UHL Reconfiguration – update

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Trust Board 5 May 2016 paper H

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.

The internal assurance process for the programme has recently been reviewed to further develop the reporting arrangements, providing assurance at different levels aimed at different audiences; Trust Board/Executive, Programme and workstreams. This integrated approach reflects the shift in focus to monitoring progress against key milestones, holding workstreams to account and ensuring the programme is on track to deliver. It also serves to provide sufficient assurance across the organisation and escalate risks in a timely manner through appropriate channels.

This paper provides the Board with a monthly update on the Reconfiguration Programme, employing the level one dashboard to show an overview of the programme status and key risks, with an accompanying focus on one workstream each month. This month, the focus is on the Emergency Floor project, which is in its delivery phase. The new Emergency Floor is due to open in March 2017, with less than a year to go there are critical activities going on that the organisation needs to be aware and supportive of.

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 three risks from across the programme that the Board should be sighted on.
2. This summary follows submission of highlight reports from all UHL reconfiguration workstreams in April 2016.

3. The workstream update looks at the Emergency Floor Project in more detail; the project is in Phase 1 of construction and due to open in March 2017. Key activities the Trust Board need to be aware of as part of this phase include; workforce and activity planning, IT Plan B implementation (in lieu of EPR), operational, technical and equipment commissioning and communication and engagement. Phase 2 planning continues alongside this work.

Input Sought

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.

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:	2 June 2016 Trust Board
Executive Summaries should not exceed **1 page**.	[My paper does not comply]
Papers should not exceed **7 pages.**	[My paper does comply]

Update to the Trust Board 7 April 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 27 April. Any issues identified at this meeting are not covered in this update paper and 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; the capital availability for 2016/17, activity plans for 2016/17 that are agreed with commissioners, and the timeframe for the Better Care Together consultation are known.

3. The Trust has updated the capital plan in the last month based on the most likely scenarios. Due to the number of variables (set out above) and the need to align the Reconfiguration with the capacity planning process it would not make sense to update the Reconfiguration plan at this stage. An updated plan is likely to be developed in May 2016, however a definitive capital position may not be known until the end of Quarter 1.

Governance update

4. The dashboard at a glance highlights two red areas, due to a lack of progress at the desired pace. These include Models of Care (MOC), where the scope and objectives of the workstream are being reviewed by members of the Executive Team, and IM&T where external delays to EPR funding have impacted on the programme and a Plan B for the Emergency Floor has taken longer than planned to agree.

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 percentage complete gives an indication of the overall progress against in year plan, based on the workstream view of progress against individual project milestones. As April is the first month of the 2016/17 financial year, all workstreams have been re-set to 8%.

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).

8. The agreed SRO changes since the last update are:
    - John Jameson – Long-term ICU Business case– New project for 2016/17

9. In a follow-up to the Gateway review and agreed actions and alignment with 2016/17 capacity planning, a planning workshop was held on 18th March, and an Executive planning session on 19th April. Follow-up actions from these continue to be undertaken which may impact on the scope, timing and costs of the reconfiguration programme.

Programme risks

10. The top three UHL reconfiguration programme risks to delivery this month remain as:

11. **Risk:** The Better Care Together (BCT) Strategic Outline Case (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 the 109 beds worth of demand management where the BCT SOC assumed this would occur, which has significant impact on delivery of overall plan.

12. **Mitigation:** Demand management will need to be reconsidered. Vehicles for delivery are UHL's MOC strategy and the Vanguard MOC. More focus needed on reducing patients admitted four times or more and on readmissions as well. This is being reviewed through the BCT programme.
Action required: For noting

13. **Risk:** Capital funding not guaranteed for the estimated £330m, this will affect our three to two site strategy if not secured. Notification received from the Department of Health national has said that capital availability is limited, the impact on UHL not yet known.

14. **Mitigation:** Limited capital available until end of March 2016. Unclear on implications for 2016/17 as yet; re-phasing plan is ongoing. Outline Business Cases and Full Business Cases continue to be implemented as per original plans. Options for alternative funding are being reviewed.
Action required: For noting

15. **Risk:** Consultation timelines significantly impact on the business case timelines, and ability to achieve 2019/20 target for moving off the General site. Particular impact on planned ambulatory care hub and women's projects moving forward.

16. **Mitigation:** 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.
Action required: For noting

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

Workstream update

18. Each month a reconfiguration workstream is selected for inclusion with more detail provided on the 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 on delivery. There will be the opportunity for all

workstreams to be considered. This month, the focus is on providing an update to the Trust Board on the Emergency floor project.

Emergency Floor Project

19. Construction of Phase 1 of the Emergency Floor development commenced in the autumn of 2015 and is on track for completion in early March 2017. As soon as the space currently occupied by the existing Emergency Department (ED) and Urgent Care Centre (UCC) can be released construction will commence on the development of Phase 2 Medical Assessment Units, GP Assessment and the Emergency Decisions Unit. Key to the successful delivery and implementation of Phase 1 will be the execution of the comprehensive commissioning programmes and transition plan which were shared with the Executive Strategy Board in April 2016.

