UHL Reconfiguration – update

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Trust Board paper G

Executive Summary

Context

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

This paper provides the monthly update on Reconfiguration to the Trust Board, employing the Level 1 dashboard to show an overview of the programme status and key risks, with accompanying focus on one workstream each month. This month, the focus is the Children's business case project (appendix three) which is currently concluding activity and model of care work (with commissioners), has completed an architectural design brief and undertaken the tender process for the design team. The appointment will be made when capital funding is available.

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 decision required by the programme between June 2016 and September 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?
2. Is there any specific feedback/suggestions in relation to the Children's Hospital business case project?

Conclusion

1. 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.
2. The report provides a summary of key activities and issues which the programme and/or workstreams are currently working through. This month there are a number of key factors the programme team are working to revise to enable an updated programme plan to be developed by September 16.
3. This summary follows submission of highlight reports from all UHL reconfiguration workstreams in June 2016 and the outcomes of discussions at Reconfiguration Board on 29th June 16.
3. The workstream update looks Children's business case beds project (appendix three); where it is up-to in design, next steps and key risks and issues.

Input Sought

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

For Reference

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

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

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

Organisational Risk Register /Not applicable]
Board Assurance Framework [Yes]

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

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

Scheduled date for the **next paper** on this topic: 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 29 June 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 the Executive Strategy Board); 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 Integrated Finance, Performance and Investment Committee (IFPIC). 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 the Leicester, Leicestershire and Rutland Sustainability Transformation Plan).

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 (MOC) where a revised scope and milestone plan will be discussed at the August Executive Strategy Board (ESB) (due to links to on-going programme resourcing work). Leicester General Hospital (LGH) Rationalisation where the Better Care Together (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 percentage 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 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 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. These include: beds, theatres, diagnostics and long-term ICU.

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 three UHL reconfiguration programme risks (>20) to delivery this month remain as:

   Risk: 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 109 beds worth of demand management where the BCT SOC assumed this would occur, which has significant impact on delivery of overall plan.

   Mitigation: Demand management will need to be reconsidered. Vehicles for delivery are UHL's MOC strategy, BCT workstreams and the Vanguard MOC. More focus needed on reducing patients admitted four times or more and on readmissions as well. This is being reviewed pan-LLR through the BCT programme.

   Action: To review internal impact and actions following conclusion of BCT programme demand and capacity review/ STP / NHS England assurance panel response (end June 16).

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

   Mitigation: Limited capital available until end of June 2016 at earliest (likely to be later - update expected in July). Unclear on implications for 2016/17 as yet; re-phasing plan is on-going. Capital plan D has been developed to re-phase development of Outline Business Case (OBC) and Full Business Case (FBCs). Options for alternative options of funding are being reviewed.

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

   Risk: Consultation timelines significantly impact on 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.

   Mitigation: Updated assumptions across BCT plan to be agreed in June 2016 for ICS and other out of hospital beds, then plans to address identified capacity gap will be developed. Role of BCT SROs and programme/ project boards to be refreshed. 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. Glenfield beds being progressed by Reconfiguration Programme and CSI requirements at CMG by CMG.

   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. 4 Project manager roles and a Head of PMO role are currently out to advert and a full update will be provided next month.

10. 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 phasing of the programme and develop an overarching programme plan.

11. The key programme aspects being reviewed include:

- **Programme resource**: recognising that the Trust is currently spending significant volumes on improvement across the organisation the programme is testing to ensure that the right resource are in the right place to ensure effective delivery of organisational priorities. This review is being led by Paul Traynor and Mark, with proposals currently being reviewed by the Executive team, and will report to July ESB.
- **Workstream and programme structure**: many of the workstreams (apart from the major capital business cases) don't have clear objectives or deliverables. The review described above will also propose a revised structure e.g. number of workstreams, membership and governance structure. This review will be undertaken following on from the resourcing review described above.
- **Programme planning assumptions**: The BCT programme, as required for the Trust's STP, are currently refreshing the demand and capacity assumptions (focussing on inpatient beds) from the original Strategic Outline Cases (SOC). This work will review and update the delivery potential of all proposed initiatives (demand management, internal efficiencies and left shift). The updated assumptions need to be agreed by BCT programme and submitted to NHS England by 30th June. The accountability and delivery arrangements also need to be updated and reflected in the Reconfiguration and BCT / Programme structures.
- **Programme end-state (e.g. number of beds, theatres required):** changes to the planning assumptions will change the end-state in terms of how and where services are configured. As the planning work is concluding, it is looking likely that the STP submission will reflect an overall end-state similar in size to the 2014 SOC, however how, when and where these beds will be released from may change. The programme continues to plan for a 2-site configuration however alternative options may be considered if they still bring the system to balance within a 5-year period. A review of available options and their impact on capital and revenue positions is being undertaken to report by mid-July.
- **Sequencing of required moves**: once the end state is known, 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. Once the end-state and phasing is known this will be mapped

against the estate requirements to enable the estates strategy to be refreshed. Phase 1 of this refresh has been completed on a set of worst-case scenario bed numbers, which will be updated to reflect the STP submission. Then when there is confidence in the end-state configuration, the detailed planning for phase 2 will be undertaken.

