UHL Reconfiguration – Update

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Executive Summary Paper G

Context

The UHL Reconfiguration Programme is an ambitious and complex undertaking which has been established in order to deliver the strategic direction and clinical strategy. It is important that the Trust Board has visibility of progress and is able to provide appropriate challenge to ensure there is sufficient assurance associated with activities undertaken to achieve the desired future state.

The Reconfiguration Programme is currently working through a number of key issues that will enable the development of a re-phased programme plan. These include: programme resourcing, programme structure, the impact of revised demand and capacity planning and the anticipated availability of capital funding. The re-phased programme plan will provide the Board with a forward view of activities being planned and timescales for delivery. It is anticipated that the re-phased programme plan will be available in November 2016.

Questions

1. Does this report, dashboard and risk log provide the Board with sufficient and appropriate assurance of the UHL Reconfiguration Programme and its delivery timeline?

Conclusion

- This report provides an overview of the programme, the top risks from across the programme that the Board should be sighted on, an update on the Emergency Floor project, and a 'focus on' the Women's Hospital Project.
- Due to the timings of meetings in August, this report has been prepared prior to receipt of highlight reports from reconfiguration workstreams and prior to discussions at the Reconfiguration Board on 31st August 2016. Verbal updates will be provided as appropriate.

Input Sought

The Trust Board is requested to:

1. Note the progress within the reconfiguration programme
2. Comment on the content of the report
3. Advise on whether the format of the paper can be improved

For Reference

The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

This matter relates to the following **governance** initiatives:

Organisational Risk Register	[N/A]
Board Assurance Framework	[Yes]

Related **Patient and Public Involvement** actions taken, or to be taken: [Part of individual projects]

Results of any **Equality Impact Assessment**, relating to this matter: [N/A at this stage]

Scheduled date for the **next paper** on this topic: [Thursday 6th October 2016]

Executive Summaries should not exceed **1 page**. [My paper does comply]

Papers should not exceed **7 pages.** [My paper does not comply]

UHL Reconfiguration Programme - Update to the Trust Board September 2016

Programme Overview

1. This report provides a brief summary and overview of the current programme status, and is a reflection of recent discussions at the Executive Strategy Board (ESB) (9 August 2016). Two documents are appended for information; the Executive Level Dashboard (Appendix 1) provides an update and a RAG status for each of the Reconfiguration workstreams, and the Programme Risk Log (Appendix 2) presents the top ten Programme risks.

Sustainability and Transformation Plans (STP)

2. Leicester, Leicestershire & Rutland (LLR) have submitted their STP to NHS England, which includes refreshed demand and capacity assumptions focussing on inpatient beds at UHL. The refresh was carried out under the condition that capital requirements could not increase as part of the process, and health systems had to be financial viable by the end of the five year period. This means that UHL is committed to delivering a reconfigured estate with 1,497 beds at a maximum capital cost of £327m, as outlined in the 2014 estates strategy.

3. Part of the refresh process looked at whether the capital requirement could be reduced by retaining some clinical services on the LGH site e.g. elective orthopaedics, the planned ambulatory care hub, women's outpatients/scanning. This piece of work concluded that while there would be a marginal reduction in capital requirement of £6m, there would be recurrent £8.8m deterioration in the revenue income and expenditure performance. This was proposed by the Reconfiguration Board and agreed at ESB as not being a viable way forward.

4. Initial feedback on the STP submission indicates that LLR is in cohort one of submissions (meaning they are nearly ready to go), however further work/detail has been requested with regards to how the years 3-5 year bed reductions will be delivered (in particular the integration dividend). This is currently being reviewed by the Executive Team.

5. Further national guidance has been issued which references the planning expectations for STP delivery. This guidance will require new ways of working across the system in terms of contracting and planning, but should help with alignment between operations and strategy in the annual planning process and increase the likelihood of successful delivery of the STP. This planning process needs to be closely aligned to the estates strategy re-fresh and workforce planning.

Estates Strategy Refresh

6. The original 2014 Estates Strategy was based on a total bed complement of 1,497 inpatient and day-case beds on two UHL sites, (plus a further 23 community beds). Since the STP reflects this as the reconfiguration end-state, the high level feasibility and costs (£327m) remain valid.

7. A plan for UHL's future bed state split by speciality has now been finalised and signed off by Richard Mitchell, Chief Operating Officer. The estates team are therefore now in a position to progress from phase one of the Estates Strategy refresh to phase two. The outputs will be:

    - Production of revised site Development Control Plans (DCPs) which identify stacking of the future estate and buildings by site, based on a refined schedule of accommodation and the clinical adjacency matrix
    - Updated DCP phasing plans and outline decant strategies, considering access, site flow and traffic management
    - Refreshed capital costs by project within £327m, updated cash-flow and revised Strategic Outline Case cost forms
    - The UHL route map and organisational communication material, aligned to existing projects, the estates infrastructure programme and EMPATH.

