# 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.

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, Workstream. 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 monthly update on Reconfiguration to the Trust Board, employing the Level one 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 on the Children's Hospital project, which is part of the major capital business case workstream.

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 reconfiguration business case?

### 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 March 2016. Please note there was no programme board in March due to lack of availability of key personnel.
3. The workstream update looks at the Children's Hospital Project in more detail, which continues to make progress in the development of the Outline Business Case. The Project Team are currently putting a particular focus on the challenge and development of models of care and clinical operational policies to ensure an innovative and efficient scheme is delivered, which best serves the needs of the children and families who come into the care of Leicester Children's Hospital.

## 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

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|---|---|
| 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 24 February. Any issues identified at this meeting, not covered in this update paper, will be provided verbally by the Reconfiguration Director at the Trust Board meeting.

2. The programme is currently working to the re-phased capital plan (agreed as best case scenario January 2016 ESB); which added 12 months to the final delivery date for completion of the programme. However it is recognised that further re-phasing will be required once there is more clarity regarding; capital availability for 2016/17, activity plans for 2016/17 are agreed with commissioners, and timeframes for the Better Care Together consultation are known. The Trust has updated the capital plan in the last month due to most likely scenarios but due to the number of variables (set out above) and the need to align 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 June 2016.

**Governance update**

3. The dashboard at a glance highlights 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 material. The only red indicator is the Model of Care workstream and that is due to the scope and plan for the workstream being updated to reflect organisational needs. The RAG is based on progress against delivery, and the % complete gives an indication of overall progress against in year plan, based on the workstream view of progress against individual project milestones.

4. 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.

5. 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).

6. The agreed SRO changes since the last update are:
   - Richard Mitchell – Beds (LRI & Glenfield Hospital) – New project
   - Louise Tibbert – Theatres (LRI & Glenfield Hospital) – New project
   - Catherine Free – Emergency Floor – taking over from Andrew Furlong
   - Matt Metcalfe – Planned Ambulatory Care Hub (PACH) – taking over from Andrew Furlong
   - Debra Mitchell - ICU & Vascular – taking over ICU from Helen Seth

7. In follow-up to Gateway review and agreed actions and alignment with 2016/17 capacity planning a planning workshop was held on 18th March. Follow-up actions from this are being undertaken which may impact on the scope, timing and costs of the reconfiguration programme. This work will report to clinical senate in May 2016. A further workshop is being considered to extend this process beyond 2016/17.

**Programme risks**

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

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

**Mitigation:** Demand management will need to be reconsidered. Vehicles for delivery are UHL's MOC strategy and the Vanguard MOC. More focus needed on reducing patients admitted four times or more and on readmissions as well.

Action required: For noting

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

**Mitigation:** Limited capital available until end of March 2016. Unclear on implications for 2016/17 as yet; re-phasing plan is on-going whilst the Trust remains in dialogue regarding the high priority schemes included in the capital plan as requiring external funding. OBC and FBCs continue to be implemented as per original plans. Options for alternative sources of funding are being reviewed.

Action required: For noting

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

**Mitigation:** Impact of consultation incorporated into refreshed business case timeline. Business cases continue to progress as per plan. Consultation now delayed to late Spring 2016; change control process enacted for capital projects, all reviewed at reconfiguration board.

Action required: For noting

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

**Workstream update: Children's Hospital**

10. 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.

11. This month, the focus is on providing an update to the Trust Board on the Children's Hospital capital reconfiguration business case.

Scope

12. The UHL Five Year Strategy articulates a vision for Children's acute services in Leicester, Leicestershire and Rutland which brings together all services into one defined location, to maximise clinical adjacencies and efficiencies and create an identity for Leicester Children's Hospital.

13. The scope of the Children's Hospital project is:-
    - The relocation of paediatric East Midlands Congenital Heart Centre (EMCHC) and orthodontic services from the Glenfield Hospital to the Leicester Royal Infirmary
    - To consolidate all Children's services into one area of the Leicester Royal Infirmary site, creating a defined Children's Hospital
    - To create an identity for the Leicester Children's Hospital, ensuring it best serves the needs of the children and families who come into its care
    - To maximise clinical adjacencies and efficiencies through the delivery of the project.