- **Availability of funding:** funding for 16/17 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 16/17. The plan then assumes funding is available at the desired rate to complete the programme within 5 years (aligned to STP). An update on capital availability is now expected in July 16 rather than June 16.
- **Funding routes:** the Trust is working with external partners e.g. Private Funding Unit and Deloittes) to explore alternate funding arrangements. Any divergence from the assumed central funding will impact on the overall cost of the programme but may accelerate delivery of some key aspects.

12. Clarity or preferred direction / updated assumptions for each of these areas are required to update the phasing of the programme and develop the underpinning programme plan. A workshop for all workstream leads had been planned for July 16 to consolidate all this work and develop the plan. However it is not expected that all the issues will have been resolved by this point, and therefore this session will now be utilised for a clinical dialogue on configuration options.

13. Development of the updated plan is important to put the right structure and discipline in to the programme to enable visibility, monitoring and ultimately benefits realisation. Therefore a revised programme plan will be developed in July by the programme team and tested with broader stakeholders at an event in the autumn (when there is greater clarity on direction and capital availability).

14. 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.

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 August ESB and in use as a monitoring tool from September 16. In advance of this plan being available there are a number of key decisions that will be required, these are summarised below:

Workstream / Project	Decision	Target deadline	Current deadline
Programme	Sign-off updated programme governance structure including any changes to workstreams / meetings.	June ESB	August ESB (completed following resource review)
Emergency floor	Sign-off revised activity and workforce – change control from FBC	June ESB	September ESB (work more complex and on-going)

Workstream / Project	Decision	Target deadline	Current deadline
Clinical Service s Strategy	Sign-off of scope and deliverables for Model of Care (or associated) workstream(s).	June ESB	August ESB (completed following resource review)
Programme	Sign-off updated BCT bed bridge and impact on UHL capacity planning / reconfiguration programme.	July ESB	July ESB – for information as STP submission will have taken place.
Beds	Sign-off scope of Reconfiguration beds workstream	July ESB	September ESB (to be done following STP submission)
Programme	Agree capital assumptions for yrs2-5 to enable plan to be developed	July ESB	July ESB – update on approach
Programme	Sign-off updated capital plan / estates strategy for revised programme	July ESB	TBC – no confirmation received
ICU/ Beds	Decision on preferred option for Glenfield capacity creation	July ESB (subject to capital)	September ESB (linked to STP / beds programme)
Theatres	Sign-off of PID	July ESB	August ESB – due to attendance of SRO (approved at Reconfiguration Board)
Vascular	Decision to proceed with moves without ICU move (and required revenue implications).	July ESB	August ESB (work complex and on-going)
Emergency floor	Approve IM&T (EPR) plan b recommendation	July ESB (subject to capital)	Signed off at June ESB
Emergency floor	Approve OD, comms and engagement plan	August ESB	Not required at ESB
Estates	Outcome and implications of Infrastructure review and business case	August ESB	On-track
Programme	Proposal for interim use of LGH / options appraisal	September ESB	Brought forward to August ESB
Clinical support services	Sign-off scope of Reconfiguration clinical support services requirements e.g. diagnostics / therapies projects.	September ESB	On-track
Corporate services	Sign-off scope of Reconfiguration corporate working requirements	September ESB	On-track

Workstream update: Children's Hospital Business Case project:

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

17. This month the update is on the Children's Hospital business case project, as a further update was requested by Trust Board 3-months from the last update (April 16). The project is currently concluding activity and model of care work (with commissioners), has completed an architectural design brief and undertaken the tender process for the design team. The appointment will be made when capital funding is available. The full update is provided in a separate paper (appendix three)

Recommendation

18. 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.