8. It is currently estimated the phase two of the refresh will be complete by the end of October/start of November 2016.

Procurement Routes

9. UHL has explored alternative financing options to reduce the requirement of traditional Department of Health (DH) capital borrowing. This process has concluded that PF2 is the only potential alternative source of capital; but it is only appropriate to use this for the Women's Hospital project (£65m) and Planned Ambulatory Care Hub (£58m) where there is significant new build. Although the timescale for PF2 arrangements is longer than traditional DH capital borrowing, it has a clear advantage while DH capital is constrained.

10. This could therefore potentially contribute £123m of funding and reduce the remaining DH funded capital requirement substantially. It is important to note that the revenue impact of this is yet to be assessed in full, but experience from the national PF2 pilot (the Midland Metropolitan Hospital) indicates that in current market conditions the revenue impact would not be materially different from that incurred using public capital.

11. A detailed update on PF2 will be brought to a future Trust Board meeting.

Capital Availability

12. The total capital requirement for the Reconfiguration programme, assuming the move to two sites with 1,497 beds, remains at £327m. The breakdown of capital taking account of the funding already received, the CRL and PF2 is shown in the table below. It leaves a DH funding requirement of £96.5m:

	Prior years	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**Total**
Reconfiguration programme	63.0	20.4	46.2	79.4	80.0	38.0	327.0
Approved to date	(50.7)	-	-	-	-	-	(50.7)
Internally funded	(12.3)	(6.9)	(5.0)	(4.0)		-	(28.2)
External funding requirement	**-**	**13.5**	**41.2**	**75.4**	**80.0**	**38.0**	**248.1**
Site disposal	-	-	-	-	-	(28.4)	(28.4)
PF2	-	-	(14.8)	(31.3)	(44.0)	(33.0)	(123.1)
DH funding requirement	**-**	**13.5**	**26.4**	**44.0**	**36.0**	**(23.4)**	**96.5**

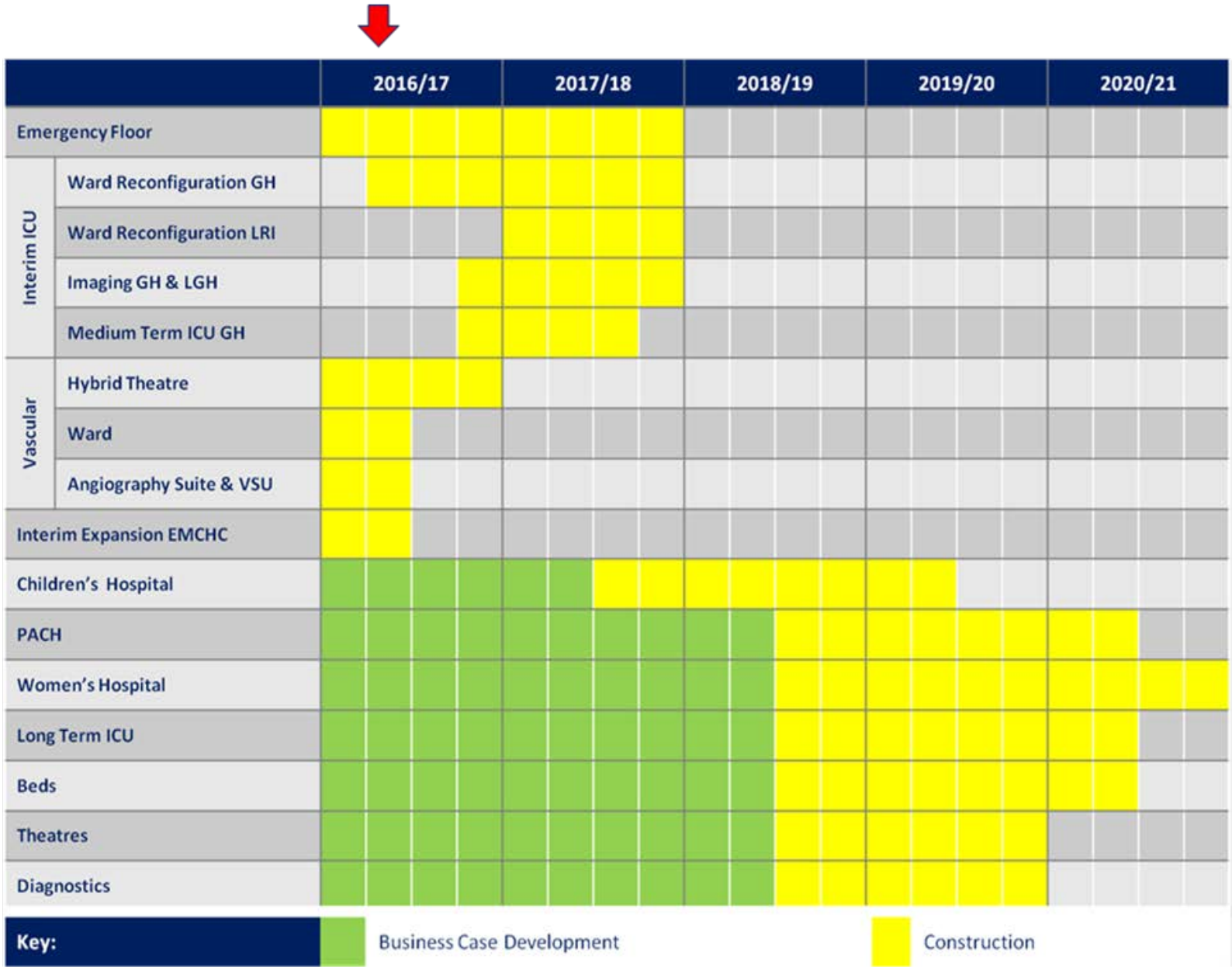
13. It must be noted that delivery of the reconfiguration programme within the overall cost envelope of £327m will be extremely challenging. A process of value engineering will be required within each project, and scope creep will be managed to keep the programme within the 2014 baseline, and any omissions will need to be managed within this budget. The phasing of capital expenditure is also subject to the re-phasing of the programme plan (details below).

