UHL Reconfiguration – update

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Executive Summary Trust Board paper I

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, rather than update on an individual project or workstream, the focus is on a number of required business cases that have or will be set up as projects in 2016/17.

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 September 2016 (due to key dependencies) and in lieu of this information this paper provides a summary of the key decisions required by the programme between August 16 and October 2016.

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?

Conclusion

- The report provides a summary overview of the programme governance, an update from a key workstream, and the top three risks (>20) from across the programme that the Board should be sighted on.
- 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 September 16.

- This summary follows submission of highlight reports from all UHL reconfiguration workstreams in July 2016 and the outcomes of discussions at Reconfiguration Board on 27th July 2016.
- The workstream update looks at new business case areas that have or will be established in 2016/17, including their purpose, progress and inter-dependencies with other business case areas.

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.

Is there any specific feedback/suggestions in relation to the new business case projects for the project / programme team?

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: Next Trust Board

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 July 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. The Reconfiguration Programme Board last met on 27 July so this paper covers any outcomes from that 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 has now been agreed that this plan will be updated based on Capital Plan D, with funding available from 1st September 2016, and signed-off at July IFPIC. However the programme has subsequently been informed that a decision re 2016/17 capital will be October 2016 at the earliest. Plan D is based on the minimum requirement to keep the reconfiguration programme moving and to start to address the capacity issues identified in 2016/17. The plan then assumes funding is available at the desired rate to complete the programme within 5 years (aligned to STP).

Governance update

3. The dashboard at a glance shows no red areas this month; however it does highlight two workstreams where activities against their current work-plan have been paused. These include Clinical Services Strategy (previously) Models of Care, where a revised scope and milestone plan will now be agreed at September ESB (due to links to on-going programme resourcing work), 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).

4. 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.

5. In addition to the workstream updates, individual business cases are now being included, instead of an over-arching update for Reconfiguration Business Cases. This recognises the different stages of the business cases are at and will provide greater visibility of any issues or risks. Over the next few months a number of further capital business case areas will be initiated and start monthly reporting, including; beds, theatres, diagnostics/clinical support services and long-term ICU. Further information on these is provided in the Trust Board focus section at the end of this report.

6. 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

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

Risk: 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, which is circa 400 beds fewer than current configuration. There is a risk that some bed closures may not be achievable as the level of detail in plans is variable.

Mitigation: 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. Estates options planning to include contingency options. ACTION: To review internal actions and processes for monitoring / holding to account

Action: To review internal actions and processes for monitoring / holding to account system plans.

Risk: There is a risk that NHS England specialised commissioners will not continue to commission EMCH services from UHL leading to loss of service.

Mitigation: Continue to plan project on basis service retained. Design solutions to reflect uncertainty e.g. space that can be easily re-utilised. On-going discussions with NHS England and other stakeholders.

Action required: For noting

Risk: There is a risk that 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 not known for 2016/17 or subsequent years.

Mitigation: Limited (internal only) capital available until end of September 2016 at earliest. Capital plan D has been developed to re-phase development of OBC and FBCs in 2016/17. Options for alternative options of funding are being reviewed with external partner e.g. PF2. On-going discussions with NHS England and NHSI to ensure Leicester as priority.

Action required: For noting (to be reviewed following capital confirmation)

Risk: There is a risk that non-delivery of out of hospital beds capacity could jeopardise ability to provide additional bed base at Glenfield, which is required to relocate HPB.

Mitigation: 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 capacity and ICU moves have been sequences around this. Options to move Vascular in advance of ICU services are being explored.

Action required: For noting (to be reviewed following capital confirmation)

Risk: There is a risk that there is 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.

Mitigation: On-going Demand and Capacity work to plan for 2016/17 underway includes options to reduce demand, create capacity 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).

Action required: For noting

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

Programme update

9. A revised structure has been developed and approved for the Business-case team within the Reconfiguration Programme. This has identified the need to standardise roles across the range of projects and hopefully recruit substantively to posts currently covered by interims. Interviews were held for the Head of PMO role in July but no appointment was made, this post and interim arrangements have been made to support this role. Five Project Manager roles are currently out to advert with interview date planned for late August. The delay in recruitment to these posts is due to a change in banding. A further update will be provided next month.

