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Dermatology coming together

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27th February 2019

Background

- 'Current state of play'…

Challenges

- Consultant losses at AUH
- Loss of 2wr RLBUHT
- Restriction of new patients @ AUH
- Impact on the 'system'

Current services in Dermatology…

AUH

1 x Consultant Dermatologist; 1 x Locum Consultant Dermatologist

1 x Specialty doctor

2 x Specialist nurses

Closed to 2WR and general new referrals (recently seeing some generals)

Minor surgery

Ward referrals

No on call service

Phototherapy & laser service

Current services in Dermatology…

- **RLBUHT**
- 11 x Consultant Dermatologists; 1 x Locum
- Consultant Dermatologist
- 2 x Nurse Consultants
- 6 x SPRs
- 3 x CNS
- 4 x Specialist Nurses
- 2 x Research Nurses
- Ward referrals

- On call service
- 2WR clinics
- General adult dermatology – secondary care
- ICATS (community)
- Minor surgery
- Specialist clinics
- Phototherapy service

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Things to consider…

- BGH vs AUH – COMPETITION
- FINANCIAL VIABILITY
- CCG “ACTING AS ONE” CONTRACT
- PRIVATE PROVIDERS

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Transaction & Integration – the journey to merge…

BACKGROUND TO MERGER

- Anfield - LFC (Nov 2013) – joint Consultants event
- Clinically driven from the start – “if we merge it had to achieve specific design principles” (next slide)
- This led to the SOC & OBC – each clinical area produced a vision for single service – narrative used in the OBC submission.
- Proposal and OBC agreed by Trust Boards – November 2017
- ‘Deep dives’ for FBC and Patient Benefit Case - chosen by identifying areas of clinical priority, volume, competition and areas with current operational.

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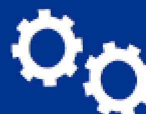
Alignment Against Design Principles **Dermatology**

Context

- There are a number of key principles that all Integrated Planning Teams across the different services/spec to take account of in their integration planning. These design principles (agreed in the Strategic Outline Ca merger should aim to address when developing service models for the combined organisation.
- This document sets out how the expected benefits from the proposed Dermatology integrated service moc the design principles.
- A summary of the principles are set out below for ease of reference:

Patient Outcomes & Experience

- Improved patient outcomes e.g. mortality, morbidity, readmissions
- Improved patient experience e.g. access/ equity of service, waiting times, Length of Stay



Alignment & Strategic Fit

- Alignment v & Care Part
- Considerati place based and social c

Clinical Sustainability

- Improve rota sustainability
- Improve recruitment and retention
- Increased volume and critical mass
- Contribution to training and research

Deliverability

- Practicality including:
  - Manage
  - Affordal
  - Compet

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Transaction Timeline

(Day 1: October 2019)

April 2018	May 2018	June 2018	July 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019

'BAU' & Other Trust Programmes

- New Hospital Implementation (RLH) TBC
- Manage Winter pressures
- Manage Winter Pressures
- EPR Implementation (TBC)
- Financial Turnaround Support
- Deliver CIP/QEP schemes

Transaction / FBC

- Update MoU
- Heads of Terms
- Trust Boards approve FBC/PTIP
- NHSI Board to Board (end June)
- Develop FBC
- NHSI Review: Reporting Accountant opinion
- NHSI B2B
- NEW TRUST AUTHORISED *(earliest date)*. Subject to NHSI/ CMA review process
- External advisors commence support following NHSI approval
- Develop PTIP
- LTFM
- Approval Applications
- Full Due Diligence
- DD risks incorporated into integration planning
- CMA Notified
- CMA Approves Phase 1 Review
- Develop Patient Benefits Case for CMA
- pre notific ation (min
- CMA Phase 1 Review (40 days)
- CMA Phase 2 Review (if required)

Integration

- Target Operating Model & Synergies
  - Clinical & Corporate IPT deep dive planning
  - Light touch IPT development /review
- Confirm & Challenge (inc. clinical validation)
- Commence Day 1 Readiness Checks
- Integration Planning & Implementation (IPTs and cross cutting areas eg Workforce, IM & T, Estates, Finance, etc.)
- Demand & Capacity Modelling
- Develop benefits log & approach to monitor the realisation of benefits
- Benefits realisation tracking
- Culture Assessment
- Engagement & Communications

Governance

- Develop new Organisation & Governance Model
- Agree Corporate Governance Requirements for new organisation
- Preparation for & holding of Council of Governor elections
- First meeting of CoG & ratification of Chair, NEDs, CEO following elections
- Interim Statutory Board process completed
- First Interim Statutory Board Meeting as new Org.
- Finalise Shadow Interim Board & procure external support
- Shadow IB process - support
- Shadow IB – interviews process starts 7/1/19
- Interim Statutory Board in place & oversees progress of actions
- New Board
- First Meeting of New Statutory Board
- Monitor, report & mitigate risks (ongoing)

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NHS

Timeline and next steps

Key actions and next steps

1. Each IPT will have a series of actions to complete following the confirm and challenge session and will update to HSRG on the defined date. These actions are listed on the following pages and progress against these actions must be documented in the integration planning template.

2. Further work is still required to quantify merger benefits. Benefits quantification continue to be developed as an 'iterative' process with new benefits being defined as the models progress.

