UHL Reconfiguration – update

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Trust Board paper J

Executive Summary

Context

A key part of the Trust Board's role is to inform strategic direction and provide appropriate challenge to plans being put forward. This ensures there is sufficient assurance associated with activities undertaken to achieve the desired future state. The UHL Reconfiguration Programme is an ambitious and complex undertaking and, where the programme is moving more into delivery, it is important that the Trust Board has visibility of the progress and challenges.

This paper provides the monthly update on Reconfiguration to the Trust Board, employing the Level 1 dashboard to show an overview of the programme status and key risks, with accompanying focus on one workstream each month. This month, the focus is the Out of Hospital Beds project, which is in delivery phase with 130 additional Intensive Community Support (ICS) Service beds open. The update has been timed to provide the Board with the outcomes of a recent evaluation of the services to date, and update the board on the planning assumptions for ICS in the updated BCT plan.

The Reconfiguration is currently working through a number of key issues that will enable the development of a re-phased programme underpinned by a revised programme plan. Examples of the key issues include; programme resourcing, programme structure, the impact of revised demand and capacity planning and the anticipated availability of capital funding. The updated plan will provide the Board with a realistic plan and a forward view as to activities being undertaken and delivery timescales for milestones. It is anticipated that the updated plan will be available in August 16 (due to key dependencies) and in lieu of this information this paper provides a summary of the key decision required by the programme between June 16 and September 16.

The purpose of the update is to ensure that the Trust Board is sighted on key issues that may impact on delivery of key milestones of the programme.

Questions

1. Does the report, with dashboard and risk log, provide the Board with sufficient (and appropriate) assurance of the UHL Reconfiguration Programme and its delivery timeline?
2. Is there any specific feedback/suggestions in relation to the Emergency Floor project?

Conclusion

1. The report provides a summary overview of the programme governance, an update from a key workstream, and the top four risks (>20) from across the programme that the Board should be sighted on.

2. The report provides a summary of key activities and issues which the programme and/or workstreams are currently working through. This month there are a number of key factors the programme team are working to revise to enable an updated programme plan to be developed by August 16.
3. This summary follows submission of highlight reports from all UHL reconfiguration workstreams in May 2016.
3. The workstream update looks at the Out of Hospitals beds project; where it is up-to in delivery, findings from a recent service evaluation and revised planning assumptions.

Input Sought

We would welcome the Board's input regarding the content of the report, and any further assurance they would like to see in future reports.

For Reference

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

Safe, high quality, patient centred healthcare	[Yes ~~/No /Not applicable~~]
Effective, integrated emergency care	[Yes ~~/No /Not applicable~~]
Consistently meeting national access standards	[Yes /~~No /Not applicable~~]
Integrated care in partnership with others	[Yes ~~/No /Not applicable~~]
Enhanced delivery in research, innovation & ed'	[Yes ~~/No /Not applicable~~]
A caring, professional, engaged workforce	[Yes
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	Not applicable]

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

Organisational Risk Register	/Not applicable]
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]

Scheduled date for the **next paper** on this topic: Trust Board 7.7.16

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

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

Update to the Trust Board June 2016

UHL Reconfiguration Programme

1. This update paper provides a brief summary and overview of the current programme status, and is a reflection of the regular monthly updates provided to the Reconfiguration Programme Board. The executive level dashboard (appendix one) and programme risk log (appendix two) are provided; these reflect the integrated governance structure of the programme. It should be noted that the Reconfiguration Programme Board last met on 25 May 2016. Any issues identified at this meeting, not covered in this update paper, will be provided verbally by the Reconfiguration SRO at the Trust Board meeting.

2. The programme is currently working to the re-phased capital plan (agreed as best case scenario January 2016 ESB); which added 12 months to the final delivery date for completion of the programme. However it is recognised that further re-phasing will be required once there is more clarity regarding; capital availability for 2016/17, revised updated Better Care Together (BCT) planning assumptions are agreed, and timeframes for the consultation are known. An updated capital plan has been developed in May 2016 (plan C) however a definitive capital position may not be known until the end of Quarter 1. Plan C is based on the minimum requirement to keep the reconfiguration programme moving and to start to address the capacity issues identified.