Progress to date

20. The construction of Phase 1 is on track and the interiors strategy has been signed off by clinical team.

21. The review of operational policies completed through clinical and key stakeholder involvement and handed over to the design team to inform final design solution for Phase 2.

22. Preparation for the move in March 2017 started through the development of commissioning plans, sharing these with the wider organisation and beginning to act on first actions.

23. Plans developed and shared with the organisation detailing how patient care will be delivered as usual whilst Phase 2 is being built

24. Active clinical involvement and engagement in working groups and Project Boards

25. A weekly blog along with time-lapse videos are on the UHL website along with articles in the Leicester Mercury to publicise progress.

Next steps

26. In order to manage this complex project on time and within budget a focused attention is being given to:

- Reviewing the workforce, activity and financial plan assessed against original Full Business Case (FBC) assumptions
- Developing an Organisation Development (OD) plan to ensure smooth transition into a new live environment
- Confirming the interim IT solution since the EPR will not be live at the time of opening
- Planning for design development of Phase 2
- Initiating robust arrangements for preparing teams to move into the new environment that are being shared with internal and external stakeholders
- Ensuring a robust communications and engagement plan

27. Over the next three months, there will be focused discussion and agreement/sign off on the following areas:

- **May 2016**- Update on progress made in reviewing the workforce, activity and financial model;
- **June 2016**- Sign off workforce activity and finance plan (including gap analysis against the original FBC assumptions);
- **July 2016**- Delivery and sign off the preferred IT solution and associated costs;
- **August 2016**- Update on the initiation of the commissioning programmes, how key stakeholders are being engaged and how lessons learned from other organisations are being incorporated into the plans.

Key Challenges

28. There are a number of key challenges within the project including:

- Managing the difference in the workforce, activity and financial assumptions against the original expectations set within the FBC as a result of the activity changes and the urgent care work stream;
- Ensuring alignment of activities to prepare staff for the move to Phase 1 with improvements that are currently being made within the existing emergency department
- Using the new activity modelling to show how each area of the new emergency floor will increase in capacity over time against the original FBC assumptions which identified capacity for the next 20 years;
- Developing innovative workforce solutions, ensuring OD and cultural challenges are addressed in advance of the move to the new department
- Ensuring all staff groups and external stakeholders are considered and included in planning and commissioning arrangements
- Agreeing, designing and implementing the preferred IT solution in advance of the move into Phase 1
- Ensuring that the plans for Phase 2 development are managed on time and within budget

Recommendation

29. 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 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**: Need response from BCT re next steps.	16	Jun-16	Paul Traynor	27-Apr-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	15	PT	Limited capital available until end of March 2016. Unclear on implications for 2016/17 as yet; re-phasing plan is ongoing. OBC and FBCs continue to be implemented as per original plans. Options for alternative options of funding are being reviewed.	20	N/A	Paul Traynor	27-Apr-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	Impact assessment of ICS beds underway and will report in May 16 to support future decision-making. Updated assumptions across BCT plan to be agreed in May 16 and then plans to address identified capacity gap will be developed. Feasibility study into additional ward space has been completed. 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	27-Apr-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	0	JE	Services that must be maintaoned to be identified. Decant plan established. Options for phasing and time and costs for phasing in development.	16	Aug-16	Paul Traynor	27-Apr-16	
5	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	Feb-16	Mark Wightman	27-Apr-16	
6	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	12	PG	Resource requirements identified in line with capital plan (Plan A &Plan B), and are curerntly being validated through reconfiguration programme. 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	28-Oct-15	
7	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	
8	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	0	JE	Development and implementation of OD plan.	12	Jul-16	Louise Tibbert	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	12	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.	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	24-Sep-15	
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	N/A	Louise Tibbert	26-Nov-15	

Workstream progress report - May 2016

	This month	Last month	Comments
Overall programme progress	**Amber**	**Amber**	Programme Implementation Document being developed for ESB in February. Interim PMO arrangements in place following departure of reconfiguration director. Action plan in place following Trust Board January Thinking Day to strengthen programme approach.

