 of the Town & Country Planning Act 1990 (agreed March 2012) requires: • the development of an Interim Development Travel Plan (to be completed during the construction of the Stage 1 building) and Final Full Travel Plan (to be completed within three months of occupation of the Stage 2 building) to promote and enable increased use of walking, cycling and public transport as alternatives to the car; • employment of a Travel Plan Coordinator; and • annual updates on progress (following the Occupation of the Stage 2 building). The Trust is a member of the Brighton & Hove Travel Plan Partnership and already has a Travel Plan in operation.
Scope	Staff, patients and visitors travelling to the RSCH campus.

Project	Travel Planning
Risks	Without appropriate management support, the risk is that the new facilities will not be fully used, and that the Trust will not meet the stepped targets (to be developed as part of the Travel Plan).
Work involved	The programme of work would be developed in 2018/19 as part of refreshing the Trust Travel Plan.
Products	• Interim Development Travel Plan • Final Full Travel Plan
Benefits (incl. financial)	• Meeting legal obligations set out in the Section 106 Agreement. • Individual health and wider environmental benefits associated with modal shift to walking, cycling and public transport as alternatives to the car.
Early Benefits	• The Trust already has a Travel Plan in operation.
Governance	• The Chief Operating Officer is the Lead Director for the 'green travel plan'. • Governance for any 3Ts team input to the development of the Travel Plan would be considered nearer the time (2018/19). • The 3Ts Programme Director/SRO has overall accountability for the quality of the 3Ts team's input/support.

Commissioning

Introduction

79. This section summarises the commissioning plan that the Trust intends to adopt to bring all stages of the 3Ts hospital redevelopment project into operation. The 3Ts Commissioning Plan, which provides further detail on the Trust's approach, is appended.

80. The commissioning plan sets out the approach, the team structure, the communications plan and the key work tasks that will need to be undertaken prior to occupation in order to achieve the following objectives:-

- Opening of the new facilities on a timescale that maximises the benefits of the new buildings for patient care but is based on safe and efficient transition.
- Work in partnership with the contractor to ensure that the risks to service continuity and quality are mitigated.
- Based on good communication with all stakeholders.
- Minimises all associated costs including double running.

The Trust Commissioning Team

81. The 3Ts programme management office will incorporate a dedicated team to manage the commissioning of each stage of the project. The commissioning team will be resourced by Trust personnel who have experience of the 3Ts project, hospital commissioning and knowledge of the services included within the moves.

82. Trust internal advisors will form part of the extended commissioning team to ensure agreements and contributions are made by:

- Clinical Operations;
- Lead Clinicians and Senior Directorate Management;
- Infection Prevention & Control;
- Facilities & Estates;
- Finance;
- Human Resources; and

- any other department or service relevant to specific commissioning work streams.

83. The commissioning team will interface with the 3Ts programme governance structure by providing monthly progress reports and any exception reports to the 3Ts Main Scheme Delivery Group. It will therefore monitor progress against programme and enable early identification of any deviation from the forecasted timescales and outcomes. Laing O'Rourke will be represented on the Trust's commissioning team to ensure that there is full alignment between construction, building handover and the Trust's commissioning process.

Commissioning Programme

84. An outline commissioning programme has been developed to enable the Trust to occupy 3Ts facilities as early and as safely as possible, in a manner that minimises service downtime. This programme sets out the milestones for departmental moves and the commissioning activities that need to be completed pre occupancy for Stage 1.

85. Service move phasing has been discussed with Trust stakeholders which influences the sequence of moves set out in the commissioning programme. Low impact services such as Facilities Management and front of house departments will be relocated first, flowed by ambulatory care and concluding with interventional/surgery and acute in patient services. This was perceived to be the least risky and most robust strategy.

86. The dedicated 3Ts commissioning team will develop detailed departmental specific work stream programmes that will feed into the main commissioning programme. Service commissioning leads will be supported by members of the 3Ts commissioning team to ensure that the relevant activities are completed within the timeframes dictated by the master programme. Any threats to business continuity will be managed via liaison with the specific departments, and alternative service locations identified if necessary.