Workstream progress report - May 2016

	Workstream	Executive Lead	Operational Lead	Objectives	On track against delivery (RAG)*	Complete (%) against in year plan**	Brief update on status
1	Clinical 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. Use of gateway review, Kings Fund LLR event, and clinical engagement used to present update paper to ESB on future of workstream.Revised workstream objectives and milestone plan to May Reconfiguration Board for approval. Proposla includes closer working with BCT, optimisisng existing structures and calrity on speciality requirements.
2a	Future Operating Model - Beds (internal)	Richard Mitchell	Simon Barton	To deliver bed reductions through internal efficiencies and achieve a 212 total reduction by 18/19 with a footprint capacity requirement by specialty	Amber	25%	Supported CMGs (RRCV & ESM) to develop and implement detailed 16/17 LoS improvement action plans. Devised and launched ward level performance reports. Continued to support ALOS reduction plan in Cath labs. Agreed mechanism to record inappropriate referrals and refusalus to ICS. Presented the board round diagnostic for ESM to highlight areas of discrepancies from standards. Next month will broaden circulation of ward level summary report, update bed dashvboard and update on UHL 3 W project (findings from pilot and next steps).
2b	Future Operating Model- Beds (out of hospital)	Richard Mitchell	Sue Tancock	To increase community provision to enable out of hospital care and reduce acute activity by 250 beds worth	Amber	17%	Service data has not been received from LPT to formally report on ICS service utilisation, however operationally it is known beds have ben available this month. Therefore work to optimise the ICS service needs to continue. A new UHL ICS lead will be identified by early July, following departure of Phil Wlamsley. Remit of workstream to be reviewed following finalisation of STP and updtaed requirement and model for out of hospital 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	25%	Sign-off of activity between ITAPS and CMGs to realign sessions between areas of surplus and deficit. Formal handaover from EY to UHL theatres programme team. 3/9 specialities have identified shifts from GA to LA including 4 potential clean room sessions. 13/15 CIP schemes have detailed action plans - remaining 2 escalated to programme board. Next month will delievr an implementation plan for all day operating at LGH, a plan to reduce cancellation in Orthopaedics and identify space for remaining 6 specialities shifting activity to GA.
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	Green	25%	Continued validation of of BSU and DNA report to improve accuracy. Work with underperforming specialities continues. Haematology identified as pilot for clinic template review to improve clinic utilisation and patinet experience. Prospective DNA report in development and DNA text reminders revised. Next month will finalise roll-out of prospective DNA report. Jpob planning support to Respiratory and Genral Suregery and impact on Outpatients and Orthopaedic clinic template standardisation to begin.
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	25%	Engagement wiyh GP loaclitys to share curernt inititives and opportunities to improve pathways / reduce unnecessary pathways. Ultrasound shoulder guidance in development with GPs and orthopaedics. Nex pathways include MRI Spine, Ultarsound Abdominal and Ultrasound Neck. ESAC clinic audit showed 83% of scanned patients mnaged without admission - hot clinic with direct access to ultrasound.
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	25%	Better Care Together workforce assumptions being revisited as part of STP submission. UHL contributing to completion of plan for joint solution by 30.06. Further input into Emergency Floor Workforce Plan to reflect remodelled urgent care workstream and increased activity. Undertook second Women's Hospital Workforce Profiling workshop focussed on planned and unplanned pathways in regards to Maternity assessment. Initiated development of The Childrens Hospital final activity and acuity updates across wards and outpatients. 5. Agreed interdependencies and the impact of Vascular and ITU move on junior, middle and theatre Medical rotas.
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	25%	**Emergency Floor** - phase 1 construction continues, activity model and impact on workforce being refreshed, IM&T plan B agreed and delivery plans to be developed.
					Amber		**Interim ICU -** Awaiting ITFF / internal capital availability. Plan updtaed to reflect need to create additional capacity, plan for service moves now January 18. Team have undertaken clinical risk review to ensure safe to manage service for this period.
					Amber		**Vascular -** Construction continues, . Operational commissioning group reconvened - planning for February 17 move (subject to solution to move without ICU being agreed)
					Green		**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.
					Amber		**Women's** - Model of care, activity and operational policy work continues. Delays due to consultation and capital funding.
					Amber		**PACH** - Activity modelling and model of care continues. Increased clinical engagement in core specialities, revised working relationship with the Alliance. Delays continue due to capital and 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	Green	25%	Phase 1 of estates strategy refresh completed on worst case bed scenario and presented to Reconfiguration board. This process to be aligned to STP processes and numbers. Updated existing site wide infrastructure report received, this needs to be reviewed and converted to action plan / business case scope. LRI medical gas report complete and passed to Capita.
6	IM&T	John Clarke	Elizabeth Simons	To enact the IM&T strategy and have a modern and fit for purpose infrastructure which supports the 2 acute site model and community provision strategy	Amber	17%	EPR - Developing plan in response to HSCIC gateway review and responded to NHSI questions on costs to sustain legacy, clinical impact and CRL profile. ED Floor - Business Case (Plan B) presented to CMIC and approved by ESB. Next month an action plan / PIDs for implementation to be developed.
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 (Plan D) and how any capital funding will be used post June. July availability assumptions in year to be updated.
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	25%	Development of EF comms plan in line with OD plan, latest issue of Blueprint issued and narrative developed for ICU timeline delay and clinical risk. Next month implementation of EF comms plan and meeting with colleagues from children's project on patient and public engagement over new hospital proposals.
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	25%	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. Once BCT revised bed numbers / STP has been signed-off this group will hold SROs accountable to delivery and ensure UHL contribution to workstreams is effective.

