STP, BCT and UHL Reconfiguration – Update

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Trust Board paper J

Executive Summary

Context

In order to provide a vision for transformation across the whole health economy, this paper provides an update on the LLR Sustainability and Transformation Plan (STP)/Better Care Together (BCT) Programme, which sets the context for UHL's Reconfiguration Programme.

The LLR STP describes how the local health and social care system plans to restore financial balance by 2020/21 through new ways of working. The STP builds on the work developed as part of the BCT programme but with clearer focus on implementing system priorities. Crucially, it makes our case for national / external capital investment and access to transformational funding to support our reconfiguration programme (note Appendix 1 provides the Trust Board with the latest update on STP Structure and Plans).

Our Reconfiguration Programme is an ambitious and complex undertaking which has been established in order to deliver the broader system priorities within the STP, the Trust's strategic direction and clinical strategy. It is important that the Trust Board has visibility of progress in delivering the STP, as well as the reconfiguration programme, and is able to provide appropriate challenge, to ensure there is sufficient assurance associated with activities undertaken to achieve the desired future state.

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

Questions

1. Does this report provide the Trust Board with sufficient and appropriate assurance of the UHL Reconfiguration Programme, its links to the STP, the delivery timeline and management of risks?

Conclusion

1. This report provides an overview of the STP and Reconfiguration programme, an update on the programme plan, programme risks for escalation, an update on the Emergency Floor Project, and a "focus on" the Children's Hospital Project.

Input Sought

The Trust Board is requested to:

- Advise whether reporting on the STP and the reconfiguration programme together assists in the debate around the whole programme
- Note the progress within the reconfiguration programme and the planned work over the coming months.

For Reference

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

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

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

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

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

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

Scheduled date for the **next paper** on this topic: [Thursday 3rd November 2016]

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

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

Sustainability and Transformation Plans (STP) & Impact on Reconfiguration

1. The STP describes our ideas for restoring financial balance by 2020/21, by working differently through new models of care that help manage demand and deliver more efficient services. It also makes our case for national/external capital investment and access to transformation funding.

2. The STP is a system plan (which we have shaped and influenced) which builds on Better Care Together (BCT) work, but with clearer focus on implementing system priorities, in particular:

    - Urgent & Emergency Care
    - Integrated teams (to manage some of our most complex and vulnerable patients)
    - General Practice Resilience
    - Service Reconfiguration
    - Operational Efficiency

3. With this in mind, a review of BCT governance arrangements is underway with a view to simplifying and mainstreaming ownership (Boards/Health and Wellbeing Boards) and increasing senior clinical leadership and public visibility. It is envisaged that we will have a new joint executive/clinical System Leadership Team (commissioner and provider with delegated authority) and greater stakeholder transparency (public meetings and Quarterly Forum).

4. There will also be a more localised arrangement for each of the key localities (or CCG geographies) with multi-agency implementation teams set up to deliver priorities with strong patient involvement.

5. The current BCT Programme Management Office function and resource will need to evolve and partner organisations will need to release senior individuals to drive key pieces of work over the next 12 months. New governance arrangements will be in place swiftly (from November 2016), shortly after the final STP is submitted on the 21st October.

6. The STP itself makes our case for external capital investment to support our reconfiguration plans; the final submission will be followed by public consultation on some elements within our reconfiguration plan.

7. Linked to this is our own operational planning process – our operating plans will cover a 2-year period (2017/18 and 2018/19) and must describe how we are supporting delivery of the STP. National planning guidance, published on the 22nd September, sets out very clear expectations for providers on this.

8. In order to balance, the STP (in the broadest sense) seeks to reduce the growing demands on the acute hospital sector by adopting new ways of working around the 5 system priorities above. For UHL, this means the ever increasing demands on services like A&E should be dramatically curbed, or reduced in some cases i.e. outpatient referrals.

9. Work to describe what the volume / level of demand for hospital services looks like is very much work in progress at the time of writing. However, over recent weeks, further work has been undertaken on the potential impact of schemes to sense check the early assumptions. It is important to note that the benefits of 'Integration' (or Integrated Teams) is less than was initially thought. In short, this means LLR will need more acute hospital beds than our original STP submission (June) assumed; approximately 200 more. This has significant implications for our Reconfiguration Programme of course, and our Capital Plan, which this paper addresses below.