Governance update

4. The dashboard at a glance shows no red areas this month, however it does highlight two workstreams where activities against their current work-plan has been paused. These include Models of Care, where a revised scope and milestone plan will be agreed at June ESB, and LGH Rationalisation where the BCT wide Demand and Capacity work needs to conclude before this workstream continues (and it may not be required in the same guise).

5. It also shows a number of amber areas. These are flagged as such due to some key risks affecting delivery; however, they are being effectively managed and therefore, at this time, are not deemed to be showstoppers. The RAG is based on progress against delivery, and the % complete gives an indication of overall progress against in year plan, based on the workstream view of progress against individual project milestones.

6. In addition to the standard workstream updates included in the dashboard, individual business cases are now being included, instead of an over-arching update for Reconfiguration Business Cases. This recognises the different stages the six live business cases are at and will provide greater visibility of any issues or risks.

7. The programme risk log has been updated to ensure the risks are recorded in the right place and attributed to the right people, and accurately reflect the impact on delivery of the programme. To make the register ‘live’, a ‘by when’ column has been added to ensure risks are regularly reviewed and mitigations enacted. The programme risks and process for reporting are currently being reviewed by the Reconfiguration Board. The top programme risks are aligned with, and reflected in, the Trust’s Board Assurance Framework (BAF).

Programme risks

8. The top four UHL reconfiguration programme risks (>20) to delivery this month remain as:

Risk: BCT SOC assumed 571 bed closures, 109 of which were predicated on demand management. There is a risk that some bed closures may not be achievable as there are no clear plans for 109 beds worth of demand management where the BCT SOC assumed this would occur, which has significant impact on delivery of overall plan.

Mitigation: 'Demand management will need to be reconsidered. 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 and on readmissions as well. This is being reviewed pan-LLR through the BCT programme.

Action: To review internal impact and actions following conclusion of BCT programme demand and capacity review / NHS England assurance panel response.

Risk: Capital funding not guaranteed for the estimated £330m, and will affect 3 to 2 site strategy if not secured. Notification received from Department of Health that national capital availability is limited and impact on UHL not yet known.

Mitigation: Limited capital available until end of March 2016. Unclear on implications for 2016/17 as yet; re-phasing plan is ongoing. Capital plan C has been developed to re-phase development of OBC and FBCs. Options for alternative options of funding are being reviewed.

Action required: For noting

Risk: Consultation timelines significantly impact on business case timelines, and ability to achieve 19/20 target for moving off the General site. Particular impact on planned ambulatory care hub and women's projects moving forward.

Mitigation: Updated assumptions across BCT plan to be agreed in May 2016 for ICS and then plans to address identified capacity gap will be developed. Feasibility study into additional ward space has been completed and progressed to options appraisal stage. 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.

Action required: For noting

Risk: 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.

Mitigation: Services that must be maintained to be identified. Decant plan established. Options for phasing and time and costs for phasing to be developed and agreed as part of GMP process.

Action required: For noting

9. The risk log is reviewed and updated each month.

Programme update

10. In follow-up to Gateway review and a number of other areas impacting on the Reconfiguration Programme, the programme is currently undertaking an internal review / stock-take of many key aspects. Following updates in each of the areas described below the programme will be in a position to update on the phasing of the programme and develop an overarching programme plan.

11. The key programme aspects being reviewed include:

- **Programme resource**: recognising that the Trust is currently spending significant volumes on improvement across the organisation the programme is testing to ensure that the right resource are in the right place to ensure effective delivery of organisational priorities. This review is being led by Paul Traynor, Mark Wightman and Richard Mitchell, and will report to June 2016 ESB.
- **Workstream and programme structure**: many of the workstreams (apart from the major capital business cases) do not have clear objectives or deliverables. The review described above will also propose a revised structure e.g. number of workstreams, membership and governance structure.
- **Programme planning assumptions**: The BCT programme are currently refreshing the demand and capacity assumptions (focussing on inpatient beds) from the original Strategic Outline Cases (SOC). This work will review and update the delivery potential of all proposed initiatives (demand management, internal efficiencies and left shift). The updated assumptions need to be agreed by BCT programme and submitted to NHS England as part of Assurance Panel requirements.
- **Programme end-state (e.g. number of beds, theatres required):** changes to the planning assumptions will change the end-state in terms of how and where services are configured. The programme continues to plan for a 2-site configuration however the size and therefore cost of this will be different to the original plan. It is likely to require more beds, theatres and supporting infrastructure at both remaining hospitals. This work will be led by the estates team following conclusion of the demand and capacity work.
- **Sequencing of required moves**: once the end state is known, how it can be delivered wit least disruption may change from the original plan, e.g. need to build wards at Glenfield before moving ICU and associated services from LGH. A workshop is planned for mid-June to develop optimal sequencing.
- **Availability of funding:** funding for 16/17 is still unknown but likely to be lower than originally planned. Beyond this planning assumptions are required to enable activities to be scheduled (on-going).
- **Funding routes:** the Trust is working with external partners e.g. Private Funding Unit and Deloittes) to explore alternate funding arrangements. Any divergence from the assumed central funding will impact on the overall cost of the programme but may accelerate delivery of some key aspects (on-going).