Programme Plan

14. The programme plan for major business cases currently reflects 2016/17 capital requirements being available from September 2016 and capital for the remaining years of the programme being available in line with desired timescales. This is already out of date with the recent confirmation that the availability of capital will not be confirmed until October 2016.

15. A high level summary of the programme plan is shown on the following page. As detailed in section 7, this is subject to revision once the Estates Strategy refresh is complete; once the 2016/17 capital funding availability position is clear; as well as any changes caused by the STP or the uncertainty around EMCHC. Once the Estates roadmap is complete, the summary programme will be refreshed to ensure it includes the entirety of reconfiguration e.g. corporate services review.

16. This will be used to update the Trust Board monthly on progress against plan.


2016/17
2017/18
2018/19
2019/20
2020/21
Emergency Floor
Interim ICU
Ward Reconfiguration GH
Ward Reconfiguration LRI
Imaging GH & LGH
Medium Term ICU GH
Vascular
Hybrid Theatre
Ward
Angiography Suite & VSU
Interim Expansion EMCHC
Children's Hospital
PACH
Women's Hospital
Long Term ICU
Beds
Theatres
Diagnostics
Key:
Business Case Development
Construction

17. There are two issues with the latest programme plan, which will be resolved once it is updated to align with the Estates Strategy refresh. These issues are:

    - Due to delays to date in capital availability and consultation, there are a number of projects that would be ready to move to design/construction at the same time from the point funding becomes available
    - Alignment of interdependencies to ensure correct sequencing (e.g. parts of the Theatres project will need to be accelerated to ensure the Children's hospital theatre requirements are met within required timescales)

18. The table below outlines some key decisions which will be made by the Executive Strategy Board over the coming months:

Workstream / Project	Decision	Current deadline	Cause of Delay
Programme	Sign-off updated programme governance structure including any changes to workstreams / meetings.	~~August ESB~~ October ESB	To be completed following resource review.
Clinical Services Strategy	Sign-off of scope and deliverables for Model of Care (or associated) workstream(s).	~~August ESB~~ October ESB	To be completed following resource review (Septemebr).
Estates	Outcome and implications of Infrastructure review and business case	~~August ESB~~ October ESB	External report to be submitted in September.
Estates / Programme	Phase 2 Estates Strategy re-fresh including DCPs, realignment of project costs and programme plan	November ESB	
ICU/ Beds	Decision on preferred option for Glenfield capacity creation	~~September ESB~~ November ESB	Decision will be made as part of Estates Strategy refresh.
Emergency floor	Sign-off revised activity and workforce – change control from FBC	~~September ESB~~ October ESB	An update will be provided at September ESB, with the final paper presented at October ESB.
Vascular	Decision to proceed with moves without ICU move (and required revenue implications).	~~August ESB~~ November ESB	Reconfiguration Board agreed to review in October 16.
Beds	Sign-off PID	September ESB	
Support services	Sign-off PID	~~September ESB~~ October ESB	Initiation delayed due to lack of resourcing.
Corporate services	Sign-off PID	~~September ESB~~ October ESB	Initiation delayed due to lack of resourcing.