Interface with Construction Programme

87. The scheme will be completed and handed over to the Trust in a number of phases:

- Phase 1 – the Helideck;
- Phase 2 – Stage 1 building (later completion of the Sanctuary on Level 6 – dependent on demolition of existing buildings;
- Phase 3 – Stage 2 building; and
- Phase 4 – residual works

88. Phases 2 and 3 present a number of major clinical commissioning challenges that have already been discussed with Laing O'Rourke. Laing O'Rourke have significant experience of large scale hospital construction projects and are fully aware and appreciative of the issues raised and are anticipating requests for early access for pre handover activity tasks to be undertaken e.g. early access for IT installation and radio pharmacy commissioning. The commissioning programme is appended.

Engagement with Clinicians

89. There will be a service lead for each affected department, who will cascade information regarding the project and the relocation to frontline service staff. The 3Ts commissioning team member aligned to each service will liaise with and provide required information to the service lead. Support will be provided to the service lead if required from the 3Ts Commissioning Team.

90. A detailed commissioning communications plan will be developed for each stage of building handover and incorporated into the master commissioning programme.

Key Activities and Workplan

91. The length of the construction programme, which currently proposes handover of Stage 1 in April 2020 and Stage 2 in October 2023, means that this plan focusses in detail only for the commissioning of Stage 1. Stage 2 commissioning planning will be developed in detail at a later date. Sweett group were commissioned to assist in the planning of the activities below based on their experience within similar capital schemes.

92. The tables below list the key tasks, timescales and service relocation milestones for the commissioning of the Stage 1 building.

Task	Target Completion Date
Establish the commissioning team	01/09/19
Appoint departmental/service leads	17/09/19
Confirm the commissioning budget	01/09/19
Develop and agree service continuity strategy	01/10/19
Implementation of the Interface plan	01/10/19

Task	Target Completion Date
Staff Training Plan Developed	01/10/19
Develop and implement IM&T strategy	01/10/19
Develop equipping strategy including a) Audit b) Agreement and implementation of procurement strategy c) Contractor interface d) Development and implementation of the training strategy	09/11/19
Develop strategy for client changes	01/10/19
Infection control plans	01/11/19
Communications strategy	01/12/19
Co-ordination with the Arts Strategy	01/01/20
HR Strategy	01/02/20
Retail Contracts Awarded	01/02/20
Decommissioning plan	01/03/20
Obtain necessary licences and approvals	02/04/20

93. The table below sets out the key tasks and milestones for the commissioning of Stage 1.

Task	Start Date	End Date	Milestone
Stage 1 Handover to Trust			23/04/20
Theatre Deep Clean	23/04/20	29/04/20	
Microbiology Testing	30/04/20	03/06/20	
Clinical Clean	Thu 23/04/20	Wed 20/05/20	
Staff Training	Thu 23/04/20	Wed 26/05/20	
Staff Change Operational			25/05/20
Rheumatology, ENT, Audiology and			14/05/20

Task	Start Date	End Date	Milestone
Maxillofacial Move			
Therapies and Non Invasive Cardiology Move			18/05/20
Neurosciences Physiology and Outpatients Move			20/05/20
Cold Imaging Move			25/05/20
Fracture Clinic Move			27/05/20
Level 6 Café Operational			29/05/20
CIS Ward and Outpatients Move			29/05/20
Discharge Lounge Move			29/05/20
Medical Wards Move			02/06/20
Neurology and Stroke Therapies Move			04/06/20
Neurology and Stroke Ward Move			04/06/20
Level 5 Imaging			04/06/20
HWP Neurosurgical Wards Move & HWP vacated			09/06/20
Critical Care Move			09/06/20
Theatres and Recovery Move			09/06/20
Nuclear Medicine Move			13/06/20
Radio pharmacy Move			13/06/20

94. The full commissioning programme for Stage 1 only is appended. Other stages will be added as required.

Budget

95. A budget of £15.1m was established for transitional costs including commissioning, in line with the strategic approach set out in this plan. Cost elements within that budget will be confirmed as the commissioning details and risk management strategy are established. A contract monitoring/ management plan will be put in place. (Further details are costed and appended). A £0.5m allowance has been made for loss of activity during commissioning.