10. The following table shows what this means for beds although there are a number of caveats / considerations still to work through. For example, the 'starting point' doesn't reflect the fact that we currently have an imbalance between demand and capacity (we have very high occupancy) and the numbers do not allow for winter flex / additional capacity i.e. the end state of 1700, which is what our current Capital Plan is based on.

STP Acute Bed Bridge						
Starting Position ('summer beds at UHL i.e. without winter capacity = 1940						
Impact on Acute Beds	**2016 / 17**	**2017 / 18**	**2018 / 19**	**2019 / 20**	**2020 / 21**	**5 Years**
Growth (if we did nothing)	46	42	42	45	35	210
Making Best Use of Resources (provider efficiency i.e. LOS improvements)	-24	-25	-27	-29	-29	-134
Delivering Care in the Right Setting (shifting care into the community)	-45	-42	0	0	-12	-99
Improving Health Outcomes and Independence (admission prevention)	-35	-50	-41	-44	-47	-217
Total Acute Beds by Year End / March	**1882**	**1806**	**1781**	**1753**	**1700**	

Demand & Capacity: Estates / Development Control Plan (DCP) Refresh

11. As previously reported, the DCPs are being refreshed in light of the STP work above in order to provide the Trust with:

    - Revised site Development Control Plans (DCPs), which identify the plan for the future estate and buildings by site, based on a refined schedule of accommodation and the clinical adjacency matrix.
    - Updated DCP phasing plans and outline decant strategies, considering access, site flow and traffic management.
    - Refreshed capital costs by project within the estimated capital budget of £248.1m, updated cash-flow and revised Strategic Outline Case cost forms.
    - The newly created UHL route map and organisational communication material, aligned to existing projects, the estates infrastructure programme and EMPATH.

12. In order for the DCPs to triangulate with the STP, the detailed work has been stalled in order for it to be based on an agreed specialty bed breakdown. This is important since we need to map the specialties by site. At the time of writing this paper, the specialty breakdown of beds and activity models are still being reviewed. Work to date has focused on the baseline i.e. what is the possible available bed capacity at the 3 sites. The Reconfiguration Board supports the need for the Trust to sign off the assumptions in the STP since these are fundamental in delivering the future reconfiguration programme.

13. The DCPs will take eight weeks to complete, so will now be delivered mid-December. The DCPs form a fundamental part of the Strategic Outline Case (SOC), and as such it is important that this date is not changed again owing to the need to deliver the SOC to the February 2017 Trust Board.

Additional Ward Capacity at Glenfield

14. As previously reported, there is now a need to produce a robust business case for the additional ward capacity needed at GH to move the HPB service as a consequence of the move of the level 3 ICU beds. The delivery of the business case is being monitored through the Beds Project Board.

15. Progress has been made in developing the options for location on the GH site; and an options appraisal will now be set up to establish the best physical location, and whether this facility will be modular or permanent build.

16. It must be noted that this now represents the slowest component of the ICU project delivery programme, and the ICU level 3 moves cannot take place without this facility being available. This will be factored into a review of the capital programme for 2017/18.

Vascular Project: Update

17. The vascular surgeons have confirmed that the most significant factor for the service is the ability to work in a hybrid environment (a surgical theatre equipped with advanced imaging facilities) – in relation to safety for both the patients & the operators. They have also reconfirmed that the co-location with cardio services is important – the ideal is the ultimate strategic configuration of cardiac, renal, respiratory and vascular all provided from a single site.

18. Agreement was therefore made by the Executive Team on 21st September 2016 that the vascular surgery service move to Glenfield should proceed in May 2017. The revenue implications of separating the move from that of HPB and transplant have been validated and will be supported and prioritised in financial planning for 2017/18.

19. Work undertaken to review overall bed capacity at Glenfield, following the vascular surgery move, has identified a number of mitigations to be pursued in order to ensure sufficient bed capacity will be in place at Glenfield for the winter of 2017/18 to support increased emergency pressures during this period.

20. The Clinical Commissioning process to move the service will now commence.

Reconfiguration Structure

21. The advert for the Reconfiguration Programme Director has been placed and the application period has now closed. The short-listing process has been carried out in advance of interviews, which are scheduled for 24 October 2016.

22. The three new Senior Project Managers will commence working at UHL on 5 October 2016, 28 November 2016 and 5 December 2016. It has been agreed that Capita will continue to support the Trust's reconfiguration programme until the end of December 2016, filling the roles of Head of Reconfiguration PMO, Director level Clinical Challenge, Activity Modelling & Project Manager (to end of November).