Project Objectives

14. The following objectives are outlined in the Project Initiation Document and were agreed by the Project Board:
    - To provide safe, high quality care for children and their families through new models of care, which reflect best practice and improve outcomes and experience.
    - The creation of a child-centred hospital with a focus on age-appropriate facilities to improve the environment and experience of the Leicester Children's Hospital, for patients, families and visitors.
    - The delivery of clinical, operational, workforce and estates solutions for children's services across LLR.
    - To protect the long-term future of EMCHC by co-locating paediatric cardiac services with all other paediatric services to meet national standards and requirements.
    - To establish Leicester Children's Hospital as both a physical entity and a brand within its own right, attracting an international reputation reflecting high-quality, responsive services.
    - Deliver an Estates solution which will facilitate the modernisation of services, prioritising the co-location of specialist services, diagnostics and support services wherever possible to ensure an efficient model of care and improved clinical adjacencies, resulting in operational savings, improved clinical safety and an enhanced patient experience.
    - Provide capital and operational solutions which are based on robust activity modelling, to support the development of secondary, tertiary and quaternary paediatric services within the context of affordability, appropriately staffed to meet service needs.
    - To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards.
    - To provide a solution that is aligned to the Trust's Estate Strategy identified in its Development Control Plan (DCP) and allows for future development of the service and site.
    - Develop a strategy to involve charitable fundraising to supplement the available NHS capital.
    - To ensure that the Children's Hospital solution aligns to the work of the Better Care Together (BCT) programme in the development of models of care and in its engagement with public and key stakeholders.
    - To equip the service to respond effectively to existing and known commissioning requirements, as well as changes in future service direction and demand.

- Deliver to the agreed timescale and budget with minimal disruption to the current delivery of the service.

Progress to date

15. A formal project structure is established and the project is directed by a Project Board. Mark Wightman is the Senior Responsible Officer (SRO) for this project.
    - The Project Initiation Document (PID) was completed and signed off by IFPIC in October 2015.
    - Models of Care/Patient Pathways have been completed for all paediatric services, outlining patient pathways through hospital and the way that services will work.
    - Meetings have been carried out with all 44 clinical specialties, sub-specialties, diagnostic and support services, to identify their future requirements, and confirm and challenge their service provision to ensure efficient models.
    - The Models of Care and outcome of the clinical meetings have helped to inform the Clinical Operational Policy. This describes how clinical services will work in the future. There is currently a piece of work underway which is challenging the agreed models of care and ways of working, to ensure maximum efficiencies are achieved through transformation in order to deliver the required CIP.
    - Activity data has been provided by the Trust's Business Intelligence Specialists, and has been modelled to provide 20 year projections (as required by an NTDA Business Case). This is being reviewed, with help from Public Health partners.
    - The Clinical Operational Policy, Models of Care and Activity Projections inform the Design Brief, a document which describes how we want to work in the future, informs the technical brief which includes the Schedules of Accommodation. This document is used by the design team to create the design solution.

The Options Appraisal Process

16. An options appraisal process was undertaken to identify the short list of options.
    - The first phase of the options appraisal process was the identification of benefit criteria (key advantages arising from the successful completion of the project). These were then weighted by the Children's Hospital Project Team as not all benefits are of equal importance. The weighted benefit criteria were then signed off by the Project Board.
    - The Estates team developed a 'Long List' of 14 possible locations for the Children's Hospital. This long list was then signed off by the Project Board.
    - On the 8th January, the 'Long to Short List Options Appraisal' was carried out by the Children's Hospital Project Board. Each of the 14 options were individually appraised and scored, and the top five options then created the 'Short List'.
    - A Feasibility Review of the 'Short List' was carried out by the Reconfiguration Projects Director, Major Projects Technical Director and the Head of Financial Performance and Planning to ensure that money was not needlessly spent on design work of a financially unaffordable option. This produced a 'Short List' of four options.
    - The 'Short List' of Options are as follows:
        - New build on the site of the Knighton Street Offices – no detailed design will be carried out, it will be costed on a price per $m^2$ basis
        - Refurbishment of Balmoral Wards with an entrance atrium
        - Refurbishment of Balmoral Wards
        - Do minimum (relocation of paediatric EMCHC and support services from the Glenfield Hospital to the LRI)

Key Risks and Issues

17. There are a number of key challenges that face the Children's Hospital Project, including:

- The design team is due to be appointed at the beginning of April to start working on plans for the short list of options; this will be dependent upon the availability of capital in 2016/17.
- Further challenge regarding the proposed models of care is required to ensure true transformation and efficiencies. This would benefit from Organisational Development input to help articulate the 'art of the possible' for the future.
- Closer working with LPT is required to design and deliver models of care and movement of work out of the acute setting (into the community) wherever possible
- Interdependencies with other capital projects including:-
  - The future bed complement by specialty at the LRI is required to inform where displaced adult wards could be appropriately located;
  - The Theatres Project needs to deliver paediatric theatres at the LRI site in order to move the paediatric EMCHC service. This will require a theatre of increased size to those currently in place to house the large cardiac operating equipment;
  - The Diagnostics workstream needs to deliver a cardiac-enabled MRI scanner on the LRI site to enable the transfer of the paediatric EMCHC service from the Glenfield Hospital.
- Design for the clinically preferred option may exceed available capital budget
- It is expected that a charitable appeal will provide a significant contribution.

