Programme Board Report

19th November 2015

The purpose of this report is to provide stakeholders with a summary of the last Programme Board meeting. All final papers considered by the Board are published on the Programme website - **nhsfuturefit.org**.

1 PROGRAMME TIMELINE

At the October Board meeting it had been agreed that the Core Group should set out a new programme timetable which reflected the implications of the decision to defer any conclusion on reaching a preferred option until there is an approvable case for investment.

Since that meeting the Core Group has held a number of discussions, including with representatives of NHS England and NHS Trust Development Authority. Advice has also been received from NHS England's Project Appraisal Unit which supports the national Oversight Group for Service Change and Reconfiguration. These conversations highlight the difficulty in setting a comprehensive timetable to consultation in advance of the Department of Health and HM Treasury confirming the acceptability of the deficit reduction plan. They also note the limited availability of capital funds for which a number of schemes may find themselves competing.

In the light of the advice received, the proposed revised critical path sets out the key pieces of work for the next phase and notes the risks around external approvals which are not within the Programme's control. Subject to those approvals the timeline indicates that:

- Public Engagement activities would continue, focusing initially on the Clinical Model and, especially, Urgent Care services;
- A preferred option would be identified in June 2016;
- Formal Public Consultation would take place from December 2016, and;
- The two CCGs would reach a final decision in June 2017.

The high-level timetable can be found at Appendix One.

2 MANAGING KEY INTERDEPENDENCIES

Key to the development of a plan for the next phase are two critical interdependencies:

a) Developing a deficit reduction plan for the Local Health Economy, and;

b) Completing a revised Strategic Outline Case for acute services which prioritises the most pressing clinical challenges.

An overview of how the programme proposes to manage these independencies was discussed and agreed, and of the scope and timing of these two pieces of work was noted. It was also agreed that a similar approach should be taken in relation to the development of Information Technology dependencies.

3 RURAL URGENT CARE

Following receipt in October of the sub-group's report on rural urgent care, plans have been developed to:

a) Get further clarity on how urban Urgent Care Centres could work and on what support they will require from the wider Health Economy, and;

b) Further explore how best to provide enhanced urgent care services in rural localities.

A separate report provides more detail about these two pieces of work.

In addition, the Workforce workstream is considering the requirements for an urgent care workforce, and the Communication and Engagement workstream has developed a plan for enabling a greater public understanding of urgent care provision.

4 COMMUNITY FIT

The NHS Community Fit programme (formally outside the scope of the Future Fit Programme) is progressing well and remains on track to complete its first phase by end March 2016. This will provide a uniquely valuable and integrated view of out of hospital activity (Third Sector, Mental Health, Primary Care, Social Care and Community Healthcare).

The terms of reference of the NHS Community Fit steering group and a paper setting out the potential broader scope of the overarching programme of work have been submitted to CCG boards for approval and to agree any future phases. It was agreed that CCG Governing Bodies should consider their requirements from future phases of Community Fit.

A separate report set out current progress in more detail.

5 CLINICAL DESIGN

The workstream of key Clinical Leaders is collaborating with the Communications Team to shape plans for communicating with the public about the case for change, the clinical model and the urgent care offer. This includes a document summarising where patients would attend with a variety of conditions – both currently and as a result of Programme proposals. Plans for the ongoing engagement of clinical staff will also be considered.

In addition, the workstream will begin preparations for presenting Programme proposals to the West Midlands Clinical Senate for assurance around the clinical evidence base prior to Public Consultation.

6 IMPACT ASSESSMENT

The next phase of Integrated Impact Assessment (IIA) work will run in parallel with public consultation. Nearer that time, the workstream's plans for the required activity will be finalised (in the light of the exact scope of the proposals to be consulted on). Until that time is reached the activity of this workstream has been paused.

7 WORKFORCE

The October Board meeting reviewed the draft Workforce Case for Change and asked for the scope of the document to be extended beyond hospital staff.

The Workstream has since expanded its membership to reflect the wider health and social care economy, and this larger group has started to take an overview of local challenges faced by all providers. A summary of those challenges is set out in a separate report.