23. A number of vacancies remain in the team, including Reconfiguration Programme Support, Reconfiguration Communications Manager, Emergency Floor Commissioning Manager, 3 x Senior Project Managers. A review of these vacancies will be undertaken once the capital position is confirmed.

Reconfiguration Reporting

24. Currently, highlight reports are submitted to the Reconfiguration Programme Board for all work-streams; despite each work-stream (other than Reconfiguration Business Cases) having a separate accountability, governance and approvals structure. It has therefore been agreed that from October 2016 onwards, only the highlight reports for Business Cases will be presented to the Reconfiguration Board. A new 'dashboard' style report template has also been approved for trial at the October Reconfiguration Programme Board.

25. In order to ensure that work-stream milestones which impact on the Reconfiguration Programme are monitored by the Reconfiguration Programme Board, such as the beds,

theatres and outpatients cross cutting workstreams, a new high level dependency chart will be created and included as part of the monthly programme update paper to the Reconfiguration Programme Board.

Site Reconfiguration Groups

26. Previously the Reconfiguration Programme ran three Site Based Groups, originally set up by the interim ICU Level 3 project to prepare for the moves. These were chaired by a CMG Head of Operations, and the impact of the ICU / vascular moves on that site were discussed by a wide range of stakeholders from a variety of services. However, when the moves were delayed due to capital, the groups ceased meeting.

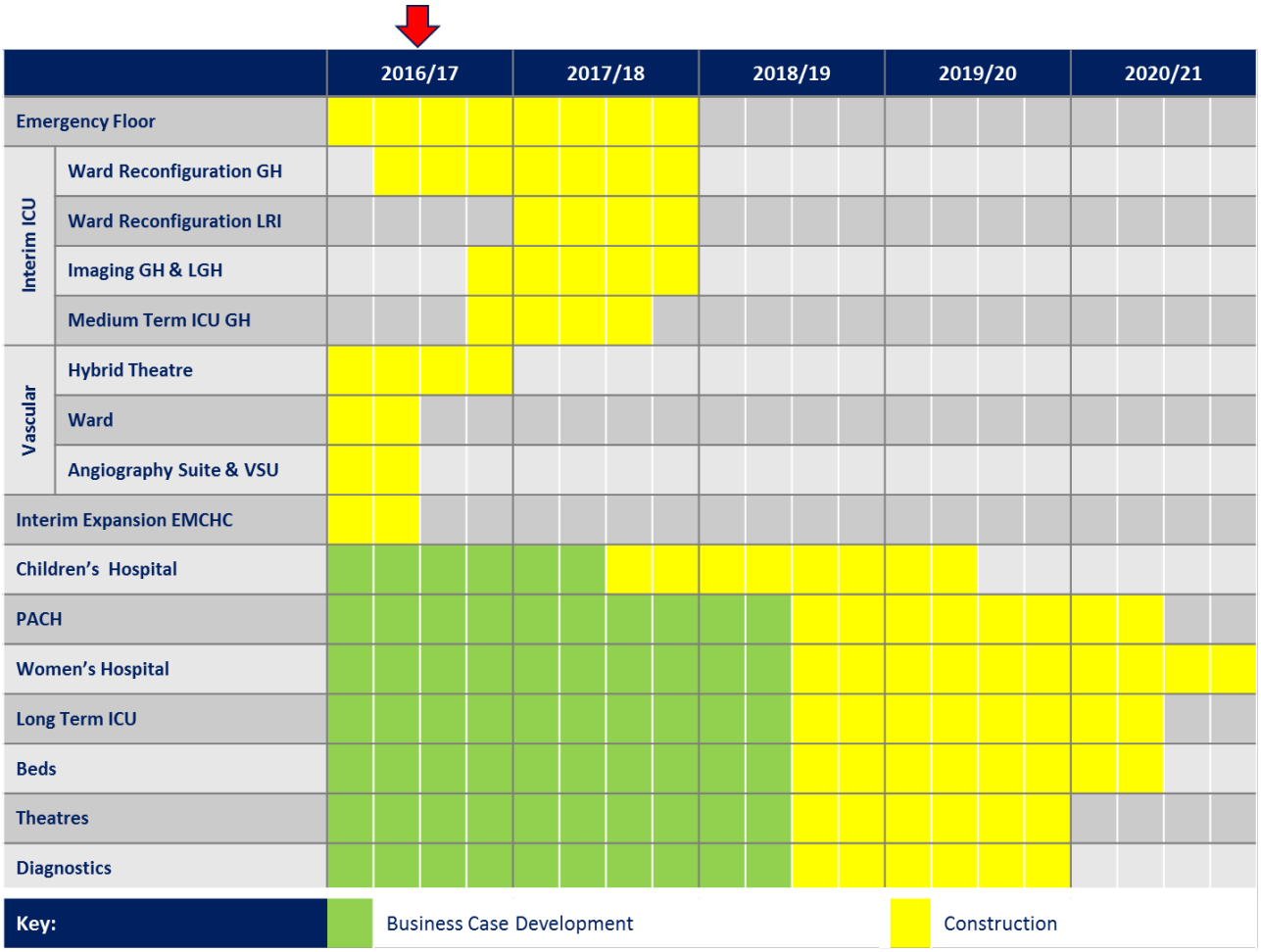
27. As part of a review into the communications and engagement carried out by the Reconfiguration Programme, the Reconfiguration Programme Board has approved that these groups are re-instated and re-named Site Reconfiguration Groups as soon as there is visibility on this year's capital. Changes to the format of these groups are currently being considered.