10. The Interim Programme Director finishes at the end of July and this post will be merged with the Major Projects Director post going forward. The HR process for appointment to this post is underway and Nicky Topham (current Major Projects Director) will act-up into the role following departure of the Programme Director whilst longer-term arrangements are finalised.

11. In follow-up to the Gateway review and a number of other areas impacting on the Reconfiguration Programme (e.g. the STP plan), the programme is still 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 shape and phasing of the programme and develop an overarching programme plan.

12. The key programme aspects being reviewed include:

- **Programme resource**: recognising that the Trust is currently spending significant volumes on strategic 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 and Mark Wightman. A preferred direction has been identified to promote and strengthen the strategic and reconfiguration function. This is now being worked through to understand its impact on structures and individual roles.
- **Workstream and programme structure**: many of the workstreams (apart from the major capital business cases) don't have clear objectives or deliverables aligned

to reconfiguration objectives. Once the review described above has completed changes will be reflected in a revised programme structure e.g. number of workstreams, board membership and governance structure.

- **Programme planning assumptions and end-state**: The BCT programme, as required for the Trust's STP, have refreshed the demand and capacity assumptions (focussing on inpatient beds) from the original Strategic Outline Cases (SOC). However this review had to be undertaken within the parameters of a maximum of £327m capital and the LLR system being in financial balance by 2020/21. Therefore the STP submission reflected an overall end-state the same in size to the 2014 SOC (1497 Inpatient and day-case beds). However how, when and where these beds will be released from has shifted significantly through the review of all BCT workstreams. The programme has reviewed with clinical colleagues the option of using the LGH site differently, however early financial analysis do not suggest this to be viable. Therefore the programme continues to plan for a 2-site configuration.
- **Sequencing of required moves**: Once the end state has been formally signed-off, how it can be delivered with least disruption may change from the original plan, e.g. need to build wards at Glenfield before moving ICU and associated services from LGH. The estates strategy refresh will continue to phase-2 once the end-state has been agreed at August ESB, this will provide detailed planning on the exact location of services within the two-site model and therefore the required sequencing. The challenge for UHL alongside this is how it delivers the bed reduction it is responsible for and holds the broader system to account for the remainder of the reduction to ensure the configuration it is planning for is viable.
- **Availability of funding:** funding for 2016/17 is still unknown but likely to be lower than originally planned. Plan D has been submitted to NHS England, which is based on the minimum requirement to keep the reconfiguration programme moving and to start to address the capacity issues identified in 2016/17. The plan assumes 2016/17 funding available from September and then assumes funding is available at the desired rate to complete the programme within 5 years (aligned to STP).
- **Funding routes:** the original SOC had assumed all capital requirements from traditional routes. The Trust has now reviewed alternate options and PF2 is the only one which does not either have a prohibitive cost or require CRL from the Department Expenditure Limit (DEL). Therefore this option is to be explored further for appropriate PF2 schemes (best suited to stand alone new build infrastructure), which makes it potentially applicable to the PACH and Women's hospital developments.

13. 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 had been planned for July 2016 to consolidate all this work and develop the plan, this is now planned for autumn 2016. It is not expected that all of the areas identified above will have been resolved by then, but sufficient progress should have been made to enable the planning process to take place. 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.

14. Development of the updated plan is important to put the right structure and discipline into the programme to enable visibility, monitoring and ultimately benefits realisation. Therefore a revised programme plan will be developed by November by the programme team and tested with broader stakeholders at an event in the autumn.