Next Steps and milestones

18. The next steps and milestones are as follows:
    - Continue to engage with all clinical teams to ensure that the Models of Care, Clinical Operational Policy and Design Brief are thorough and robust to enable the best design solution, in terms of clinical safety, wellbeing of patients and their families, and efficiencies and transformation for the future.
    - Appoint the design team to progress the short list of options.
    - Continue the options appraisal process to reach the preferred option.
    - Continue to develop the Outline Business Case.
    - Completion of the Outline Business Case by August 2016, and Full Business Case by February 2017.
    - The relocation of the paediatric EMCHC is the first phase of project delivery, which is due in 2018 in line with national co-location requirements.

**Recommendation**

19. 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.

## 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** | EMS | 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 4 times or more and on readmissions as well. Escalation re demand management through BCT Delivery Board. **ACTION**: Need response from BCT re next steps. | **16** | Jan-16 | Paul Traynor | 21-Dec-15 | |
| 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, has been modelled and timelines for delivery being rephased. Scenarios for future years discussed at ESB in January. Options for alternative sources of funding are being reviewed. Delivery of ICU and vascular business cases delayed until April 2016. | **20** | N/A | Paul Traynor | 21-Dec-15 | |
| 3 | 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 | Discussions with BCT programme lead on consultation timelines and process, and seeking legal advice on options moving forward. Consultation now delayed to Spring 2016; change control process enacted for capital projects, all reviewed at reconfiguration board in December and approved; potential delay of between 4-6 months. | **12** | Feb-16 | Mark Wightman | 26-Nov-15 | |
| 4 | 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. | **12** | Feb-16 | Simon Barton | 24-Sep-15 | |
| 5 | 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 | There is a 'change team' now in place at Glenfield to develop new models of care; work underway includes a combination of Out of Hospital shift, internal efficiencies and exploration of out reach provisions. Feasibility study into additional ward space also being carried out. | **12** | Feb-16 | Debra Mitchell | 26-Nov-15 | |
| 6 | Capital reconfiguration business case: Emergency floor | EPR will not be available ahead of ED build which impacts on required space estimated within business case, and therefore has cost implications. | 4 | 4 | **16** | **16** | John Clarke | Monitoring plan with NTDA. Ensure timely responses to TDA and DH. John Clarke developing plan B to support ED paperless environment, update due in January. | **12** | Overdue | John Clarke | 22-Dec-15 | |
| 7 | Out of hospital beds | UHL not fully utilising available capacity through the opening of ICS beds (now 32). | 3 | 4 | **12** | **20** | HS | Dashboard created to monitor utilisation of increased capacity. Oversight group in place to oversee usage. Comms plan in place to raise awareness of service. Utilisation currently at 90.1%. | **9** | Feb-16 | Richard Mitchell | 15-Dec-15 | |
| 8 | 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** | EW | Feasibility study on additional ward space at Glenfield being carried out; clinical change team in place at GH reviewing patients suitable to be looked after in the community; additional ICS beds open. | **9** | Jan-16 | Paul Traynor | 15-Dec-15 | |
| 9 | 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** | **15** | KS | 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 | |
| 10 | 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. | 3 | 4 | **12** | **15** | EW | Resource requirements identified and process for internal management (ahead of external approval) agreed with central tracking in place. Monthly updates to programme board on costs committed. Resource requirements will be reprofiled once rephasing of capital plan finalised. | **9** | Jan-16 | Paul Gowdridge | 28-Oct-15 | |