3. Each IPT will now have complete detailed integration plans to support the delivery of the future state operating model linked to an interdependency matrix.

4. Further work will commence to define KPI's and develop the Integration Planning Templates into PIDs for organisation operationalisation.

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PMO leadership…

- Exec level leadership.
- Using robust PM via PMO to move at pace.
- Robust governance processes.
- Robust risk/issue escalation.
- Capacity & Demand, Due Diligence, Patient Benefit Case, Exec led Confirm & Challenge, FBC, PTIP.
- Clinical project group to move forward at pace.
- Development.
- ‘Leg work’.
- Relationships & trust!

Clinical Reconfig process & leadership…

- **Workshop 1** – clinicians developed number of options – options appraisal.
- **Workshop 2** – define the model in detail i.e. estate, governance, ROTA.
- **Workshop 3** – ‘sense check’ the proposed model & agree the timescales for implementation.
- **Options appraisal** - Hospital Services Reconfiguration Group (HSRG) wider clinical discussion & preferred option.

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Dermatology: Proposed Hub & Liaison model Overview

HUB @ BGH
In-patients & Day Cases (ward 4), Phototherapy, Out-patients, Minor surgery

- Tele dermatology - pilot
- RAS Triage – pilot to be rolled out
- Utilising SPN's – piloting ideas
- Skin Cancer Clinics
- Laser

Spoke @ RLH
Ward Referrals, On call service

Spoke @ AUH
Ward Referrals, On call service, Minor surgery, OPD clinics (general and 2WR)

Community
ICATS clinics

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Clinical Recommendation for Dermatology Site Configuration 5 Year Vision

AUH Site:

- Ward Referrals & liaison (on call)
- Minor Surgery (Clinic rooms)
- General Out Patients
- Cancer (within next 2 years)

A
A&E
Aintree
W
STHK
6.2 Miles
7.9 miles
A H
B
LHC
Broadgreen

RLBUHT site:

- Royal
- Ward Referrals & liaison (on call)

R
CCO
3.7miles
A&E
Royal Liverpool

BG Site: Main Dermatology 'Hub'

- General Out-patients
- Minor surgery
- In-patients & Day cases (ward 4)
- Phototherapy

Key

AUHFT & RLBUHT hospital sites	W	The Walton Centre	LHC	Liverpool Heart & Chest	*Travel times represent off-peak journey times (Source: Google maps)
Other neighbouring Trusts	CCO	Clatterbridge Centre for Oncology	A H	Alder Hey	

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Proposed Dermatology & Clinical Design principles

Patient Outcomes & Experience	Clinical Sustainability	Operational	Workforce	Financial	Alignment & Strategic Fit	Deliverability
✓ Improvements in access to sub-specialty clinics ✓ Improved access to research nurses and trials ✓ Equity of access and reduce variation in service for the population ✓ Maintain OPD clinics & minor surgery at BGH & AUH ✓ Increase access to skin cancer clinics at AUH ✓ Access to on call at AUH	✓ Model ensures we can maintain dermatology in RLBUHT & AUH ✓ We can increase our new patient capacity ✓ Clinical staff can develop specialist skills/new skills ✓ Model allows for growth ✓ AUH consultants on ROTA ✓ Greater use of new technology to 'free up' clinical time	✓ SPR / Consultant on call service ✓ RAS triage ✓ Expand North Liverpool ICATS clinics (community working) ✓ Reductions in current long waiting times with extra clinics available. ✓ Reduction in costly waiting list initiatives.	✓ Improve Recruitment and Retention ✓ Extra consultant at AUH needed – more attractive proposition as a merged service. ✓ Develop specialist nurses & Nurse Consultants ✓ Flexibility of place of work for staff ✓ Greater access to research for staff – wider patient cohort and more attractive to larger studies/clinical trials.	✓ Increased use of ward 4 (BGH) for day case working and in-patient working ✓ Phototherapy 'hub' making best use of resource. ✓ Develop & expand laser at AUH ✓ Single directorate management and clinical structure leading to small reductions in PAs and WTEs over 5 years ✓ Optimisation of skill mix over 5 year timeframe via larger pooled staffing within single directorate structure	✓ SPR / Consultant on call service. ✓ RAS triage – requirement of local CCG priorities and objectives. ✓ Expand North Liverpool ICATS clinics (community working) – requirement of local CCG priorities and objectives. ✓ Optimised Multi Disciplinary Team working – reduces variation in clinical practice and releases clinical time to focus on patient care.	✓ Adoption of best practice service models and patient pathways helps achieve and sustain process improvement. ✓ Workshop process has helped to define initial implementation milestones and next steps. ✓ The model can be developed within current staffing structures – without implementation costs as current service has capacity with extra consultant at AUH site.

Net Expenditure Base 2018/19	9,811,163
Synergy Saving 10%	981,116
Synergy Saving 5%	490,558
Synergy Saving 2%	196,223
Current Synergy Saving (£s)	192,067
Current Synergy Saving (%)	2.0%

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ROUND TABLE DISCUSSIONS

- What are the key issues facing dermatology services in your patch (STP/ICS/locality)?
- What ideas can we adapt from today to transform services and patient outcomes locally?
- Who else should we involve to help transform and sustain dermatology services across our region whilst addressing the key issues?