Decant Commissioning

96. Commissioning for the decant phases will be undertaken using the same principles set out for the commissioning of the main scheme. The Trust's Capital Development team, alongside the 3Ts Communications and Engagement team have identified and liaised with front line service leads in each service affected to routinely update them on project progress, how and when the temporary relocations will take place.

97. The 3Ts equipping team will be working with the Capital Development team and end users to undertake equipment audits to determine the level of equipment that need to be procured or transferred. The 3Ts equipping work-stream lead will ensure that the interface is managed between the project and the Trust wide capital replacement programme.

98. Closer to the temporary relocation move dates, the project team will support the services in ensuring that their temporary accommodation is ready and cleaned to the standard required to deliver patient care.

Communications

Overview

99. The Communication and Engagement programme started in 2009 and will conclude with the completion of the 3Ts redevelopment. It focuses on planning and construction milestones throughout the process, including the commissioning of Stage 1 and Stage 2.

100. Each construction milestone will have an individual communications and engagement plan drawn up. As an example, the plan for the decant to St Mary's Hall is appended.

101. Many of the engagement tools required for commissioning will have been developed and used in previous elements of the programme. This will ensure their efficacy. The decant programme, that involves moving services to temporary or permanent new accommodation to allow for construction, will inform the C&E approach used prior to and during the commissioning of the new buildings.

102. Established electronic, paper and cascade systems of information and feedback will form the central core of communication during the commissioning phases.

103. The C&E programme has been and will continue to be informed by experiences from other, recently opened healthcare facilities both within the Trust and elsewhere within the NHS in order to incorporate best practice and lessons learned.

Staff

104. The key emphasis will be on direct engagement with staff at all levels of 3Ts services.

105. Each service affected by the commissioning process will have a named contact in the Commissioning Team. These contacts will build a relationship with identified service representatives through the commissioning planning role. Service representatives will act in a cascade role for the distribution of information to service staff and as the first point of contact for service staff enquiries. Service staff will also be able to contact the redevelopment team directly.

106. Question and answer sessions with all the services affected by the commissioning phase will be organised. Where possible these will take place in established team / service meetings. Ad hoc sessions will be arranged if this is not feasible. These sessions will involve as many staff members as possible. Along with information passed on by the service representatives these sessions will also act to direct staff to available resources about the redevelopment and the commissioning / decant process.

107. As the planning process for the commissioning phase progresses the C&E resources made available to services will be reviewed and, where it is deemed necessary, altered to meet the needs of services.

108. The existing comments tracker will be used to ensure all enquiries and concerns are followed through and the results fed back to the appropriate service or individual staff member.

109. On completion of the move to the new facilities staff will be supported with further open forum meetings where comments and issues can be raised. The information from these sessions will form the basis of a review of the C&E programme.

Patient and Public

110. Information about the new facilities will be communicated to the general public using established channels. New and existing patients will be identified and information about the changes will be sent to them through the service(s) involved with their care. The services will act as the initial point of enquiry for patients. Services will be free to escalate such queries to the Commissioning Team and patients will be given the option of contacting the team directly. The comments tracker will be used to ensure all concerns are recorded and addressed appropriately.

111. During the early phase of service transition an increased volunteer presence is planned for the public areas of the new facilities to assist with wayfinding and patient and public orientation.

112. Lessons learnt from patients and the public in early clinical service relocations, such as Stage 1 decant, will be applied to commissioning phases of the redevelopment.

Summary

Summary Points
1. The Trust, and its partners across the local health economy, has put in place robust governance arrangements which are owned at the highest level in all partner organisations.
2. The framework for risk management follows Prince 2 methodology and allows risk to be identified, owned and managed at the lowest possible level, with suitable mechanisms for escalation when required. The register is jointly managed in collaboration with the PSCP as required under P21 and P21+procedures.
3. The Gateway recommendations from the 3 reviews have been implemented in full. The programme has also received a rating of 'significant assurance' from our external auditors.
4. The Trust, supported by its local partners, has established an extremely strong and experienced development team who are managing the programme in accordance with good practice.
5. The Trust also has in place, overall frameworks, governance and resources for the management of the transformational change currently underway and that planned for the future, with a sound track record of delivery.
6. The Trust has selected a strong Procure 21 supply chain in Laing O'Rourke, which has established an experienced team to deliver the 3Ts programme.