Programme Plan & Availability of Capital

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

29. The programme is subject to revision once the Estates/DCP refresh and the STP are complete; and once the 2016/17 capital funding availability position is clear. At this time, the reconfiguration programme will be refreshed to ensure it reflects the latest information and resolves two issues with the current programme plan:
    - Due to delays to date in capital availability and consultation, there are a number of projects that would be ready to move to design/construction at the same time from the point funding becomes available
    - Alignment of interdependencies to ensure correct sequencing (e.g. parts of the Theatres project will need to be accelerated to ensure the Children's hospital theatre requirements are met within required timescales)

30. A high level summary of the current programme plan is shown on the following page.



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

Workstream / Project	Decision	Current deadline	Cause of Delay
Programme	Sign-off updated programme governance structure including any changes to workstreams / meetings.	~~August ESB~~ October ESB	To be completed following resource review.
Clinical Services Strategy	Sign-off of scope and deliverables for Model of Care (or associated) workstream(s).	~~August ESB~~ October ESB	To be completed following resource review (September).
Estates	Outcome and implications of Infrastructure review and business case	~~August ESB~~ October ESB	External report to be submitted in September.
Estates / Programme	Phase 2 Estates Strategy re-fresh including DCPs, realignment of project costs and programme plan	November ESB December ESB	Delay to hand-off of STP assumptions
ICU/ Beds	Decision on preferred option for Glenfield capacity creation	~~September ESB~~ ~~November ESB~~ December ESB	Decision will be made as part of Estates Strategy refresh – delay due to STP.
Emergency floor	Sign-off revised activity and workforce – change control from FBC	~~September ESB~~ ~~October ESB~~ November ESB	Discussed at oversight group and further work required culminating in a stakeholder discussion to agree contracting, activity, budgetary and workforce implications.
Diagnostics	Sign-off PID	~~September ESB~~ ~~October ESB~~ December ESB	First reduced Project Board October to agree scope, full Project Board November.

Programme Risks

32. Each month we report in this paper on risks which satisfy the following criteria:
    - New risks rated 16 or above
    - Existing risks which have increased to a rating of 16 or above
    - Any risks which have become issues
    - Any risks / issues which require escalation and discussion

33. This month there are three risks to be reported as follows:

Risk	RAG	Mitigation	Reason for Reporting
Not enough capacity in the system to create headroom to implement reconfiguration plans.	20	Ongoing D&C work includes options to reduce demand, create capacity & move services between sites.	Existing risk: rating has increased from 16 to 20 since last month.
Interim ICU: Non-delivery of out of hospital bed capacity means beds at GH do not become available for HPB to relocate.	25	Feasibility study for additional wards at GH has been completed: now at options appraisal stage. Moves delayed due to capital funding. NHSI advised both OBC and FBC will be required.	Risk has become an issue and is being managed as such (rated 25).
Children's: NHS England will not continue to commission EMCHC from UHL.	16	Project continues assuming EMCHC retained. Discussions with NHSE & other stakeholders continue.	Existing risk: rating has increased from 15 to 16 since last month.