12. Clarity or preferred direction / updated assumptions for each of these areas are required to update the phasing of the programme and develop the underpinning

programme plan. A workshop for all workstream leads has been proposed for late June 16 to consolidate all this work and develop the plan. It is not expected that all the issues will have been resolved by this point, but it is important to put the right structure and discipline in to the programme to enable visibility, monitoring and ultimately benefits realisation. Following development of the programme plan, changes or additional clarity will be managed in line with change control processes and reported to ESB and Trust board as required.

13. It is anticipated that the plan will provide a long-term view of key milestones and key-decision-points and be available for sign-off at August 2016 ESB and in use as a monitoring tool from September 16. In advance of this plan being available there are a number of key decisions that will be required, these are summarised below:

Workstream / Project	**Decision**	**By-when**
Programme	Sign-off updated programme governance structure including any changes to workstreams / meetings.	June ESB
Emergency floor	Sign-off revised activity and workforce – change control from FBC	June ESB
Model of care	Sign-off of scope and deliverables for Model of Care (or associated) workstream(s).	June ESB
Programme	Sign-off updated BCT bed bridge and impact on UHL capacity planning / reconfiguration programme.	July ESB
Beds	Sign-off scope of Reconfiguration beds workstream	July ESB
Programme	Agree capital assumptions for yrs2-5 to enable plan to be developed	July ESB
Programme	Sign-off updated capital plan / estates strategy for revised programme	July ESB
ICU/ Beds	Decision on preferred option for Glenfield capacity creation	July ESB (subject to capital)
Theatres	Sign-off of PID	July ESB
Vascular	Decision to proceed with moves without ICU move (and required revenue implications).	July ESB
Emergency floor	Approve IM&T (EPR) plan b recommendation	July ESB (subject to capital)
Emergency floor	Approve OD, comms and engagement plan	August ESB
Estates	Outcome and implications of Infartructure review and business case	August ESB
Programme	Proposal for interim use of LGH / options appraisal	September ESB
Clinical support services	Sign-off scope of Reconfiguration clinical support services requirements e.g. diagnostics / therapies projects.	September ESB
Corporate services	Sign-off scope of Reconfiguration corporate working requirements	September ESB

Workstream update: Out of Hospital Beds (Intensive Community Support (ICS) Service) project:

14. Each month a reconfiguration workstream is selected for inclusion with more detail provided on the current status, progress and any issues. Those selected are based primarily on where there has been a lot of activity in the previous month or where an issue, or risk, might exist which could impact delivery. There will be the opportunity for all workstreams to be considered.

15. This month, the focus is on providing an update to the Trust Board on the Out of Hospitals bed project:

Scope

16. In June 2014 the Local Health and Social Care Economy (LHSCE) developed a 5 year strategic plan setting out its ambition to transform local services in line with the models of care set out by the BCT programme.

17. A Multi-Agency Business Case was agreed in October 2015 that justified the expansion and enhancement of LPT's existing ICS service from 126 to 256 beds in 2015/16, thereby allowing UHL to remove 130 acute beds as per the LLR capacity planning agreement. The intention at this time was to develop a separate business justification to cover any further expansions of ICS by another 120 beds and the transfer of 80 sub-acute beds from UHL to the community hospitals in 2016/17.