15. 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 November ESB and in use as a monitoring tool from December 2016. 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**	**Target deadline (as per July update)**	**Revised deadline**
Programme	Sign-off updated programme governance structure including any changes to workstreams / meetings.	August ESB	October ESB (to be completed following resource review)
Emergency Floor	Sign-off revised activity and workforce – change control from FBC	September ESB	
Clinical Services Strategy	Sign-off of scope and deliverables for Model of Care (or associated) workstream(s).	August ESB	September ESB (completed following resource review)
Programme	Sign-off updated BCT bed bridge and impact on UHL capacity planning / reconfiguration programme. Decision as to phase 2 planning scenario	July ESB	August ESB – for decision re phase 2 planning (following LGH analysis)
Beds	Sign-off of PID	September ESB	
Programme	Sign-off updated capital plan / estates strategy for revised programme	November ESB - TBC	
ICU/ Beds	Decision on preferred option for Glenfield capacity creation	September ESB	October ESB (due to links with broader beds project and availability of capital)
Theatres	Sign-off of PID	August ESB	
Vascular	Decision to proceed with moves without ICU move (and required revenue implications).	August ESB	TBC: Reconfiguration Board agreed to review in October 16.

Workstream / Project	Decision	Target deadline (as per July update)	Revised deadline
Estates	Outcome and implications of Infrastructure review and business case	August ESB	October ESB (external report to be submitted in September)
Programme	Proposal for interim use of LGH / options appraisal	August ESB	
Clinical support services	Sign-off scope of Reconfiguration clinical support services requirements e.g. diagnostics / therapies projects.	October ESB	
Corporate services	Sign-off scope of Reconfiguration corporate working requirements	September ESB	October ESB (due to annual leave of key individuals)
Estates	Phase 2 estates strategy re-fresh including DCPs and realignment of project costs		November ESB

Trust Board Focus On: Reconfiguration Projects starting in 2016/17

16. Three new reconfiguration projects have been set up since the beginning of this financial year; these are the Theatres, Beds and Long Term ICU projects. These three projects will spend 2016/17 working on the development of their future vision, models of care, clinical operational policies and activity profiles.

Project	Description	Senior Responsible Officer & Project Board Chair	Current Budgets (subject to re-alignment between projects)
Theatres	Review of the capacity requirements for inpatient theatres at the GH, and inpatient & day-case theatres at the LRI; taking into account service moves between sites and off the LGH. This project will include expansion of the existing central operating departments (whether in refurbished space or as new build), but excludes the day-case theatres at GH that will be provided in the planned ambulatory care hub.	Louise Tibbert (Director of Workforce & OD)	£11m (excluding PACH theatres)
Beds	Review of the bed requirements in line with the STP at the LRI and GH, taking into account service moves between sites and off the LGH. This project will include refurbishment of the retained estate and will recognise the need for contingency.	Richard Mitchell (Chief Operating Officer)	£36.9m

Project	Description	Senior Responsible Officer & Project Board Chair	Current Budgets (subject to re-alignment between projects)
Long Term ICU	Review of the long term ICU capacity requirements to support activity at the LRI and GH, taking into account the move of level 2 ICU off the LGH. This project will include refurbishment of the existing ICUs and expansion to provide new beds, and assumes that the move of level 3 beds off the LGH has already happened.	John Jameson (Deputy Medical Director)	£16m

Theatres project

17. The Theatres project held its first Project Board meeting in May 2016, and has also held two clinical launch meetings to engage with theatre staff and other clinical services which utilise theatres. The Project Initiation Document (PID) was signed off at the Theatres Project Board and the Reconfiguration Board in June. This will now go to ESB in August and IFPIC in September for approval. Key members of the Theatres Project Board are hoping to undertake visits to other Central Operating Departments around the country later this year, to learn from their recent reconfiguration projects.

18. Key interdependencies include:
    - PACH project: to ensure all theatre provision is accounted for across reconfiguration and that there are standardised ways of working across both (The Theatres Project Board, Planned Ambulatory Care Hub (PACH) Project Board and the Reconfiguration Board have agreed that at the Glenfield; day-case theatres will be managed by the PACH project, and inpatient theatres will be managed by the Theatres project).
    - Women's Hospital project: to ensure that the new women's hospital has access to gynaecology theatres and flows are standardised working principles are agreed across projects.
    - Children's Hospital project: to ensure that the new children's hospital has access to theatres for all required specialties and flows are agreed across projects and delivered within required timeframes.
    - Beds project: to ensure consistent activity flows are mapped across all sites

Beds project

19. The Beds project held its first Project Board in July 2016. The team are currently drafting an initial programme and risk register, as well as the PID which will go to the August Reconfiguration Board, September ESB and IFPIC for approval.