The workstream's other main focus has been the workforce requirements for urgent care centres. Information has been sought both from the pilot UCCs at PRH and RSH and from a range of other UCCs in the region and beyond.

8 ASSURANCE

The Assurance workstream had met in the days before the Board meeting to seek assurance about:

- The proposed new timeline;
- The process for managing interdependencies, and;
- The communications plan for the next phase.

The workstream also review the updated reconfiguration guidance from NHS England - *Planning, Assuring and Delivering Service Change for Patients.* This does not replace the 2013 guidance but seeks to add clarity around assurance processes and decision making levels. It also sets out the requirements for Pre Consultation and Decision Making Business Cases for the first time. Key points include in the guidance include:

a) The planning and development of reconfiguration proposals are rarely linear. The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.

b) There must be clear and early confidence that a proposal satisfies the four tests and is affordable in capital and revenue terms.

c) Proposals affecting services valued under £350m may be determined by the NHSE Regional Director rather than the Chief Financial Officer or Investment Committee.

d) CCGs should assure themselves that those proposals have the support of their member practices.

e) Schemes have struggled to build public support where they have not adequately addressed public concerns that:

- The proposals are perceived to be purely financially driven.
- Patients and their carers will need to make journeys that may reduce access.
- Emergency services will be too far away, putting people at risk.

f) Until approval for the SOC is in place organisations should not incur material costs progressing to the next formal stages of the scheme (OBCs and FBCs).

g) Commissioner decision making involving two or more CCGs can be based on two models – committee in common or joint committees.

9 ENGAGEMENT AND COMMUNICATIONS

Following the Board meeting at the beginning of October, an announcement and a more detailed statement was shared with the public and stakeholders about the necessity of delay whilst a plan is developed to reduce the deficit.

Regular statements and media briefings have continued, a newsletter is being used to provide updates to key stakeholders and a range of engagement events has taken place with Local Joint Committees, Parish Councils, Community Groups, Patient Groups and GP surgeries. A comprehensive engagement programme is also speaking to specific groups, including the homeless, older people and Eastern European workers.

Politicians continue to be updated on a regular basis through MP briefings by the SROs and there are plans to hold further pop-up shops out in the community.

The website has been updated to improve document access. Presentations to workforce groups have been taking place and more are planned in the months ahead.

A summary document containing the Programme's key outputs to date has been published on the website.

The workstream will shortly be finalising plans for the critical next phases of activity before and after the identification of a preferred option. This will involve a significant amount of work both by the Communications team and by key people in sponsor organisations.

10 FINANCE

The Finance workstream met on 5th November. Although the work to develop a deficit reduction plan is outside of the scope of the Programme, the meeting provided an opportunity for discussion of the scope and approach of the work to be undertaken. The need for external support was highlighted.

The Programme is facilitating a meeting of Finance Directors and Chief Officers which will take place in early December to take this work forward. It will involve all local NHS organisations as well as NHS England as the commissioner of specialised services.

It was recognised that the priority is to move towards a sustainable health economy for the long term. Although individual organisations may continue to carry deficits over the intervening period, the focus should be on making progress against the plan as whole health economy.

Any potential impact on social care services, and vice versa, would also be considered.

11 PROGRAMME RISKS

The Risk Register continues to be comprehensively reviewed by the Programme Team each month, and by the Core Group, after which it is published on the Programme website. All workstreams may raise new risks or recommend revision of existing risks at any point.

The Board has previously agreed that all red-rated risks (both pre- and post-mitigation) should be reported to it. These are appended to this summary (see Appendix Two).

There are currently a significant number of risks for which the post-mitigation rating remains above the indicated risk appetite of the Programme. The view of Programme Team is that, whilst the appetite to reduce certain risks further is appropriate, it is also to be expected that a Programme of this scale and complexity will carry a significant degree of risk.

Board agreed that there was a particular risk currently around change in leadership in sponsor organisations, and the register will be reviewed to ensure that this risk is adequately captured and mitigated.

12 PROGRAMME EXECUTION PLAN

An update of the PEP will be produced following agreement by the Board on the scope and timing of the next phase of Programme work.

The schedule of Board meetings will be reviewed as part of this.