Reconfiguration Resourcing

19. Ruth Spring, the previous Interim Programme Director has now left the Trust and this post has been merged with the Project Director / Head of Reconfiguration Business Cases position. Nicky Topham is now acting as Interim Programme Director until longer-term arrangements are put in place.

20. Interviews were held for the Head of Reconfiguration PMO position in July but no substantive appointment was made. Therefore Paul Traynor has agreed that Anna Fawcett from Capita will fulfil this role until the end of December 2016; prior to which longer-term arrangements will be considered.

21. Interviews for six Senior Project Manager positions were held on Thursday 18th August; following which three people were offered substantive positions. Due to notice periods, these individuals will commence working at UHL on a range of dates before the end of 2016.

Programme Risks

22. The Programme Risk Log (Appendix 2) presents the top ten Programme risks in full; these are summarised below:

Risk/ Issue	Current RAG	Mitigation
Non-delivery of out of hospital bed capacity means additional ward capacity at GH is required for HPB (part of interim ICU) – however there is no capital in the reconfiguration plan for this.	**25**	Risk has now become an issue: Feasibility study into provision of additional ward space at GH undertaken; capital plan D includes funding. Need for additional beds tied in with Estates Strategy Refresh.
Capital funding is not guaranteed for reconfiguration; if not secured 3-2 site strategy would be affected.	**20**	Options for alternative sources of funding e.g. PF2 have been reviewed (possible for Women's Hospital & PACH). Ongoing discussions with NHSE and NHSI re Leicester's ambitions.
Not enough capacity in the system to create headroom to fully implement reconfiguration plans whilst coping with winter pressures & increased demand.	**20**	Demand &Capacity work on-going, includes options to reduce demand, create capacity (repatriation and/or new build), and move services between sites.
NHSE will not continue to commission EMCH services which may impact on the Childrens Hospital project	**16**	Continue Children's Hospital to original scope and programme; design solutions to reflect uncertainty. Ongoing discussions with NHSE and other stakeholders.
Consultation timelines delaying Women's & PACH projects; impact on ability to achieve 20/21 deadline for 3-2 site strategy.	**16**	Lack of capital funding also delaying projects; impact of consultation is programmed into relevant project plans. Engagement continues with NHSE re the STP which will determine when consultation can progress.
UHL may not be fully utilising available capacity through ICS beds; therefore not getting value from the service investment.	**16**	Optimised utilisation required to deliver benefits and financial sustainability. Plan for service optimisation and overcoming blocks is required.
Ongoing transitional funding required to deliver programme in future years may not be available due to limited capital.	**16**	Spend against Capital Plan D continues at risk for 16/17. Recruitment to substantive posts where possible is underway to help relieve pressure on future years.
EF project: the inability to release the phase 2 development area may generate a move away from construction phasing as agreed in FBC. This will add cost & delay completion.	**16**	Agreement at ESB that phase 2 will be completed in one phase. Options appraisal to be developed across Reconfiguration and Operations to identify solution to enable this approach to be carried out.
EF project: cultural changes required to deliver new MOC and workforce may not be delivered in time for phase 1 opening (ED)	**16**	Development & implementation of Organisation Development plan; OD lead supporting the clinical team using the UHL Way required.
The planned level of bed reduction required to deliver the STP and reconfiguration plan (end state of 1497 beds) is not achievable.	**15**	Focus on delivery utilising UHL's MOC strategy, BCT workstreams and Vanguard MOC; and reducing patients admitted 4+ times, re-admissions and frail elderly.

Emergency Floor Project Update

23. With only 6 months (29 weeks) before the opening of Phase 1 of the new Emergency Floor (EF), the priority for the scheme is ensuring that the EF teams and the wider organisation are fully prepared for the transition into the new build. Phase 1 remains on time and on budget. Handover of the building to the Trust is planned for early March 2017.

24. Detailed work is being undertaken to finalise the workforce plans by area. This work is underpinned by the models of care that are being developed for children who require admission, the integration of Urgent Care within the adult Minor illness, Minor Injuries and Eye Emergencies (MIaIMEE) area and the creation of the single front door for Children's emergencies. In addition, a significant piece of work is being undertaken to refresh and develop Standard Operating Procedures (SOPs) that will describe how staff across all disciplines will work within the new department in order to minimise patient journey time and improve patient experience.

25. Delivery of the Organisational Development (OD) Plan for the EF Project, as a Better Change Exemplar, will be increasingly important as teams are prepared for the move into the new environment. A whole systems approach is being adopted in order to integrate OD interventions with relevant work stream activities and to provide a consistent approach to change. This includes:

    - Reviewing the ED Standard Operating Procedures (SOPs) and associated staff development
    - IT staff training user workshops
    - Commencement of 'team relationships and behaviours' OD sessions
    - OD support to service development and new ways of working groups in order to embed culture, feedback and behaviours required
    - Communications and engagement using a variety of media and approaches
    - Drafting systems leadership competencies across LLR to inform future leadership development interventions.