*On track against delivery - Progress against delivery. Red = Planned timeline is unlikely to be achieved, Amber = current timeline is at risk of not being achieved but mitigations in place, Green = planned timeline expected to be met or exceeded

** Completion % against in year plan is based on workstream view of milestones within project highlight report.

	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	**Red**	8%	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. Discussions ongoing as how best to utilise workstream, likleky to include focus on Emergency care, closer working with BCT and mapping of existing improvement inititives across LLR.
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**	8%	Development of 16/17 bed reduction plans for some CMGs (£4.6m). Revised LoS variation tool presented to MD. Four specialties identified to further deep-dive. Bed dashboard updated for all specialities with 16/17 targets. Changes to programme governance to link with Emergency Flow work - ward meetings to be held with new membership to focus on quality and flow metrics to drive efficiency. .
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**	8%	Additional ICS beds have opened to the agreed trajectory and target of 130 beds by the end of March 16. Focus is now to increase occupancy, refine referral processes and to actively promote and educate staff and stakeholders on the scope and service model. There will be increased focus on clinical leadership and operational processes for proactive case-finding to support this. A revised data strategy has been developed to support transfer of reporting and data analysis between stakeholders. BCT commissioned analysis through PI tool to evaluate impact of ICS on LOS / patient outcomes to support formal decision re progressing to phase 2 (further ICS and sub-acute beds).
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**	8%	Mitigation plans to offset additional demand; CIP delivery (c362 sessions) and shift from GA to LA work (c. 520 sessions). 3 out of 9 dspeciailities identified shift to LA outside theatres. Work to continue to identify procedures and location for remaining specialities. 13/15 CIP plans have detailed action plans - 2 escalated. Permanent theatres permanent PMO resource to lead from June 16. Overhaul of thetare timetable to increase all day operating lists in progress.
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**	8%	Development of robust plans for 16/17 CIP opportunity, 28/37 schemes rAG rated as Green, areas odf risk identified. Further work on high risk areas to continue next month. OP Initiative check completed by CMGs to provide assuranceon Booking Slot Utilisation and DNA actions. Average cost per clinic now included in SMS reminder service to support DNA reduction. Workshop in high DNA areas to be held next month. Issues with reports resolved, summary report of all available slots within 14 days to be reviewed weekly.
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**	8%	Imaging workshop held for City CCG on pathway redesign and reducing variation. Events with other CCGs to be scheduled. Advanced Practitioner Radiographers in post to report on MSK plain film x-rays to reduce cost / backlog and improve turnaround times. PDSA cycle of imaging referral clinical variation pack completed with Breast Surgery and to be tested with Respiratory in May. Audit of NEDDIpathway and testing of dashboards due in May. Workstream to link more closely with D&C work at Glenfield.
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**	8%	Visit to Circle Treatment Centre in Nottingham presented new workforce and employment model opportunities through PACH. Workforce supporting review of ICS impact via staff who have rotated with service. Workforce strategy (part of consultation) with TDA for review. LERTC monies for 16/17 confirmed with investment in Advance practice, apprentiships and workforce profiling. Operational workforec plan submitted (with significant top down adjustment due to agency ceiling figures). Next month workforce profiling for EF will conclude and women's hospital will commence.
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** **Green** **Amber** **Amber**	8%	**Emergency Floor** - phase 1 construction continues , operational policies completed for phase 2. Operational issues continue to be worked up. See Reconfiguration update for more information. **Interim ICU -** Awaiting ITFF / internal capital availability. Site implementation groups held. Capacity and operational issues comntinue to be worked throuhgh. **Vascular -** Construction started. Operational commissioning group reconvened - planning for February 17 move (subject to D&C work).Operational issues re junior dr rotas and emergency admissions continue to be worked through. **Children's -** MoC planning and op policy development continues, discussion on proposed age of children's services held with each CMG (proposal to ESB in May). **Women's** - Further delays to OBC due to BCT consultaion. Model of care, activity and operational policy work continues. **PACH** - Team visited Circle Treatment Center in Nottingham. Outpatient clinical workshop held. Daycase clinical workshop at end April. Further delays to OBC due to BCT consultation.
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**	8%	Re-patriation of clinical space through the de-clutteing of wards and option appraisal development (at Glenfield and LRI). DCP completion is reliant on outcomes of Trust D&C and reconfiguration conversations. Infastructure and investnment surveys in progress and due to rreport in May.
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	**red**	8%	EPR - NTDA have requested audit and legal review of the financial approach using IBM funds and confirmation of the financial treatment is lease or loan. Next month need to respond to NTDA and confirm approvals mechanism. EF - Plan B scoping continues, options appraisal to be completed and business case (costs need 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	Continuation of work to fully understand the implications of different capital scenarios and how any capital funding will be used post April.
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.	**Amber**	8%	Road map work cannot be progressed further at this stage due to links with demand and capacity. Workstream supporting this the D&C work through clinical space repatriation options. Feasibility study for future use of LGh site ongoing and due to report July 16. Review of corporate areas and future ways of working continues (including links to Carter recommendations).
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**	8%	Ongoing work with BCT on consultation and workstreams within, update of Reconfiguration website and intranet page. Creation of children's communication plan, and women's newsletter issued. Next month further work on EF and link to OD programme.
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**	8%	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. Key representatives from across BCT met with the NHS England Assurance Panel as part of the pre-consultation business case and process and work continues to respond to requirements. See BCT update for more information.

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