Note: The RAG and % complete is based on workstream lead evaluation and detail provided in highlight 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	25	PT	Demand management will need to be reconsidered. Vehicles for delivery are UHL's MOC strategy, BCT workstreams and the Vanguard MOC. More focus needed on reducing patients admitted four times or more and on readmissions as well. This is being reviewed pan-LLR through the BCT programme. **ACTION**: To review internal actions following conclusion of BCT programme demand and capacity review / NHS England assurance panel response (completed 30th June 2016).	16	Jul-16	Paul Traynor	29-Jun-16	
2	Overall programme	Capital funding not guaranteed for the estimated £330m, and will affect 3 to 2 site strategy if not secured. National capital availability at risk and impact known for 15/16 but not yet for future years.	4	5	20	20	PT	Limited capital available until end of June 2016 at earliest (likely to be later - update expected in July). Unclear on implications for 2016/17 as yet; re-phasing plan is ongoing. Capital plan D has been developed to re-phase development of OBC and FBCs . Options for alternative options of funding are being reviewed.	20	Jul-16	Paul Traynor	29-Jun-16	
3	Level three ICU	Risk of non- delivery of out of hospital beds capacity could jeopardise ability to provide additional bed base at Glenfield, which is required to relocate HPB.	4	5	20	20	CG	Updated assumptions across BCT plan to be agreed in June 16 for ICS and other out of hospital beds, then plans to address identified capacity gap will be developed. Role of BCT SROs and programme/ project boards to be refreshed. 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. Glenfield beds being progressed by Reconfiguration Programme, CSI requirements at CMG being lead by CMG.	12	Aug-16	Richard Mitchell	29-Jun-16	
4	Capital reconfiguration business case: Emergency floor	There is a risk that the transition plan and the inability to release the entire space for phase 2 construction will generate a movement away from construction phasing as agreed in FBC and add costs and delays to completion.	4	4	20	20	JE	Services that must be maintained to be identified. Decant plan established. Options for phasing and time and costs to be developed and agreed as part of GMP process. Option appraisal to be developed across Reconfiguration and Operations as to how to utilise space in this period.	12	Aug-16	Paul Traynor	29-Jun-16	
5	Capital reconfiguration business case: Emergency floor	There is a risk that the scale of cultural changes required to deliver new models of care and workforce requirements will not be delivered in time for the commissioning of Phase 1 resulting in historical ways of working being transferred to new ED.	4	4	20	20	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	Aug-16	Louise Tibbert	29-Jun-16	
6	Overall programme	Consultation timelines significantly impact on business case timelines, and ability to achieve 19/20 target for moving off the General site. Particular impact on PACH and women's projects.	4	4	16	16	RP	Impact of consultation incorporated into refreshed business case timeline. Business cases continue to progress as per plan. Consultation now delayed until after the June EU referendum and work continues with the NHS England Assurance Panel (through STP process); change control process enacted for capital projects affected. Expected to be Autumn at earliest now.	16	Sep-16	Mark Wightman	29-Jun-16	
7	Overall programme	Ongoing transitional funding required to deliver programme beyond 15/16 will need to be secured to ensure ongoing delivery. In year resource requirements identified and on track but future years at risk in connection with limited capital.	4	4	16	16	PG	Minimum Reconfiguration resource requirements identified through Capital Plan 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.	12	Jul-16	Paul Traynor	29-Jun-16	
8	Out of hospital beds	UHL not fully utilising available capacity through the opening of ICS beds.	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	
9	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	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	29-Jun-16	
10	Overall programme	Operational delivery/pressures may be negatively impacted by requirements of reconfiguration i.e., operational resource/input, space.	3	5	12	15	RM	Gateway review actions identify need for CMGs and operations to work differently going forward. Actions are all being addressed including review of structures and relationships. Specific issues within workstreams (e.g. EF) have been escalated and alternate roles / structures implemented.	9	Aug-16	Paul Traynor	29-Jun-16	
11	Workforce reconfiguration	Culture of organisation needs to embrace reconfiguration and recognise need to do things differently. This has not been addressed previously and OD programme not yet in place.	3	4	12	12	PT	Director of HR and Workforce reconfiguration sits on programme board and is developing a proposal for Trust wide OD. Draft plans aligned to all business cases being developed, and will align with UHL way (launch 3/12). OD resource for business cases being secured.	9	Oct-16	Louise Tibbert	29-Jun-16	