26. A significant piece of work is concentrating upon organisational readiness for the move. Whist emphasis will be placed upon making sure staff who are directly involved in delivering services from the new facilities are prepared well in advance, priority is also being given to the delivery of locally owned and managed commissioning plans within CMG's and corporate services. Targeted support is being offered to ensure that these local plans address service needs and that interdependencies are effectively managed.

27. Dialogue has commenced with partners in the wider Health and Social Care Community (such as EMAS, Leicestershire Fire and Rescue Service, Local Resilience Forum and Social Care) in order to agree how they will support the opening of the new department and performance whist services settle into the new premises. Plans will be developed in partnership with these services over forthcoming weeks.

28. Development of the LRI site Access and Transportation Strategy will form part of our preparations for the opening of the new build. Whilst this is reliant upon the refresh of the Development Control Plan (DCP), early work is progressing to consider the requirements of the new department. Patient Partners have been invited to, and will play a key role, in informing the way finding strategy. A workshop is being organised in September to work with our Patient Partners on this agenda.

29. As a consequence to the delays in funding approvals for the EPR Business case, capital funding was approved for an interim IT solution to be implemented. IT have worked with key EF stakeholders to confirm requirements for the interim IT solution, which comprises four key projects (NerveCentre ED Module, Document Management, Digital Display and Patient Tracking). There are also a number of other IT solutions that are being delivered in parallel, which will deliver further improvements, and future proofing for the EF new Build. These solutions are being developed at pace and as far as possible many of the solutions will be deployed and become operational in advance of the move.

30. Work will be progressed over the next few months to develop the plans for the delivery of Phase 2 of the EF Project. An extensive review of the Clinical Operational Policies (COP), signed off by the clinical teams in March 2016, and a comprehensive validation of the initial designs has been undertaken by the project and design teams. Clinical engagement sessions started in August 2016 to review the detailed designs. Formal sign off will be established by early November 2016. An assessment of the cost impact, detailed design and market testing will occur through the autumn 2016. It is anticipated that this phase of the EF scheme will be delivered in December 2017.

Focus on: Women's Hospital Project

31. The Women's Hospital project aims to co-locate all Women's services onto the LRI site to create a single Women's Hospital (pending public consultation). Repeated delays in the public consultation programme have delayed the project programme by over a year; but the Project Team are utilising the time to review and refine the models of care for women's services, to ensure they reflect a whole health economy model, and lean working. Clinicians and managers from the CMG have remained positive despite the delays; and have been very engaged in this process.
32. During 2016/17, project management support will be provided to ensure that by the end of the year, we have fully worked up models of care, an activity model supported by commissioners, and operational policies. This will stand us in good stead for design to commence in 2017/18, depending on the outcome of public consultation. The workforce plan will also be commenced.
33. A workshop was held at the end of June in partnership with primary care colleagues to review joint working and explore improvements to gynaecology pathways which cross the primary and secondary care sectors. The workshop was successful and identified a number of opportunities to improve our services; some of which can be implemented in advance of the Women's Hospital reconfiguration. A similar workshop is now being planned for maternity and neonates in September.
34. Workshops will also be carried out before the end of 2016 to review the internal models of care and pathways which do not impact on external stakeholders, including gynaecology, maternity, neonates and clinical genetics. We are confident that this work will also identify improvements which can be made in advance of the reconfiguration; as well as informing the pathways and design of the new Women's Hospital.
35. Once the team are confident that robust, lean, benchmarked models of care are agreed across the whole health economy, a peer review for external clinical challenge of the clinical models is planned for early 2017.
36. At the end of July, representatives from the Project Board visited Queen's Hospital in Romford (part of Barking, Havering and Redbridge (BHR) NHS Trust) to learn from their recent experiences of closing a maternity centre and merging two maternity units together. The team at BHR were exceptionally helpful; honestly sharing information about their experience and giving UHL the opportunity to learn from their successes and pitfalls. The team were also shown around the facilities at Queen's; and BHR have expressed a willingness to be involved in UHL's Women's Hospital reconfiguration peer review team.
37. The Reconfiguration Programme Director is currently assessing the impact that PF2 will have on the scope and project documentation required before Outline Business Case stage.