20. Key interdependencies include:
    - Level 3 Interim ICU project: to ensure appropriate ward capacity is provided at the Glenfield site to enable HPB to move from the LGH as part of the Interim Level 3 ICU project.
    - Children's Hospital project: to ensure ward moves at the LRI facilitate the vision of a single entity Children's Hospital at the LRI site within required timeframes.
    - Long-term ICU project: to ensure services affected by ICU expansion at LRI are re-provided as part of the beds project.
    - Theatres project: as described above
    - Diagnostics/ CSI project: to ensure consistent activity flows are mapped across all sites

Long term ICU project

21. The Long Term ICU project held its first Project Board meeting in June 2016 with good representation from commissioners and a patient representative from Healthwatch. The initial programme has been signed off by the Project Board; and the PID was signed off at the Reconfiguration Board in July. The PID will now go to ESB and IFPIC in August for approval. The project team is working in partnership with the ICU clinical teams and major service users of ICU to develop and agree the vision for the future of ICU at UHL. As part of this process, visits are being planned to local units to discover new ways of working and ensure plans deliver true transformation. The team are hoping to visit both hospital sites in Nottingham, as their ICU units recently received Outstanding (City Campus) and Good (QMC) ratings during their CQC inspection.

22. Key interdependencies include:
    - Level 3 Interim ICU project: to ensure consistent planning principles and standardised ways of working.
    - Beds project: as described above.

Additional projects to be established in 2016/17:

23. A project to understand the impact of the reconfiguration programme on diagnostics and support services is also due to commence this year. Discussions to agree the scope, identify links with the existing diagnostics improvement workstream and other projects (e.g. the Children's and EF projects) are in progress.

24. In addition, a workstream to assess the reconfiguration of the corporate directorates will be started this year. This will need to align to the wider UHL review on corporate services to meet the Carter targets, re-locate services if required to optimise clinical estate, deliver CIP savings and strategic objectives across LLR.

25. Further updates on these latter 2 projects will follow in a future Trust Board update.

26. Project Management resource has been identified for all five of these projects within the updated Reconfiguration team structure, and the recruitment process is underway.

Input sought

27. 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.

28. Is there any specific feedback/suggestions in relation to the new business case projects for the project / programme team?