13 PROGRAMME MANAGEMENT

At the inception of the Programme, Commissioners sought the support of The Strategy Unit from NHS Midlands and Lancashire Commissioning Support Unit to provide the Programme Management Office. It was expected that this support would run until 2016 after which the later phases of the Programme could be managed locally (though still with access to support from The Strategy Unit).

To avoid undue disruption, a managed transition is proposed which would take place during 2016. First, the responsibilities of Programme Director would be brought in-house by local Commissioners but with other Programme Office functions remaining in place. Then, at a later date, these other functions can also be adjusted to reflect the changing needs of the Programme.

APPENDIX ONE – PROGRAMME TIMELINE

HIGH LEVEL CRITICAL PATH

The following diagram sets out the expected timeline for the next phase of the Programme. This is critically dependent on external approval processes which are beyond the Programme's control and could materially affect the timeline. The critical path also reflects the key assumptions below:

1. Work to produce an adequate deficit reduction plan will be completed by end January 2016 and signed off by all parties by end Feb 2016;
2. A revised Strategic Outline Case for acute facilities will be approved by SaTH by end February 2016;
3. The value of the SOC will remain over £50m. TDA guidance indicates 2 month approval process but no guidance is given for DH/HMT approvals;
4. SOC and PCBC approval are required before consultation;
5. Plans for Urban UCCs will be completed alongside SOC work and space requirements, at least, will be included in SOC;
6. Work on the wider community offer continues in parallel (including rural urgent care solutions and the potential to extend Local Planned Care/develop Health Hubs) and the PCBC will include (at least) any rural urgent care offer;
7. The appraisal of options has to be repeated in the light of new information and the changed scope of proposals;
8. Options B, C1 & C2 each remain under consideration;
9. Phase 2 modelling assumptions/financial implications continue to form the basis of the revised SOC work;
10. Commissioners and SaTH are willing, in principle, to support all of the remaining options , and Commissioners set out, before the option appraisal is revisited, how they will confirm a preferred option and reach a final decision (and what factors will influence those decisions);
11. Work to reach agreement with the Joint HOSC and CHC around any recommendations they may make post-consultation is completed by mid-June2017.

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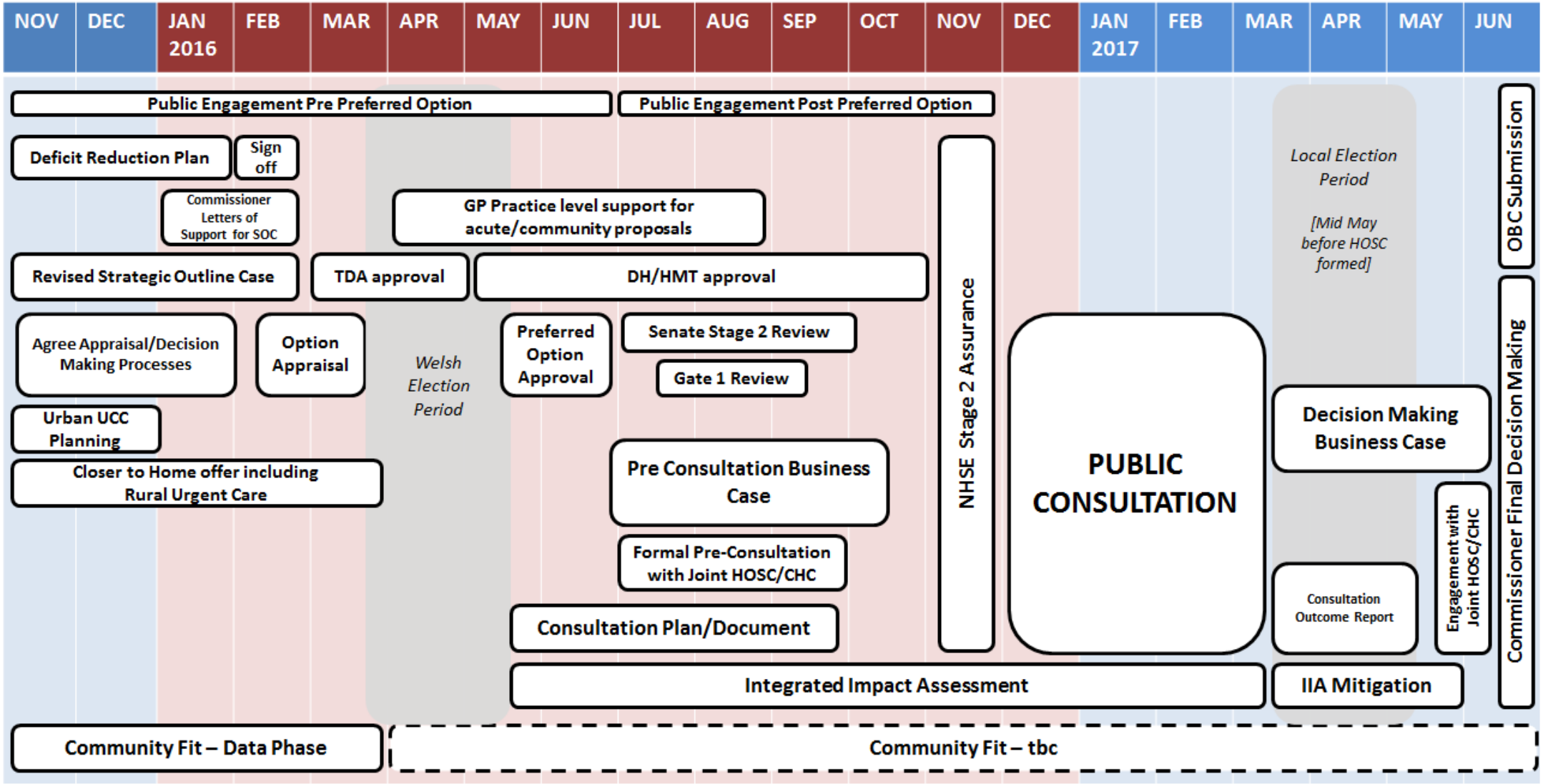