34. The Programme Risk Log (Appendix 2) presents the top ten Programme risks in full. The Reconfiguration Programme Board are planning a review of the Risk & Issues Log for the programme in advance of their next meeting in October; the outcome of which will be reported to the Trust Board in November.

Emergency Floor Project Update

35. As of Thursday 6th October, the new Emergency Department (Phase 1 of the Emergency Floor Project) will be 23 weeks away from its opening on Thursday 23rd March.

36. Time will be dedicated to the Emergency Floor project at the Trust Board Thinking Day on 13th October; where key members of the project team including the Senior Responsible Officers and project manager and will be in attendance to discuss current progress and key areas of focus to successfully commission the new build.

37. Efforts to develop a robust workforce plan are nearing a conclusion. It is anticipated that the revised plan will be supported by the Oversight Group and approved by the Executive Strategy Board in November 2016. Attention will be paid to developing a targeted recruitment and marketing campaign to secure the required workforce in readiness for the opening of Phase 1.

38. Agreement has also been reached to deliver Phase 2 as a single phase development. In order to meet this requirement, a clinical options appraisal has been undertaken to review the options for an interim location for the Emergency Decisions Unit (EDU). Discussions continue with the Oversight Group, as the clinically preferred option, which is the installation of a modular unit adjacent to the current ED, is deemed to be unaffordable while the Trust remains in a period of uncertainty regarding capital availability.

39. Emphasis continues to be placed on delivery of the commissioning plans across the organisation and developing plans to support the opening of the new Emergency Floor with partners across LLR (such as EMAS, Leicestershire Fire and Rescue Service, Local Resilience Forum) over forthcoming weeks.

40. Work continues in developing the IT solution for the new department. Particular time and effort will be spent over the next few weeks developing and testing the new NerveCentre module for the Emergency Department. Deployment is anticipated in advance of the go-live for the new department.

41. Planning for Phase 2 is currently focused on developing the detailed design in order to achieve clinical sign off by October 2016.
42. Construction of Phase 1 continues to be on track for completion and handover to the Trust in early March 2017. The scheme remains within budget. All other work-streams are currently progressing to plan.
43. The project continues to carry and manage a number of high rated risks. A workshop to review all risks and provide assurance that mitigation and further actions are effective is to take place in early October.

Input Sought

The Trust Board is requested to:

- Advise whether reporting on the STP and the reconfiguration programme together assists in the debate around the whole programme
- Note the progress within the reconfiguration programme and the planned work over the coming months

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Leicester, Leicestershire and Rutland's **Sustainability & Transformation Plan (STP)**

UPDATE

Toby Sanders, STP Lead
13 September 2016

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What is the STP?

- Health and care ‘place based’ plan for Leicester, Leicestershire & Rutland (LLR) ‘footprint’ (one of 44 nationally)
- Addressing local issues and implementing the NHS 5 year forward view to March 2021
- Makes the case for national/external capital investment and access to non-recurrent transformation funding
- Progression of BCT work, but with clearer focused on implementing a few key system priorities
- 30 page document supported by detailed finance, activity, bed capacity and workforce templates
- Final Plan by end of October followed by public consultation on some elements

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The local ‘triple aim’ gap issues our STP needs to address

Health and wellbeing outcomes gap:

- Lifestyle and Prevention
- Outcome and Inequalities (people’s health outcomes not being determined by things like where they live)
- Mental Health Parity of Esteem (mental health services on an equal footing with other parts of health)

Care and quality gap:

- Emergency Care Pathway (A&E and ambulance handover delays)
- General Practice variation and resilience
- Clinical workforce supply (ensuring we have the staff in place we need to deliver our plans)

Finance and efficiency gap:

- Provider systems and processes (internal efficiency)
- Estates configuration (how we use our buildings)
- Back office functions

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The money context

- We currently spend c£1.6billion on NHS services across LLR
- By the end of the STP 5 year plan this will *increase* to c£1.8bil
- But, demand and demographic growth plus the cost of delivering services and new treatments will outstrip these increased resources by c£450m across the local NHS and a further c£70m across the local authorities
- The STP is not about ‘cuts’ but it is about choices in how we spend public money
- The approach we are taking to this is a ‘placed based budget’ one that looks across organisations at the ‘LLR pound’
- And which focuses on new ways of working and models of care that manage demand and are more efficient