Original Drivers and Planning Assumptions

18. The following drivers and assumptions were outlined in the Business Justification Template agreed in October 2015.
    - The case for change for this project is about clinical sustainability and doing the right thing by the population of LLR, patients and service users. Based on recent publications such as the Sturgess report, the current model of care was viewed as overly reliant on inpatient care, leading to avoidable harm, particularly for older people.
    - The ICS service provides an intensive rehabilitation service to promote independence and recovery for frail older people in the environment that they are most familiar with (i.e. their own home). The multidisciplinary service is advance nurse practitioner led, with medical input from the patient's GP as required. The service aims to prevent or reduce the need for permanent or long term care packages, by promoting, supporting and encouraging self-management.
    - The likely opportunity and quantum of patients suitable for the service was based on a series of ward audits. These audits covered 160 patients across 6 UHL wards. The ward audits identified that 43 out of 160 patients could be cared for by the LPT Intensive Community Support Service (ICS), These findings were scaled up to establish which specialties the 130 beds would come from.
    - The additional 130 ICS beds will run at 90-95% occupancy, which means 44,100 bed days will be available in the community.

- A step decrease in acute LOS will be achieved across patient groups through ICS implementation.
- The benefits profile was outlined as follows;
    - Number of ICS home beds; 130 additional beds
    - % occupancy of ICS home beds; 90-95%
    - Average length of stay in ICS; 10 days
    - UHL readmissions from ICS; No baseline set
    - Average length of stay in target UHL specialties; baseline established from Sept 15 data.

Progress to date

19. The opening of the additional beds commenced in October 2015. The opening of beds was phased between October and March 2016 with the full complement of 130 beds by the end of March 2016.
    - To date, circa 900 patients have been referred into ICS from October to May 2016.
    - Occupancy has been tracked alongside the phased opening of the 130 beds, this averages weekly between 79%-85% weekly.
    - Weekly referrals into step down ICS from UHL is approximately 44 patients, based on a rolling four week average.
    - Rotational workforce posts have been implemented to support the interface and embedding of the service.
    - A cross organisational delivery group oversees the operational implementation of the model of care and future optimisation of the service.
    - Briefings on progress to wider workforce and stakeholders.

Evaluation Methodology & Findings

20. A single performance dashboard was agreed as part of the outline business case with monthly reporting on the key performance metrics.

    Table 1. April 2016 ICS dashboard performance extract;

KPI	Target	April 2016
Number of ICS home beds	130 additional beds (total ICS beds 256)	130 additional beds.
% occupancy of ICS home beds; 90-95%	90-95%	84.4%
Average length of stay in ICS; 10 days	10 days	8 days

    NB – there are significant data quality issues with accurate recording of LOS, and the significance of the reported occupancy figure for the ICS service. Actions are in place to address as part of the operational delivery plan.

21. In addition to the monthly dashboard, the Better Care Together Board commissioned an analysis of impact of ICS using a PI tool. The PI data tool enables access to critical data that resides in multiple systems including data from EMAS, UHL, LPT, Adult Social Care and NHS 111 and therefore the ability to undertake whole system impact analysis of ICS.

- A matched cohort analysis was undertaken using PI to evaluate and compare the impact of patients who transferred into ICS from UHL, with a comparison group of patients who did not transfer into ICS. Whilst statistical significance is limited firstly by the small cohort size, and secondly by data quality issues in recording data correctly by staff, the first results indicated a 0.8 LOS saving for patients who transferred into ICS, with a total of 100 bed days cumulatively for those patients that transferred into ICS.

Current Better Care Together Planning Assumptions

22. The opening of the 130 beds was achieved to plan in March 2016. The ability to evaluate impact at an early stage is limited both by the quality of data but also the statistical significance based on small cohort analysis.

23. Future capacity planning assumptions include the optimisation of the current 130 steps down beds, and to achieve the target LOS and occupancy for the service. It is recognised that provision of this type of service is the right thing to do for patients, both in terms of quality and safety. Optimisation of the service is therefore a priority through 16/17.

    - The future capacity model assumes a starting position of 34 beds activity transfer based on the PI analysis and a 0.8 LOS saving.
    - Additional bed day savings have been based on wider intelligence that additional cohorts of patients that can flow into the service with better identification and improved operational processes.
    - The predicted capacity over the next two years identified by UHL is a total of 65 beds.