Workstream progress report - July 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	Workstream paused as current process was not delivering Reconfiguration requirements. Revised workstream objectives and milestone plan were presented to June Reconfiguration Board. Proposal This now needs to be aligned to broader review of organisation strategic requirements / 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%	UHL Way workshop held for 3Ws for 4 wards and broadened circulation of ward level summary report to ensure focus on discharge planning. Board round diagnostic and patient note audit undertaken. Bed dashboard modified to include mortality and LOS in hours. Next month will support implementation of board round diagnostic and ward notes audit outcomes, and development of programme charter for 'wards' project.
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%	Service data has not been received from LPT to formally report on ICS service utilisation. Sarah Taylor is the UHL ICS lead. Work to optimise the ICS service needs to continue. Remit of workstream to be reviewed following finalisation of STP and updated requirement and model for out of hospital beds. Next month focus will be on inappropriate referrals and refusals to ICS.
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%	Intensive support has led to substantial improvement in Orthopaedics on the day cancellations. Speciality scheduling and booking matrix in development. Discussions continue with regard to shift from GA to LA procedures - 3/9 specialities have identified opportunity equating to 4 sessions in the clean room. Next month focus on timeline for delivery of all day lists, developing a sustainability plan for Orthopaedics, identify unused theatre minutes (>30 minutes), completion of remaining 3/9 action plans and 6/9 LA shift opportunity.
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%	Clinic standardisation work undertaken in Haematology, Oncology, Urology, Vascular Surgery. Identification of patient cohorts for targeted DNA action in MSS and RRCV. Weekly meetings established with Orthopaedics. Continued research into predictive DNA reports. Next month will focus on further clinic template standardisation, ESM and RRCV BSU, pilot of predictive DNA analysis with Orthopaedics, women's and children's, and the development of SOPs for outpatient clinic management.
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%	Ultrasound shoulder guidance is signed-off with GPs and orthopaedics. Next pathways include MRI Spine, Ultrasound Abdominal and Ultrasound Neck. Imaging variation data packs issued to Orthopaedics, Respiratory, Neurology and Stroke. External engagement continues. Next month focus is on Imaging referral dashboard, exploring opportunity to deliver MRCPs as urgent outpatient, expansion of specialities receiving Imaging data packs and development of pathology data packs to be initiated.
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%	LLR workforce modelling completed for STP submission, to give updated workforce profile (reduction) for 5-years. UHL modelling based on assumptions around bed numbers, CIP and EPR impact. EF Paediatric workforce plan developed ready for confirm and challenge. Continues to Vascular and ICU board re medical staffing. Alliance workforce plan developed (to be approved by Leadership Board 2nd August). Next month focus on benchmarking women's hospital workforce model, completion of EF workforce plan and development of Children's workforce plan.
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, activity model and impact on workforce being refreshed, IM&T plan B delivery plans being developed and planning for phase 2 construction is underway. **Vascular -** Construction continues. Team piloting direct admissions in current location in advance of move. Solution to move without ICU (Feb 17) developed at high cost to organisation. Further discussion required as to value of investment. Otherwise move date will be circa May 18. **Interim ICU** - Awaiting ITFF / internal capital availability. Plan updated to reflect need to create additional capacity (feasibility study underway), plan for service moves now January 18 at earliest. Team have undertaken clinical risk review to ensure safe to manage service for this period. **Children's -** EMCH construction continues (phase III) Delays to appointment of design team due to capital availability (tender complete). Continued discussion with commissioners on growth. **Women's** - Model of care, activity and operational policy work continues. Gynaecology model of care workshop held. Delays due to consultation and capital funding. Opportunities so increased savings discussed with BCT. **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** - New project initiated to establish sustainable and fit for purpose ICU services at GH and LRI. PID agreed. **Theatres**- New project initiated 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%	Phase 1 of estates strategy refresh completed on worst case bed scenario and presented to Reconfiguration board. LGH feasibility work completed indicates 2-site configuration preferred option, to be confirmed at August ESB to proceed to phase 2. 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.
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%	BCT Service Reconfiguration Board (LLR beds board) has new ToR and membership and will now oversee the development and delivery of BCT initiatives that impact on beds and ensure alignment with the UHL reconfiguration programme. Reconfiguration Programme review of relationship and governance structures between BCT and UHL Reconfiguration Programme required.

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

UHL Reconfiguration Programme Board - July 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 / 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. Which is circa 500 bed fewer than current configuration. There is a risk that some bed closures may not be achievable as the level of detail in plans is variable.	5	5	25	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. Estates options planning to include contingency options. **ACTION**: To review internal actions and processes for monitoring / holding to account.	16	Aug-16	Paul Traynor	28-Jul-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	5	20	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.	16	Sep-16	Mark Wightman	28-Jul-16	
3	Overall programme	There is a risk that 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 not known for 16/17 or subsequent years.	4	5	20	20	PT	Limited (internal only) capital available until end of September 2016 at earliest. Capital plan D has been developed to re-phase development of OBC and FBCs in 16/17. Options for alternative options of funding are being reviewed with external partner e.g. PF2. Ongoing discussions with NHS England and NHSI to ensure Leicester as priority.	20	Sep-16	Paul Traynor	28-Jul-16	PR13
4	Level three ICU / Vascular	There is a risk that non- delivery of out of hospital beds capacity could jeopardise ability to provide additional bed base at Glenfield, which is required to relocate HPB.	5	4	20	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 capacity and ICU moves have been sequences around this. Options to move Vascular in advance of ICU services are being explored.	12	Oct-16	Richard Mitchell	28-Jul-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 19/20 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 and earliest and engagement continues with the NHS England Assurance Panel / STP process).	16	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 as part of GMP process. Option appraisal to be developed across Reconfiguration and Operations as to how to utilise space in this period this includes Ward 7 option that may negate need to split into 2 phases - decision to be made by 09/08/16.	12	Aug-16	Paul Traynor	28-Jul-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. New UHL lead to be identified 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	29-Jun-16	