CVs

Programme Director

The 3Ts Programme Director is Professor Duane Passman. Duane reports directly to the Director of Strategy and Change and is a member of the Trust's Executive Team. Duane has been involved in major capital investment programmes and projects in the NHS for over 23 years, with a period as a management consultant working for a strategic healthcare planning consultancy. He worked on the Chelsea & Westminster Hospital projects in its early stages.

Duane went on to work at St. Thomas' Hospital in London as Capital Developments Manager where he brought into operational use the South Wing of the hospital after a major refurbishment, transferring St. John's Hospital for Diseases of the Skin and the Lane-Fox Respiratory Unit to St. Thomas'. He also worked on the strategic response to the Tomlinson Review of services in London and how St. Thomas' could develop as part of that.

He was then Project Director for the redevelopment of Chapel Allerton Hospital in Leeds and Deputy Project Director for the Jubilee Wing at Leeds General Infirmary. The latter project involved the centralisation of neurosciences and cardiac services in West Yorkshire. This project also involved siting a helipad on the new building. The Jubilee Wing is similar in scale to Stage 1 of the preferred option. During this time he also worked on the development of business cases in Scotland, Yorkshire and the Midlands. He was a contributor to the Capital Investment Manual and the main author of the section dealing with 'Commissioning a Healthcare Facility'.

After this, he spent three years in the private sector and worked on the clinical planning and business cases for a variety of major projects, including Central Manchester Healthcare Trust, City Hospital Birmingham and the development of a new hospital on the island of Malta.

He then joined the NHS Executive Regional Office in London, working on the capital portfolio development and approvals process. He later became the Head of Capital Investment for the NHS in London from 2001 to 2006 and established the first Centre of Excellence for Programme and Project Management outside Central Government, working with the Office of Government Commerce.

During this time, he was also the Project Director for the development of Queen's Hospital in Romford. This £250m 939-bedded District General Hospital was procured under PFI and was one of the national pilots for the Retention of Employment model where soft FM staff remained employed by the NHS but seconded to the private sector under the PFI arrangements. He was also Programme Director for the North Middlesex redevelopment project, also procured under PFI which reached financial close in 2007.

Duane is Visiting Professor at the Medical Architecture Unit, University of the South Bank.

Project Leads

Nick Groves, Associate Director for 3Ts Service Modernisation, provides the key management of service inputs to the programme. Nick has an extensive background in Human Resources, Organisational Development and service modernisation. He was an HR & OD Director in a large acute Trust and then worked internationally. He has also been a management consultant working on service development and modernisation. Nick's portfolio within the programme includes service modernisation and change management.

Management of the Programme Office and controls assurance is undertaken by the Associate Director (Head of 3Ts Programme Office & Governance), Dr Anna Barnes. Anna's role is also to challenge the processes and systems being utilised as part of the programme and to ensure that the Programme meets best practice. The intention of the programme is to be best practice in all aspects of its development. Anna previously worked at Hastings and Rother Primary Care Trust as the business change manager of a series of capital developments in primary care. She also has extensive experience of project management and staff and patient engagement.

Clinical Input

Key clinical input is also provided into the 3Ts structure. As would be expected, clinical input is provided by the user groups who work on the detail of design development and clinical care pathways. However, given the importance of the programme to the future clinical success of the Trust, the 3Ts team includes significant clinical representation through a dedicated Clinical Director and Deputy.

The Clinical Director position for the Programme is currently vacant, but was formerly held by Peter Hale. This post is to provide key strategic clinical input to the team as a whole and provides a clear source of challenge to clinical colleagues and to the non-clinical team in the development of the programme.

The Deputy Clinical Director is Dr Graham Dodge, who is also the Trust's Clinical Chief for Specialised Services, many of which are part of the 3Ts Programme. Dr Dodge is also a consultant radiologist. Given the level of diagnostic and interventional imaging which is required within the 3Ts facility, plus the cross-specialty nature of this, having a consultant radiologist closely involved in the process is key.