Input sought

38. The Trust Board is requested to:

    1. Note the progress within the reconfiguration programme
    2. Comment on the content of the report
    3. Advise on whether the format of the paper can be improved

Workstream progress report - September 2016

	Workstream	Executive Lead	Operational Lead	Objectives	On track against delivery (RAG)*	Complete (%) against in year plan**	Brief update on status
1	Clinical Services Strategy (Models of Care)	Andrew Furlong	Gino DiStefano	To ensure all specialties have models of care for the future which are efficient, modern and achieve the 2 acute site reconfiguration with optimal patient care	N/A	N/A	Work continues on a strategy/reconfiguration/transformation restructure, that will align priorities and resourcing.
2a	Future Operating Model - Beds (internal)	Richard Mitchell	Simon Barton	To deliver bed reductions through internal efficiencies and achieve a 212 total reduction by 18/19 with a footprint capacity requirement by specialty	Amber	33%	Work continues to support CMGs to deliver 16/17 LoS improvement actions and ongoing monitoring of progress against key delivery metrics; Ward Programme Board to align to 4 work streams; UHL Way, ICS, Reducing Readmissions and SAFER; Agreed audit and action plan for SAFER Flow Bundle to identify current ward level practice for admission and discharge; baseline position audit of Trust adherence to SAFER flow bundle completed at the end of August.
2b	Future Operating Model- Beds (out of hospital)	Richard Mitchell	Sarah Taylor	To increase community provision to enable out of hospital care and reduce acute activity by 250 beds worth	Amber	17%	Sarah Taylor is the new UHL lead for ICS (post Phil Walmsley's departure). Plan to re-launch the ICS workstream on the back of excellent work on W16 at the GH. Team is keen to roll out plan for the GH and to explore options to make it easier to refer patients.
2c	Future Operating Model - Theatres	Richard Mitchell	Simon Barton	To deliver in year CIP and to articulate the future footprint for theatres in a 2 acute site model including efficiency gains and left shift	Amber	33%	Completion of the activity sign off process for 7 of 13 theatre programme specialties; focus next month on delivering a General Surgery recovery plan to reverse current under-delivery trend; creation of a signed off timeline for the delivery of all day operating lists at LGH; identification of suitable space and procedures that can be moved for remaining 6/9 specialties that have been identified as having suitable activity to shift from GA to LA.
2d	Future Operating Model- Outpatients	Richard Mitchell	Will Monaghan	To deliver in year CIP and to articulate the future capacity requirements for outpatients in a 2 acute site model including efficiency gains and left shift	Green	33%	Established draft SOPs governing the administration of outpatient clinics to ensure sustainability of improved quality of scorecard data and effective administration of clinics; Next month focus on finalising clinic template standardisation in RRCV, ESM; and standard operating procedures for clinic administration, which will be shared with CMGs alongside handover packs to support transition to UHL Improvement Managers before 30 September
2e	Future Operating Model- Diagnostics	TBC	Suzanne Khalid	To articulate the future capacity requirements for diagnostics in a 2 acute site model including efficiency gains and left shift	Green	33%	New patient pathway - Ultrasound Thyroid - direct to test identified as having the potential to achieve a 20% efficiency saving in 2WW ENT slots. Sign off obtained from all areas. GP communication and engagement to now commence and launch date to be agreed; agreement for Paediatric Ultrasound opportunity to be explored next. Ongoing external engagement on clinical variation and exploring new ways of working and opportunities.
2f	Future Operating model- Workforce	Louise Tibbert/Paul Traynor	Richard Ansell; Louise Gallagher	To design the workforce model for a reconfigured organisation bringing in new roles and modern ways of working, achieving an overall headcount reduction	Amber	33%	In line with the STP September submission date, high level WTE assumptions have been linked to the different "solutions", further refinement is ongoing. The Alliance workforce plan has been delivered to the Alliance leadership board, it was well received and the discussion focussed on the future workforce and the critical alignment to the forecast workforce for the STP. Requirement to articulate future supply needs with East Midlands Universities and align STP and reconfiguration plans will be discussed with professional groups and incorporate HEE during August and September. EF workforce plan to be presented to September Project Board.