# Workstream progress report - April 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** | 40% | Workstream currently reviewing next steps to ensure supporting reconfiguartion effectively. This will involve deevelopment of updated programme plan and milestones but will have impact on scope of worksteram (focussing on priority services) resources and processes requierd to deliver. |
| 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** | 70% | Supported delivery for 15/16 and development of 16/17 bed reduction plans for some CMGs. Validated LoS variation tool for CHUGGS. Four specialties identified to further deep-dive. Prepared initial output of bed right sizing model to set-up baseline and specialty grouping for managing outliers within joint bed base defined. Capacity and demand analysis done by Information team to estimate 16/17 bed capacity. |
| 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** | 80% | 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 for ICS beds as capacity in the service is increased. Work has been inititated to test and refine referral processes and to actively promote and educate staff and stakeholders on the scope and service model. Work has been undertaken with clinical leads to identify likely cohorts of patients to deliver Phase 2 objectives (community bedded capacity). Likely cohorts include patients with falls, deliruim, patients with long term conditions in respiratory/cardiology and exploring electivpossible opportunities. Further amnalysisi is being undertaken to understand ICS beds impact on patient outcomes and UHL OBDs / LoS. |
| 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** | 60% | Capacity and demand planning completed for 16/17 which shows that, depending on activity plan finalisation with commissioners, currently the trust has a 1272 capacity pressure for 16/17 due to high levels of growth Analysis completed to show how much of the above level of sessions required can be mitigated (rated by ease of deliverability) by 550 sessions. 12/15 CIP schemes on 16/17 PMTT have detailed action plans. Handover has commenced to permanent PMO resource that will takeover theatres crosscutting workstream. |
| 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** | 80% | Supported delivery for 15/16 and development of 16/17 bed efficiency action plans and presented to Programme Board for ESM, RRCV, MSS and CHUGGS. Refreshed bed right sizing analysis with latest (Apr'14-Dec'15) data and presented findings to the SRO and bed programme membership, including recommendations on the need for seasonally flexible capacity. Reinstated base ward group to set-up targets for achieving LoS improvements in base wards to deliver CIP and improve flow into ICS. |
| 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 | **N/A** | 60% | Launch clinical variation and pathway redesign plans with City CCG GPs at PLT event. Pilot imaging referral clinical variation packs with Respiratory and Breast Surgery. Testing of the Imaging referral dashboard. Facility refurbishment to enable hot clinic imaging service to be implemented in SAU.Audit of the NEDDI pathway, to identify impact on reducing LoS and potential to roll-out to other areas. Exploration of how CSI can support emergency pathways at Glenfield is required. |
| 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** | 70% | Two planned ambulatory care hub (PACH) planning launches including workforce development highlighting the support available for the development of new roles and review of skill mixes through workforce profiling. Women's Hospital Workforce Group has agreed to adopt Workforce Profiling techniques. Out of hospital workforce group undertaking evaluation of ICS service and impact via staff who have rotated into model of care. BCT workforce planning inaugural meeting has taken place to ensure a consistent and shared approach to LLR wide planning. |
| 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**<br>**Amber**<br>**Amber**<br>**Green**<br>**Amber**<br>**Amber** | 70% | **Emergency Floor** - phase 1 construction continues , some delays to OD plan, EPR plan B, commisiioning plan and approved design solution.<br>**Interim ICU -** Awaiting ITFF / internal capital availability. Operational issues and interdependencies with ICU being worked through.<br>**Vascular -** Awaiting ITFF / internal capital availability**.** Operational issues and interdependencies with ICU being worked through.<br>**Children's -** Planning continues. Discussion with Ronal McDonald House Charity re parents accomodationand completion of charitable donations feasibility.<br>**Women's** - delay to OBC due to BCT consultaion timeframes (minimum 2-month ). Continued challenge to Models of Care to improve efficiency.<br>**PACH** - further clinical launch on 15/03 attendance at both has not been as comprehennsive as hoped. |
| 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** | 70% | Work ongoing to identify utilised space at acute sites with no clinical adjancancies. Speciality road map signed off by CMG Boards and ESB - work to populate this for all sites over 5 years continues. Refresh of estates strategy by April. Space comittee continues to be under-represented and not used as right forum for any space changes, this needs to be further addressed. |
| 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** | 40% | EPR - Updated business cases and financial models reflecting essential replacement and clinical functionality. Submitted to NTDA 10/02/16 for review. Further financial model questions received 10/03/16 to UHL. ; Project manager appointed to look at Plan B for EPR (particularly for emergency floor), ongoing development of requirements. |
| 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. | **Green** | 70% | Continued development of road map for LGH site identifying clarifications adn interdependencies. Review of future state for corporate areas and development of options in progress. Letter received from DOH re Project on Surplus Land - response and surplus land return completed for Board approval. Links established with ITU site based group and opportunities provided by future re-location on level 3 ITU and associated services |
| 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** | N/A | **General**: Network of Know-it-alls briefings continue to be issued and the worksteram continues to support and upate the organisation on the BCT consulation; **Women's** - a newsletter is in development. **Children's** - adedeicayted communications plan has been develoepd. **Programme** - update communications plan for 16/17. |
| 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** | 70% | ICS beds open in line with 16/17 plan, however due to increasing demand at UHL it has not been possible to close acute capacity in response to it opening. Plans for 16/17 LTC, planned care and urgent care being agreed across partners. A rapid cycle test for ambulatory care was undertaken in March at Glenfield CDU. The revised BCT Pre-Consultaion Business Case has been agreed by partner organisation Boards. |

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