Trust Team

The Trust team also comprises:

Gary Speirs – 3Ts Project Manager: Gary has an extensive record of project management in the acute setting, including previous roles in the IM&T division at King's College Hospital. Since joining BSUH nine years ago, Gary has been involved in a number of projects at BSUH and was the Trust's PFI Project Manager for the construction and commissioning of the new Royal Alexandra Children's Hospital (opened 2007). Gary's responsibility is to manage the overall design and construct processes, control the contracted programme and to take the lead on the design development of a number of departments;

Gary Beacham – 3Ts Clinical Planning Manager: Gary has a depth of experience in hospital operational management with an extensive record of service leadership and service improvement across a wide range of specialities. Having successfully led teams in some of London's leading Acute Hospital Trusts during times of significant organisational change, he brings a wealth of experience in working with clinical teams through major build and relocation projects. Gary will lead clinical planning, along with aspects of the design development within the programme, playing a key role in representing clinical services both in the planning and realisation of the move to new facilities.

Eoin O'Flynn – 3T'S Change Consultant. Eoin joined the team in 2014 and comes from a clinical background. Eoin worked as a radiographer in BSUH for 10 years and during that time has been heavily involved in service improvement, reconfiguration and delivery of acute imaging services. During the early stages of the 3Ts project Eoin represented the Imaging department and worked with the 3T team in developing the interior design strategy. Eoin will work closely with clinical teams supporting them during the design phase and through service modernisation;

Jacqueline Logan – 3T's Change Consultant. Jacqueline previously worked as an Operating Department Practitioner across various NHS organisations including 5 years leading BSUH orthopaedic trauma theatres, before moving into project management and service redesign. Jacqueline is working closely with our clinical teams, supporting the development of operational plans and leading teams through the design and procurement processes to ensure smooth transition for clinical services as they move into new facilities.

Richard Beard –Head of Communications and Public Engagement. Richard is an experienced communications and public engagement professional. He has the key role of ensuring that there are good communications within the Trust and externally and that the programme continues to work with patients and the public.

Hazel Belfield-Smith – Senior Information Analyst. Hazel has worked at BSUH for twelve years, most recently in one of the Trust's Clinical Divisions and was responsible for examining commissioning and performance trends and in the provision of key management information across the Trust. Within the Programme, Hazel is responsible for information analysis and clinical performance benchmarking to ensure that the 3Ts development proposals represent good practice and are consistent with the Trust's objectives of being in the top quartile for operational performance;

Phil Rolf – Programme Engineer. Phil is an experienced engineer having worked in the private sector and the NHS. His key responsibilities are to ensure that the engineering services strategy within the new facilities are developed according to sound environmental and operational principles and to ensure that the links into the existing site infrastructure is designed and implemented appropriately;

Rob Brown – 3Ts Decant Programme Manager. An estates professional with an architectural technologist background he is responsible for the delivery of the decant plan in line with the timescales for the main scheme.

Abigail Pride – 3Ts Change Consultant. Abigail has been in post since 2008, bringing a background in service redesign, project and change management in the NHS. Her responsibilities include leading staff through the design process and identifying opportunities for further efficiency and effectiveness in working practises. Abigail plays a key role in development and implementation of the Public Art Strategy and Interior Design approach to ensure that the environment is as welcoming and therapeutic as possible;

Dena Vadgama – Commercial Procurement lead: Dena is a senior Procurement professional with extensive experience in major NHS Capital schemes, gained most recently at Great Ormond Street Hospital NHS Foundation Trust. Her specialism lies in the development and implementation of Procurement Strategy. She has a proven track record of delivering large complex procurement projects in time and within budget. Her key responsibilities will be to engage with both internal and external stakeholders to ensure all procurement and equipping tasks meet user expectations and give consideration to whole life costing and capital asset management. She will be the link between the Trust's Procurement Department and the 3Ts programme.