Key Risks and Issues

24. There are a number of challenges that face the ICS model of care and achieving the benefits outlined in the original assumptions.
    - Whilst 130 step down beds are open, and daily available capacity is reported to UHL, the ability for a patient to physically transfer and occupy that home bed is dependent on LPT and Social Care partners being able to provide that package of care. At a service level, this is balanced against the packages of care the ICS service is currently delivering. The impact of this is that UHL will not be able to close beds on an equivalency basis until the reported bed capacity for ICS step down (130 beds) is consistently available.
    - Social care input to the ICS model is inconsistent across County and City Local Authorities. The City ICS teams consistently achieves 50% more throughput than their counterparts as social care is far more integrated into the service model in that locality. This is being progressed for resolution with social care partners.
    - Data Quality is impacting on the ability to accurately measure the impact of ICS and a baseline methodology for future capacity planning.
    - Operational processes are immature, and the flow of patients can be significantly enhanced by further refinement and development of systemic processes that enable the routine flow of patients into ICS.
    - The new model of care requires whole system leadership behaviours that are modelled across the programme and should be supported by on-going organisational development.

Next Steps; Optimisation of ICS

25. The ICS model is at an early stage of system development. The key focus and priority is to optimise the service with actions across UHL and LPT and includes the following actions;
    - The implementation of better tracking and tracing of likely patients suitable for ICS in UHL.
    - Improved Board Round guidance that identifies key actions required and supports decision making and clinical criteria for discharge into the service.
    - Clarifying the referral process, and inclusions/exclusions for the service.
    - Further engagement of medical staff and CMGs in UHL as key enablers to identify and extend the likely cohorts of patients suitable for ICS.
    - Improve the data recording of activity, enabling the evaluation of impact of ICS to become more robust.
    - A consistent approach to social care delivery as integral to the service and partnership model.

Recommendation

26. We would welcome the Trust Board's input regarding the content of the report, and any further assurance they would like to see in future reports.