4	Reconfiguration business cases	Paul Traynor	Nicky Topham	To deliver a £320m capital programme through a series of strategic business cases to reconfigure the estate	Amber Amber Amber Amber Amber Green Green	33%	**Emergency Floor** - phase 1 construction continues; workforce plans by area are being finalised; focus on organisational readiness; development of LRI site Access and Transportation Strategy. **Vascular -** Construction continues. Team piloting direct admissions in current location in advance of move. Further discussion with Exec Team and Vascular surgeons to consider options to move Vascular service to GH in advance of ICU moves taking place in September. **Interim ICU** - Awaiting ITFF / internal capital availability. Plan updated to reflect need to create additional capacity (feasibility study underway), plan for service moves now March 18 at earliest. Team have undertaken clinical risk review to ensure safe to manage service for this period. **Interim EMCHC -** construction continues to programme. **Children's Hospital** - Delays to appointment of design team due to capital availability (tender complete).Exploring possibility of alternative funding sources to commence design pre receipt of external capital. Written agreement from NHSE on growth, verbal agreement with CCGs (awaiting written confirmation). **Women's** - Model of care work continues; Gynaecology model of care workshop with primary care colleagues held; Maternity & Neonates workshop being planned. Delays due to consultation and capital funding; considering PF2 as a procurement route for this project. **PACH** - Activity modelling and model of care continues. Increased clinical engagement in core specialities and with CSI, revised working relationship with the Alliance. Review of scope as to whether ENT should be included. Delays continue due to capital and consultation. **Long-term ICU** - Vision is to establish sustainable and fit for purpose ICU services at GH and LRI. PID agreed. Models of care discussions with clinicians are ongoing. **Theatres**- Vision is to establish sustainable and fit for purpose theatre facilities in line with reconfigured services at GH and LRI. PID agreed.
5	Estates	Darryn Kerr	Mike Webster	To deliver a £320m capital programme through a programme of work around infrastructure, capital projects, property and maintenance	Green	33%	Confirmation received at ESB that Phase 2 of the Estates Strategy can commence, based on the preferred 2 site model. Strategy will be based on 1497 beds (as per the STP); due for completion November 16. Infrastructure review of GH and LRI now due to complete September 16.
6	IM&T	John Clarke	Elizabeth Simons	To enact the IM&T strategy and have a modern and fit for purpose infrastructure which supports the 2 acute site model and community provision strategy	Amber	33%	EPR - FBC Recommendation submitted to National Team. EF - project briefs approved for each area of Plan B IT solution. Briefs to be extended to PIDs next month and infrastructure requirements of project to be confirmed. Awaiting receipt of capital funding to progress.
7	Finance/Contracting	Paul Traynor	Paul Gowdridge	To achieve financial sustainability by 18/19 and support reconfiguration of services through effective contracting	N/A	N/A	Financial modelling of LGH variant option and 5-year capital draw-down undertaken to support STP process. Capital confirmation now expected October 16, plans need to be updated to reflect this (previous assumptions were July/September availability).
8	LGH Rationalisation	Darryn Kerr	Jane Edyvean	To review and rationalise services at LGH to deliver UHL clinical and estate strategies and wider 3 to 2 Trust vision.	N/A	N/A	Workstream paused as D&C work needs to conclude before further input. Key output of future location for all services identified. Discussion ongoing as to whether workstream will be required in longer-term or absorbed in other workstreams e.g. Estates.
9	Communication & Engagement	Mark Wightman	Rhiannon Pepper	Ensure staff, stakeholders, and public are aware of UHL reconfiguration and are able to contribute and feed into discussions.	Green	33%	Ongoing OD and comms work to support EF project, support to Children's project on patient and public engagement. Comms programme to be re-launched once capital funding and future configurations (estates phase 2 refresh) are clearer.
10	Better Care Together	Richard Mitchell	Gino DiStefano	Realising the UHL elements of BCT within the organisation through new ways of working/pathways and activity reductions	Amber	33%	Work continues to align the BCT programme with the Sustainability and Transformation Plan (STP), ensuring robust governance processes are in place.