Mark Frake – Project Financial Lead/Project Accountant: Mark has an extensive career gained mainly in the private sector and most recently worked for Unilever. His key responsibilities are to monitor the affordability of the scheme and to provide the link between the Business Case processes and the Trust's day to day financial processes, ensuring that one links smoothly into the other. He also acts as the Directorate Management Accountant for the 3Ts Directorate;

Joanne Ingram – Programme Administration Manager. Jo is responsible for the smooth running of the Programme Office and its administrative functions. Jo has been a senior administrative manager and PA in the Trust for many years;

Claire Lucas – PA to the Programme Director. She is responsible for the day to day management of the Programme Director. Claire has worked in the NHS for over 10 years;

Mariusz Przybytek – Project Administrator. Mariusz joined the Programme Office from the private sector and is responsible for general administration and logistics.

Simon Selby- Head of Workforce Planning. Simon is an experienced HR professional. He leads on the provision of a workforce planning and workforce information service for the Trust including the commissioning of the Trust's future pre and post registration education requirements for non-medical staff.

Gary Steen- -Assistant Director of IT. Gary has extensive experience in Information Management & Technology both in the private and public sectors, including most recently Strategic Health Authority Chief Technology Officer and Acute Hospital Assistant Director IT. A Prince 2 practitioner, Gary is currently leading on the BSUH IM&T infrastructure update programme including server, storage, wired and wireless networking, desktop upgrade and replacement, high availability and disaster recovery solutions, unified communications including IP Telephony and IT lead for the 3Ts programme.

Skills and Competencies

The Programme Director, based on his experience to date, has reviewed the skills and competencies which are required to deliver the programme overall. These are set out in matrix below which includes the individuals whose experience and accrued skills means that they can contribute directly to that area:

Competency Matrix

Skill / Competency	Why Required	Member of Team with requisite skills
Management of major investment programmes	Experience of large scale projects and working with design teams/contractors to ensure process runs smoothly	Duane Passman, Gary Speirs, Anna Barnes, Phil Rolf, Rob Brown.
Clinical and service planning	To ensure that the interface with the Trust User Groups runs smoothly and there is a good “translation” between clinical and service needs and the brief.	Duane Passman, Peter Hale, Graham Dodge, Gary Speirs, Gary Beacham, Eoin O’Flynn, Abigail Pride, Jacqueline Logan.
Process redesign and service modernisation.	To ensure that the processes in the proposed facilities meet good and best practice and are optimally configured.	Nick Groves, Gary Beacham, Eoin O’Flynn, Anna Barnes, Abigail Pride, Jacqueline Logan.
Facilities Management operations	To ensure that FM services can be delivered optimally.	Steve Gallagher, Gary Speirs, Phil Rolf, Rob Brown.
Site infrastructure knowledge	To ensure that the development links into the rest of the site in physical terms (including engineering services)	Gary Speirs, Phil Rolf, Gary Steen, Rob Brown.
Patient and public engagement	To ensure that patients and the public are engaged in the process.	Richard Beard, Nick Groves, Anna Barnes, Duane Passman
Staff Engagement	To ensure that staff play a full part in the development of the new facilities.	Richard Beard, Nick Groves, Anna Barnes, Eoin O’Flynn, Duane Passman, Gary Speirs, Steve Gallagher, Gary Beacham, Anna Barnes, Abigail Pride, Jacqueline

Skill / Competency	Why Required	Member of Team with requisite skills
		Logan.
Commercial Acumen	To negotiate commercially with contractors and designers/consultants – especially to negotiate a Guaranteed Maximum Price.	Duane Passman, Dena Vadgama, Rob Brown.
Equipping	To ensure that the equipment budget is set appropriately.	Duane Passman, Gary Beacham, Gary Speirs, Phil Rolf, Gary Steen.
Controls and Assurance	To ensure that the programme is managed in accordance with best practice.	Duane Passman, Nick Groves, Anna Barnes.
Financial planning and budgeting.	To ensure that affordability is monitored and costs accurately reported and interpreted.	Mark Frake, Duane Passman
HR and Workforce implications	To ensure that the project takes into account the new workforce implications such as recruitment and retention	Simon Selby
Business Case development	To ensure that an FBC is developed that complies with guidance	Duane Passman, Mark Frake, Anna Barnes, Nick Groves