UHL Reconfiguration Programme Board - April 2016

Risk log

Top 10 risks across all workstreams

Risk ID	Workstream	Risk description	Likelihood (1-5)	Impact (1-5)	Risk severity (RAG)- current month	Risk severity (RAG)- previous month	Raised by	Risk mitigation	RAG post mitigation	By when?	Risk Owner	Last updated	Alignment to BAF
1	Internal beds	BCT SOC assumed 571 bed closures, 109 of which were predicated on demand management. There is a risk that some bed closures may not be achievable as there are no clear plans for 109 beds worth of demand management where the BCT SOC assumed this would occur, which has significant impact on delivery of overall plan.	5	5	25	20	PT	Demand management will need to be reconsidered. 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 and on readmissions as well. This is being reviewed pan-LLR through the BCT programme. **ACTION**: To review internal actions following conclusion of BCT programme demand and capacity review / NHS England assurance panel response.	16	Jun-16	Paul Traynor	24-May-16	
2	Overall programme	Capital funding not guaranteed for the estimated £330m, and will affect 3 to 2 site strategy if not secured. National capital availability at risk and impact known for 15/16 but not yet for future years.	4	5	20	20	PT	Limited capital available until end of June 2016. Unclear on implications for 2016/17 as yet; re-phasing plan is ongoing. Capital plan C has been developed to re-phase development of OBC and FBCs . Options for alternative options of funding are being reviewed.	20	N/A	Paul Traynor	24-May-16	
3	Level three ICU	Risk of non- delivery of out of hospital beds capacity could jeopardise ability to provide additional bed base at Glenfield, which is required to relocate HPB.	4	5	20	20	CG	Updated assumptions across BCT plan to be agreed in May 16 for ICS and then plans to address identified capacity gap will be developed. Feasibility study into additional ward space has been completed and progressed to options appraisal stage. Vascular and ICU moves will only go ahead when assurance has been given as to Glenfield capacity in terms of beds and clinical support infastructure.	16	Jun-16	Richard Mitchell	24-May-16	
4	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	20	20	JE	Services that must be maintained to be identified. Decant plan established. Options for phasing and time and costs to be developed and agreed as part of GMP process.	16	Dec-16	Paul Traynor	24-May-16	
5	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	20	16	JE	Development and implementation of OD plan. Options for OD support to be reviewed as subbstantive appointment no longer starting. Review of OD diagnostics to identify mitigations.	12	Jul-16	Louise Tibbert	24-May-16	
6	Overall programme	Consultation timelines significantly impact on business case timelines, and ability to achieve 19/20 target for moving off the General site. Particular impact on PACH and women's projects.	4	4	16	16	RP	Impact of consultation incorporated into refreshed business case timeline. Business cases continue to progress as per plan. Consultation now delayed until after the June EU referendum and work continues with the NHS England Assurance Panel to facilitate this process; change control process enacted for capital projects affected.	16	Jun-16	Mark Wightman	24-May-16	
7	Overall programme	Ongoing transitional funding required to deliver programme beyond 15/16 will need to be secured to ensure ongoing delivery. 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 C. Including identification of impact of reduced resource on programme timeframe. Resource requirements will be reprofiled once rephasing of capital plan finalised.	15	Jul-16	Paul Gowdridge	24-May-16	
8	Capital reconfiguration business case: Emergency floor	EPR will not be available ahead of ED build. The design of the EF was based on a paperless system, as an early adopter of the Trust-wide EPR scheme. There is no space allocated in the Floor for storage of paper notes, and all work stations, reception desks, offices have been designed for IT work only.	4	4	16	16	JC	Way forward agreed at Project Board on 15.01.16 to develop Plan Band project management support in place. Options for Plan B are being developed - tfor approval at May project board. estimated implementation 9 months. Intelligence gathering from other ED departments has ben undertaken to support interim solution development.	12	Jun-16	John Clarke	27-Apr-16	
9	Out of hospital beds	UHL not fully utilising available capacity through the opening of ICS beds (now 32).	4	4	16	16	PT	Evaluation of impact of ICS beds underway and will report in May 16. Joint work between LPT and UHL using PI tool and other sources. Will review utilisation, LoS impact and patient outcomes. Plan to optimise service and overcome existing blocks needs developing. Further review of service to be planned in 6 months,	12	Jun-16	Richard Mitchell	27-Apr-16	
10	Overall programme	There is not enough capacity in the system to create headroom to fully implement reconfiguration plans and cope with winter pressures and increased demand.	4	4	16	16	PT	Clinical change team in place at GH reviewing patients suitable to be looked after in the community; additional ICS beds open. 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.	12	Aug-16	Paul Traynor	27-Apr-16	
11	Overall programme	Operational delivery/pressures may be negatively impacted by requirements of reconfiguration i.e., operational resource/input, space.	3	5	15	15	RM	Each FOM workstream has a dashboard where operational risks are identified. Operational representation on the programme board and business case meeting to ensure strategy and operations better align and issues addressed early. Lack of CMG / clinical input that will impact on programem delivery to be escalated.	9	Aug-16	Simon Barton	27-Apr-16	
12	Workforce reconfiguration	Culture of organisation needs to embrace reconfiguration and recognise need to do things differently. This has not been addressed previously and OD programme not yet in place.	3	4	12	12	PT	Director of HR and Workforce reconfiguration sits on programme board and is developing a proposal for Trust wide OD. Draft plans aligned to all business cases being developed, and will align with UHL way (launch 3/12). OD resource for business cases being secured.	9	Oct-16	Louise Tibbert	27-Apr-16	