APPENDIX TWO – RED RATED RISKS

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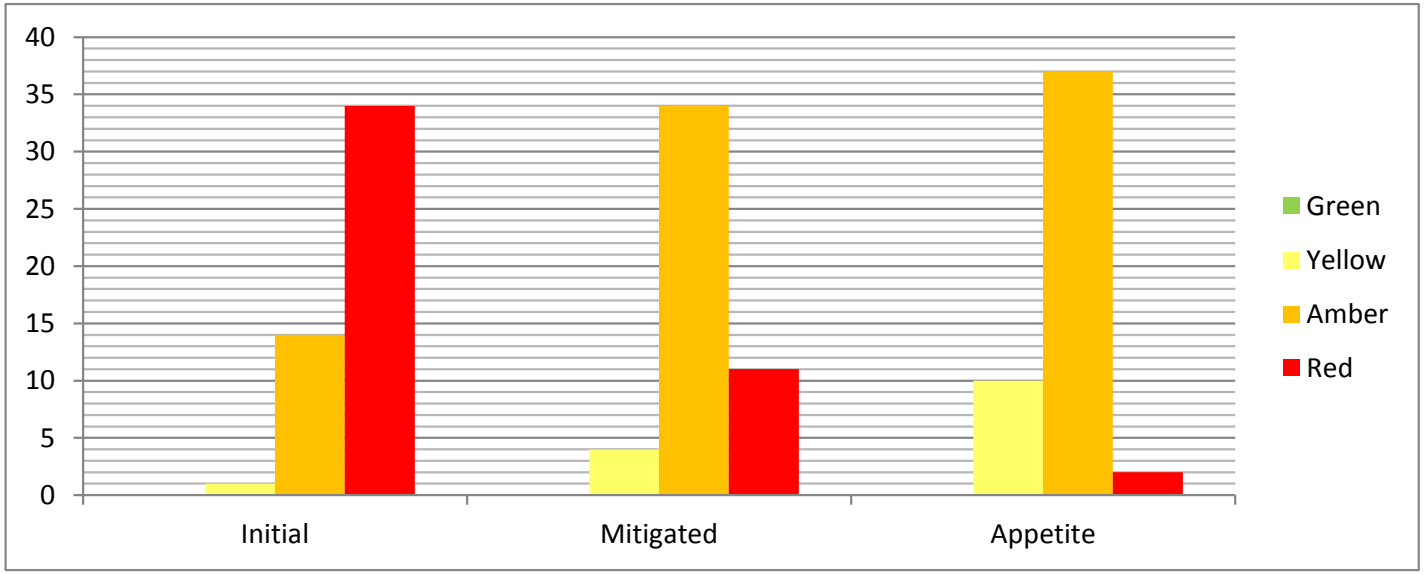
PROGRAMME RISK REGISTER