Note: The RAG and % complete is based on workstream lead evaluation and detail provided in highlight reports.

UHL Reconfiguration Programme Board - Trust Board September 2016

Risk log

Top 10 risks across all workstreams

Risk ID	Workstream	Risk description	Likelihood (1-5)	Impact (1-5)	RAG - current month	RAG - previous month	Raised by	Risk mitigation	RAG post mitigation	By when?	Risk Owner	Last updated	Alignment to BAF
1	Internal beds / Estates	There is a risk that the planned level of bed reduction required to deliver the STP and reconfiguration plan are not achievable. STP submission reaffirms BCT SOC position of future configuration of 1497 beds (circa 500 bed fewer than current). As the level of detail in the plan is variable, there is a risk that some bed closures may be significantly more challenging that others.	3	5	15	25	PT	Following submission of STP focus now needs to be on delivery of strategy. Vehicles for delivery are UHL's MOC strategy, BCT workstreams and the Vanguard MOC. More focus needed on reducing patients admitted four times or more, readmissions and frail elderly.	12	Oct-16	Paul Traynor	16-Aug-16	PR14
2	Children's project	There is a risk that NHS England specialised commissioners will not continue to commission EMCH services from UHL leading to loss of service.	4	4	16	15	DY	Continue to plan project on basis service retained. Design solutions to reflect uncertainty e.g. space that can be easily re-utilised. Ongoing discussions with NHS England and other stakeholders.	12	Jan-17	Mark Wightman	16-Aug-16	
3	Overall programme	There is a risk that capital funding not guaranteed for the estimated £320m, and will affect 3 to 2 site strategy if not secured. National capital availability at risk and not known for 16/17 or subsequent years.	4	5	20	20	PT	Limited (internal only) capital available until October 2016 at earliest. Capital plan D has been developed to re-phase development of OBC and FBCs in 16/17. Options for alternative sources of funding are being reviewed with external partners e.g. PF2. STP assumes PACH and Women's will be funded via PF2 and therefore reduced capital request from DH. Ongoing discussions with NHS England and NHSI to ensure Leicester as priority.	16	Oct-16	Paul Traynor	16-Aug-16	PR13
4	Level three ICU	Now the shift of activity from GH to home/community has not released the expected bed quantity; there is a risk that capital will not be available to provide the additional wards required at GH to house HPB, as allowance was not made in the original reconfiguration programme.	5	5	25	20	CG	This is now an issue as beds not available, however due to lack of capital funding moves would have been delayed anyway. Vascular and ICU moves will only go ahead when assurance has been given as to Glenfield capacity in terms of beds and clinical support infrastructure. Feasibility study into additional ward space has been completed and progressed to options appraisal stage. Capital Plan D includes funding for additional ward capacity at GH and ICU moves have been sequences around this.	12	Oct-16	Richard Mitchell	16-Aug-16	
5	Overall programme	There is a risk that not enough capacity in the system to create headroom to fully implement reconfiguration plans and cope with winter pressures and increased demand. STP bed numbers show reductions in yr 1 and 2 which may be reflected in contracting negotiations which may put additional pressure on beds and income.	4	5	20	16	PT	Ongoing Demand and Capacity work to plan for 16/17 underway includes options to reduce demand, create capacity (repatriation and / or build) and move services between sites. Feasibility study on additional ward space at Glenfield completed and moving to option appraisal (accounted for in Capital plan D).	12	Sep-16	Richard Mitchell	28-Jul-16	
6	Overall programme	Consultation timelines significantly impact on business case timelines, and ability to achieve 20/21 target for moving off the General site. Particular impact on PACH and women's projects.	4	4	16	16	RP	This is now an issue as beds not available, however due to lack of capital funding projects would have been delayed anyway .Impact of consultation incorporated into refreshed business case timeline. Business cases continue to progress as per plan. Consultation now delayed until Autumn 16 at the earliest and engagement continues with the NHS England Assurance Panel / STP process.	12	Sep-16	Mark Wightman	28-Jul-16	
7	Overall programme	There is a risk that ongoing transitional funding required to deliver programme in 16/17 and beyond will is not available to secure ongoing delivery resource. In year resource requirements identified and on track but future years at risk in connection with limited capital.	4	4	16	16	PG	Minimum Reconfiguration resource requirements identified through Capital Plan D. Including identification of impact of reduced resource on programme timeframe. Spend against this continues at risk in advance of capital confirmation to maintain programme. Recruitment to substantive posts where possible is underway.	12	Oct-16	Paul Traynor	28-Jul-16	
8	Capital reconfiguration business case: Emergency Floor	There is a risk that the transition plan and the inability to release the entire space for phase 2 construction will generate a movement away from construction phasing as agreed in FBC and add costs and delays to completion.	4	4	16	16	JE	Options for phasing and time and costs to be developed and agreed. Option appraisal to be developed across Reconfiguration and Operations as to how to facilitate phase 2 construction in a single phase to mitigate additional time and cost to project.	12	Oct-16	Paul Traynor	16-Aug-16	
9	Capital reconfiguration business case: Emergency Floor	There is a risk that the scale of cultural changes required to deliver new models of care and workforce requirements will not be delivered in time for the commissioning of Phase 1 resulting in historical ways of working being transferred to new ED.	4	4	16	16	JE	Development and implementation of OD plan. OD recruitment in progress, support now in place to EF project (current top priority). Closer working between UHL way and reconfiguration in place and to continue to develop. OD requirements to be reviewed when revised demand and capacity plans and structures are in place.	12	Sep-16	Louise Tibbert	29-Jun-16	
10	Out of hospital beds	There is a risk that UHL are not fully utilising available capacity through the opening of ICS beds and / or getting value from the service investment.	4	4	16	16	PT	Evaluation of impact of ICS beds undertaken recognises the need to optimise utilisation to deliver benefits and ensure service is financially sustainable. Action plan required. Sarah Taylor identified as new UHL lead following departure of Phil Walmsley. Plan to optimise service and overcome existing blocks needs developing. Further review of service to be planned in 6 months (November 16).	12	Aug-16	Richard Mitchell	16-Aug-16	