Workstream progress report - May 2016

	Workstream	Executive Lead	Operational Lead	Objectives	On track against delivery (RAG)*	Complete (%) against in year plan**	Brief update on status
1	Clinical 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	Workstream paused as current process was not delivering Reconfiguration requirements. Use of gateway review, Kings Fund LLR event, and clinical engagement used to present update paper to ESB on future of workstream.Revised workstream objectives and milestone plan to May Reconfiguration Board for approval. Proposla includes closer working with BCT, optimisimg existing structures and calrity on speciality requirements.
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	17%	Supported CMGs (RRCV & ESM) to develop and implement detailed 16/17 LoS improvement action plans. Provided access to Qliksense to the agreed clinical and management team to agree decisions for reduction in variation by consultant/HRG level. Continued supported delivery of the cath lab programme to reduce ALOS through regular C&C sessions with the lead and a focus on enabling actions. Refreshed 'Ward level' performance reports to be discussed at the board meeting.
2b	Future Operating Model- Beds (out of hospital)	Richard Mitchell	Sue Tancock	To increase community provision to enable out of hospital care and reduce acute activity by 250 beds worth	Amber	17%	A matched cohort analysis was undertaken using PI to evaluate and compare the impact of patients who transferred into ICS from UHL, with a comparison group of patients who did not transfer into ICS. Whilst statistical significance is limited firstly by the small cohort size, and secondly by data quality issues in recording data correctly by staff, the first results indicated a 0.8 LOS saving for patients who transferred into ICS, with a total of 100 bed days cumulatively for those patients that transferred into ICS. Further information provided as the worrkstream focus in the Reconfiguration updtae.
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	17%	6/17 Theatre budget agreed and funded sessions set at 15/16 outturn plus CCG activity plan at premium funding. GA to LA work ongoing - 4 potential sessions per week in clean room at the Trust identified pending confirmation.Kick off meetings commenced to agree suitable GA work which can shift to LA and be carried out outside of theatres - so far 3/9 specialties have signed up to the shift. 13/15 CIP schemes on 16/17 PMTT have corresponding detailed action plans with the remaining 2 escalated to programme board chair for resolution.
2d	Future Operating Model- Outpatients	Richard Mitchell	Simon Barton	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	Amber	17%	ESM reviewed booking process and introduced overbooking in high DNA clinics. BSU, DNA & CTS opportunity for 16/17 programme to be validated and placed on PMTT by June 16. Report to track prospective utilisation being developed. Next momth - enhanced support to General surgery, paeds and respitratory.
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	17%	Top 5 GP pathways for development agreed, to achieve standardisation, right test first time, reduce delays and reduce unneccessary testing. Focus groups established to review imaging referral clinical variation, within Respiratory and Neurology. Imaging referral dashboard being trialled with ESM. Group remit will expand to look at long-term Reconfiguration requirements. PM resource identified to attend project boards and link with local leads.
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	17%	1. Better Care Together workforce assumptions in the Pre-Consultation Business Case updated and cross checked against financial assumptions made at the time of the SOC. Clarified the link between 3-to-2 and the link to changes in bed numbers, specifically around the growth in ICS beds, and the potential impact on WTE figures. The LLR position can adapted quickly to reflect any changes to the strategy linked to the bed bridge and other assumptions linked to reconfiguration. 2. Out of Hospital workforce group evaluation conducted and reported. Plans to go through LLR and LPT groups in May 2016. 3. The first Women's Hospital workforce profiling event took place and concentrated on the split between elective and emergency pathways and the future model of care. 4. Work has commenced on the year one of the UHL data which will form part of the Sustainable Transformational Plan for LLR 5. Workforce development plan from LETC being developed and will be reported to LETC Board in May.
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 Amber	17%	**Emergency Floor** - phase 1 construction continues , activity model refershed impact on workforceto go to June ESB. **Interim ICU -** Awaiting ITFF / internal capital availability. Further delays expected due to capacity pressures at Glenfield. **Vascular -** Construction continues, . Operational commissioning group reconvened - planning for February 17 move (subject to solution to move without ICU being agreed) **Children's -** Change control approved for age change to 19-years. Delays to appointment of design team due to capital avialability. **Women's** - Model of care, activity and operational policy work continues. Delays due to consultaion and capital funding. **PACH** - Activity modelling and model of care continues. 23hhour workshop postponed. New cclinical leadership and closer working with BCT planned care workstream in place.
5	Estates	Darryn Kerr	Mike Webster	To deliver a £320m capital programme through a programme of work around infrastructure, capital projects, property and maintenance	Amber	17%	Re-patriation of clinical space option appraisal development (at Glenfield and LRI) long list of options completed - process for evaluation to be agreed. This forms part of worst case scenario capacity planning process. DCP completion is reliant on outcomes of Trust D&C and reconfiguration conversations. Infrastructure and investment surveys in progress and due to report in July.
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	17%	EPR - KPMG have confirmed to the Trust and NTDA funding arrangements with IBM as a lease. EPR - HSCIC health check review rated as Amber Green. EF - Plan B options appraisal and costs presented to the ED Floor Board. Next month 'EPR - Meeting between UHL and Regional Director for NTDA to be arranged EF - Plan B option selected and funds sourced
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	Continuation of work to fully understand the implications of different capital scenarios and how any capital funding will be used post June.
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	17%	Ongoing work with BCT on consultation and workstreams within, update of Reconfiguration website and intranet page. Network of know-it-alls briefing further work on EF comms and engagement plan. Next month blueprint and key messages for ICU and PACH.
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	17%	Plans for 16/17 LTC, planned care and urgent care being agreed across partners. This includes re-visiting the assumptions and end-state bed numbers and associated costs and saving. This work is ongoing and will provide response to NHS England Assurance Panel as part of the pre-consultation business case. All workstreams required to submit trajectories as part of this work but further challenge may be required.

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