The NHS Future Fit programme has developed this register which, in line with best practice, sets out the areas which could adversely impact the development and/or implementation of programme proposals. This uses qualitative and quantitative measures to calculate the overall level of risk according to likelihood of occurrence and potential impact.

Each risk is given an initial Red/Amber/Green rating, and a summary of how the risk is being mitigated by the programme is also provided. Where further action is needed, this is also set out. The Risk Register is formally reviewed and updated on a monthly basis by the Programme Team. Risks rated 'red' (either before or after mitigation) will be reported to the Programme Board.



	Initial	Mitigated	Appetite
Green	0	0	0
Yellow	1	4	10
Amber	14	34	37
Red	34	11	2
Totals	**49**	**49**	**49**

NOTES

- Risks are generally causes rather than consequences of an adverse event.
- Mitigation actions must be accurate, timely and owned. They may be significant enough to warrant a task within a programme plan.
- All risks and actions should be updated regularly and the owners of mitigation actions called to account for progress or lack thereof.
- All programme members have a duty to identify and report risks to the programme office.
- The programme appetite for risk (i.e. what risk overall can the programme tolerate) must be clearly articulated by the programme team.
- In general, only those risks that require defined Programme Board action should be formally raised to, and discussed with, the Programme Board
- Risks should be managed as low down the programme structure as possible.
- Issues are essentially Risks with a probability of 100% (i.e. they have materialised and are thus in need of urgent action).
- If a defined risk or issue does not threaten the success of the programme, it need not be entered in the risk

SCORING

Likelihood	Narrative	Probability
1	Rare	<20%
2	Unlikely	20-40%
3	Possible	40-60%
4	Likely	60-80%
5	Very likely to occur	>80%
Consequence	**Narrative**	**Possible Quantification**
1	Insignificant	Revenue impact <£20,000; Capital impact <£0.5m; Delay <1 month
2	Minor	Revenue impact >£20k <£100k; Capital impact >£0.5m <£1.0m; Delay >1 month <3 months
3	Moderate	Revenue impact >£100k <£500k; Capital impact >£1.0m <£3.0m; Delay >3 months <9 months
4	Severe/Major	Revenue impact >£500k <£2.0m; Capital impact >£3.0m <£6.0m; Delay >9 months <24 months
5	Catastrophic	Revenue impact >£2.0m; Capital impact >£6.0m; Delay >24 months