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LLR STP priority areas

- We've reviewed our 'triple aim' gaps, current work programmes and experience of system change through BCT over recent years as well as national best practice/evidence (e.g. Vanguards)
- From this, we have identified a smaller number of key system change priorities:
  1. Urgent & emergency care
  2. Integrated teams
  3. General practice resilience
  4. Service reconfiguration
  5. Operational efficiency

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STP Priority 1 - Urgent and emergency care

- Reducing presentations at the LRI campus through:
  - Implementing a Clinical Navigation Hub linked to NHS 111 and 999, providing enhanced clinical triage and navigation to larger numbers of patients and incorporating a professional advice line
  - Integration of Urgent Care services in the community, simplifying the number of different, overlapping services and access points and developing a model based on tiers of care. The new model will include ‘day time’ access through urgent care centres / hubs and ‘night-time’ out of hours face to face contact at Loughborough UCC and LRI
  - Integration of OOH home visiting and acute/crisis visiting services 24/7
- Improving the LRI front door and internal flow within ED, linked to the new ED floor opening next year and incorporating streaming and urgent care minors and eye emergencies
- Improving discharge processes to reduce length of stay and bring forward earlier in the day

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STP Priority 2 - Integrated teams

- Supporting targeted risk stratified cohort of patients:
  - Over 18's with 5 or more chronic conditions
  - Adults with a 'frailty' marker (regardless of age)
  - Adults whose secondary care costs are predicted to be 3+ times the average over next 12 months
- Through integrated place based teams (general practice, Federations, social care, community services & acute specialists) focused on:
  - Prevention and self management
  - Accessible unscheduled primary and community care
  - Extended primary and community teams
  - Securing specialist support in non acute settings

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STP Priority 3 - Ensuring resilient general practice

- Workforce – supply, development and skill mix
- Service model to enable GPs to spend more time with complex patients who require expertise and continuity
- At scale / federated working to drive efficiency and more networked local service provision
- IT systems and use of technology
- Improving estate (condition and capacity)
- Contractual funding arrangements (equity and alignment of incentives)

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STP Priority 4 - Service reconfiguration

- Proposals driven by clinical quality, sustainability and condition/use of estate
- Most proposals already in public domain through BCT/UHL 5-Year Plan
- Move acute hospital services onto two sites (LRI & Glenfield)
- Consolidate maternity services at LRI
- Smaller overall reduction in acute hospital beds than originally planned
- Reduce number of community hospital sites with inpatient wards from 8-6
- But invest in expanding capacity (refurb/extension) on some retained sites
- Move Hinckley day case & diagnostic services from Mount Road to Sunnyside/Health Centre
- Detailed proposals being developed for community services in Hinckley, Oakham & Lutterworth
- Changes subject to securing significant external capital investment (£400m+)
- And no decisions taken until after formal public consultation (anticipated start early 2017)

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STP Priority 5 - Reducing operating costs

Doing things more efficiently through:

- Back office efficiencies / collaboration (NHS/public sector)
- Medicines optimisation (reviews, cost and waste)
- Provider system/process efficiencies (reducing delay/duplication)
- Delivering elective treatment through most efficient model (outpatient procedures, day case, inpatient) and lowest cost setting (including Alliance community and primary delivery)
- Estate utilisation (across wider public sector)

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Strengthening implementation

- Review of BCT governance arrangements underway:
  - Simplify and mainstream ownership (Boards/HWBs)
  - Increase senior clinical leadership and public visibility
  - New joint exec/clinical System Leadership Team (commissioner and provider with delegated authority)
  - Greater stakeholder transparency (public meetings and Qly Forum)
  - Multi-agency implementation teams to deliver priorities with strong patient involvement
- Evolve BCT Programme Management Office function and resource
- Release individuals from across partner organisations to drive key pieces of work over next 12 months
- Investment in leadership, organisational development and building teams
- Arrangements in place swiftly from November 2016

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Next steps

- Re-submission of our STP by end of October
- New governance and delivery arrangements in place from November
- Translate into 2 year Operational Plans
- And provider contracts aligned by end December
- Anticipate NHSE approval to initiate formal public consultation on some elements in early 2017

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UHL Reconfiguration Programme Board - Trust Board September 2016

Risk log

Top 10 risks across all workstreams

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