Likelihood	**Consequence**				
	1 – Insignificant	**2 - Minor**	**3 - Moderate**	**4 - Severe/Major**	**5 - Catastrophic**
5 - Almost Certain	**5**	**10**	**15**	**20**	**25**
4 - Likely	**4**	**8**	**12**	**16**	**20**
3 - Possible	**3**	**6**	**9**	**12**	**15**
2 - Unlikely	**2**	**4**	**6**	**8**	**10**
1 - Rare	**1**	**2**	**3**	**4**	**5**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
1	27/03/2014	20/03/2015	Y	FI CD	**Key Staff Time**	Inability of stakeholder organisations to release key staff for the Programme leading to adverse impact on programme deliverability	SROs	4	4	**16**	Use of multi-site meetings increased. Evening meetings scheduled to support clinical involvement in design phase. Portable video-conferencing capability implemented. Critical path communicated to highlight consequences of any delay. Finance meetings moved to support attendance.	4	3	**12**	Programme Director to keep under review and to escalate to sponsors as required.	4	2	**8**
2	27/03/2014	24/08/2015	Y	CD	**Clinical Engagement**	Inadequate clinical engagement leads to lack of support for clinical model	BG	5	3	**15**	Extensive clinical engagement in developing model. Model approved by CRG and Board. GPs engaged on development of rural urgent care and 'Community Fit' plans. Staff engagement through sponsor organisations (including Trade Unions)	5	2	**10**	Further meetings of Clinical Reference Group to be held. Ongoing staff engagement.	5	1	**5**
4	27/03/2014	04/08/2015	Y	AS EC	**Engagement Assurance**	Inadequate patient and public engagement may lead to failure to meet assurance tests re: due process, contributing to Independent Reconfiguration Panel referral or Judicial Review	AO	5	3	**15**	Comprehensive engagement & comunications strategy and plans developed and being implemented. Ongoing support from Consultation Institute. Activity log to be shared every quarter with workstream and Programme Office updates shared bi-monthly.	5	2	**10**	No further action required.	5	2	**10**
5	27/03/2014	05/11/2015	Y	EC	**Public Support for Plans**	Public resistance and objections to plans leading to lack of support for preferred clinical model	AO	4	4	**16**	Communication and engagement plans to be implemented including extensive pre-consultation public engagement around the case for change/clinical model (supported by NHSE funding).	4	3	**12**	No further action required.	4	3	**12**
6	24/11/2014	04/08/2015	Y	EC	**Negative Presence in Media**	Risk includes distraction to the process including utilisation of resources; it may undermine confidence in the programme which may lead to a financial impact	AO	4	4	**16**	To implement the Engagement and Communication Strategy and subsequent plans. To undertake more proactive communications including media training with Core Group. Increased SRO engagement with press.	4	2	**8**	No further action required.	4	2	**8**
10	24/11/2014	04/08/2015	Y	EC IIA	**Powys engagement**	Confusion due to a number of programmes impacting Powys healthcare leads to reduced Powys engagement in Future Fit activities and potential challenge	AO	4	4	**16**	E&C workstream and PtHB E&C leads have met and agreed plan of action including tactics to clarify FF Powys engagement plans. E&C workstream will monitor progress on plan over next few months and report to Programme Team . Regular meetings to continue.	4	3	**12**	No further action proposed.	4	3	**12**

								Initial Rating					Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
12	24/11/2014	04/08/2015	Y	EC	**Clinical leadership**	Failure to gain and sustain support from clinicians to be visibly leading the programme. Consequences may include dwindling public support and undue burden on small number of leaders.	AO	5	4	**20**	To implement the Engagement and Communication Strategy and subsequent plans. Particular emphasis on 1. Repositioning leadership in public 2. Changing the message from 'no news' to 'we have achieved...'. Messaging workshops to be held to engage and develop clinical leaders.	5	3	**15**	Escalate to Core Group to ensure clinical leaders are able to be support programme activities.	5	2	**10**
14	24/11/2014	04/08/2015	Y	EC	**Divergence off proactive plan**	Failure to implement a process to agree a plan and all programme to comply appropriately. Risk includes inability to implement a timely plan to meet best practice standards with no subsequent ownership	AO	5	4	**20**	To implement the Engagement and Communication Strategy and subsequent plans. Additional focus includes creation and maintenance of risk register.	5	3	**15**	Review and update the plan and risk register	5	2	**10**
17	04/08/2015	04/08/2015	Y	EC	**Failure to comply with Gunning Principles**	Inadequate time allowed for consultation fails to comply with Gunning Principles leading to legal challenge	AO	5	4	**20**	Programme Board to approve plan which complies with Gunning Principles.	5	2	**10**	No further action proposed.	5	2	**10**
19	24/11/2014	04/08/2015	Y	EC	**Inadequate workforce engagement**	Failure to effectively engage with health and care staff thus raising risk for negative PR, workforce disengagement and 'on ground' lack of support / champions. This applies across commissioners, providers, and Welsh Healthboard	Key partners	4	4	**16**	Executives to take lead, fully supported by the E&C team. HJ to draw up initial opportunities starting with both CCGs and SaTh then draw out to all others including colleagues in Powys. Each organisation to provide quarterly update on workforce engagement to workstream.	4	3	**12**	No further action proposed.	4	3	**12**
21	30/10/2014	09/06/2015	Y		**Approval Requirements**	Lack of clarity about the nature and alignment of external approval processes prevents agreement of a robust timetable.	MS	4	5	**20**	NHSE/TDA proactively engaged re: approval process requirements and interrelationships.	4	4	**16**	TDA & NHSE to confirm common view on pre-consultation approval requirements.	4	2	**8**
23	27/03/2014	30/10/2014	Y	AS	**Stakeholder Strategies**	Development of stakeholder strategies and plans constrains or conflicts with the Programme	SROs	4	4	**16**	Programme model underpins 5 year plans. Stakeholders to check routinely whether plans fit Programme objectives.	4	2	**8**	No further action proposed.	4	2	**8**
24	29/05/2014	24/08/2015	Y	FI	**Sponsor Financial Risk**	The need to address short term financial risks in individual sponsor organisations compromises programme progress and/or outcome.	SROs	4	4	**16**	Programme financial model developed in alignment with sponsor 2 and 5 year plans.	4	3	**12**	Alignment to be kept under review in case of any change to long term plans.	4	2	**8**
25	27/03/2014	24/08/2015	Y		**Political Support for Plans**	Lack of political support for large-scale service changes resulting in challenge to preferred option	SROs	4	4	**16**	Regular engagement with HOSC & MPs, presentations to Local Joint Committees and workshops with Councillors. Further evidence gathered to support case for change, especially re: workforce challenges.	4	3	**12**	Local Assurance Panel to be considered.	4	2	**8**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
26	04/08/2014	04/08/2015	Y	WF	**Interim A&E Plans (SaTH Risk Register)**	Inability to safely staff the Emergency Department with medical workforce. Potential adverse impact on quality and safety of care for patients. Poorer patient flow into and within hospital. Inability to meet national guidance in relation to levels of senior cover. An increase in costs if there is a reliance on internal locum shifts. possible mismanagement of patient care. Difficulty meeting Trauma Network standards for Consultant cover.	SaTH Board	5	5	25	Attempts to recruit Locum/ Substantive Consultants ongoing. Recruitment and training of Advanced Practitioners. Additional SHO shift allocated to PRH on late shift to support flow and safety to avoid the night shift being left with a backlog leaving the department vulnerable. Negotiation ongoing to cover Trauma Rota and Job Planning to make best use of Consultant resource. We have recruited a fixed-term Locum to cover our ED Consultant who is away on a sabbatical; and a Locum Consultant to work with us until February 2016. Ad hoc consultant on site cover over the weekends to support the department when in extreme difficulties.	5	4	20	Business continuity planning underway and key stakeholders engaged. Options provided to execs however no requirement for change agreed at this point. Need to implement interim plan for sustaining A&E services. Complete job planning process. Development of ED staffing strategy. Gap analysis, development of business case to support recruitment of additional consultants.	5	3	15
27	04/08/2015	04/08/2015	Y	WF	**Non compliance with Critical Care Standards for Intensivist Cover within ITU (SaTH Risk Register)**	Critical care standards set out that ITU should have Intensivist cover 24/7 and that Intensivists should undertake twice daily ward rounds. Guidelines from the Faculty of Intensive Care Medicine (FICM) state that there is clear evidence that units with dedicated intensivists are the safest and most clinically effective way to deliver Intensive Care with reduced ICU and hospital mortalities and reduced ICU and hospital lengths-of-stay. In general, the consultant/patient ratio must not exceed a range between 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8. At both sites, these ratios are significantly exceeded. The risk has been exacerbated at PRH due to a high level of medical staff sickness and an imminent retirement.	SaTH Board	5	5	25	In order to safely staff ITU, the Trust may need to stop elective work and shift sessions to Critical Care. This will affect our ability to staff all elective lists, which will have an impact on waiting lists and patient care unless a timely solution is found as the service and the team are highly vulnerable to further vacancies or unexpected absences. Splitting the Rota at RSH means we can ensure 24/7 cover of both intensive care, by intensivists and also take care of emergency activity. Critical Care is being provided with a mix of general anaesthetists and the small number of intensivists available but consultant presence is still well below recommended levels.	5	4	20	The case has now been presented to Trust Board. The case for further recruitment has been supported. Efforts to recruit will be expedited and prioritised. A business case needs to be drafted and submitted for funding for medical capacity increase. Anaesthetic job planning needs to be completed in conjunction with management team and lead anaesthetists. Business case will be presented on 22 April. A decision will be awaited and then progressed.	5	3	15

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28	27/03/2014	26/02/2015	Y		**Interim A&E Plans**	The need to implement interim plan for sustaining A&E services over the interim period adversely affects Programme	DV	4	4	**16**	Key partners agree to engage with Programme Board on decisions which may impact on remit of Programme. Communications and engagement plan to be provided to all key stakeholders on necessary actions should interim plans be initiated. 5 year and 2 year plans submitted. ED business continuity plan supplied to with commissioners and TDA and actions to mitigate being implemented re: recruitment of consultant and middle grade staff.	4	3	**12**	Seek identification of preferred option at the earliest opportunity, taking account of work required to reach robust decision.	4	2	**8**
29	01/07/2014	05/11/2015	Y	AS	**Inter-dependencies**	Failure to effectively manage programme interdependencies adversely impacts the implementation of the preferred option	SROs	4	4	**16**	Sponsors to initiate further pieces of work to develop and implement plans to address interdependencies. Monitoring process agreed for the review of sponsor plans by the Programme's Assurance workstream. Document drafted for Board identifying all major interdependencies and setting out governance linkages and the alignment of key outputs.	4	3	**12**	Board to receive progress reports on Community Fit and IT Project activities, and to monitor development of the Powys SDM programme. Approach to managing additional interdependencies of deficit planning and acute business cases to be considered at November Board.	4	2	**8**
30	26/02/2015	05/11/2015	Y	EC	**Urgent Care Centre Offer**	Inability to adequately define UCC offer leads to lack of support for single Emergency Centre.	MS	4	4	**16**	Workshops held and initial report completed in September. Additional workshops to be held re: urban UCCs	4	4	**16**	Focused communication and engagement activities to take place around current and future urgent care offer by locality. Workshop to take place to clarify urban UCC model	4	2	**8**
31	24/08/2015	05/11/2015	Y	EC	**Urgent Care Proposals**	Failure to articulate rural urgent care offer before consultation adversely affects consultation	MS	4	5	**20**	Urban UCCs proposed for RSH and PRH at shortlisting. First phase of work to develop additional rural urgent care solutions nearing completion; next phase to actively involve local practices and patient groups to build proposals around local asset base. Scope of proposals in public consultation to be confined to EC, DTC and urban UCCs with no reduction in existing rural urgent care services. Further engagement planned around urban UCCs.	4	4	**16**	Further engagement to take place around potential rural urgent care offer aligned to the development of a primary care strategy	4	2	**8**
32	23/02/2015	20/03/2015	Y		**Out of Hospital Services**	Lack of clarity on plans for out of hospital services impacts public support for acute and community hospital proposals	SROs	4	4	**16**	Scope and initial activities of 'Community Fit' programme agreed.	4	3	**12**	Initial Community Fit work to be undertaken and reported to Future Fit Board.	4	2	**8**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
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33	23/03/2015	09/06/2015	Y	WF	**Workforce Deliverability**	Difficulties in recruiting in line with workforce plan (including new roles) adversely impacts implementation of programme proposals	tbc	4	4	**16**	Workforce workstream to identify new roles and to liaise with HEE and education providers to ensure supply of required roles. Develop a more comprehensive "work in Shropshire" offer.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
34	23/03/2015	09/06/2015	Y	WF	**Resistance to Workforce Change**	Lack of appetite for change/new roles locally and from Royal Colleges and others adversely impacts definition of a deliverable workforce plan	tbc	4	4	**16**	Workforce workstream to liaise with Royal Colleges and others to engender support.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
35	27/03/2014	24/08/2015	Y		**Option Appraisal**	The number and/or complexity of shortlisted options identified for appraisal delays the Programme	MS	4	4	**16**	Shortlist of 6 agreed in line with national guidance. Number of options reduced on affordability grounds.	4	2	**8**	No further action required.	4	2	**8**
36	26/02/2015	05/11/2015	Y	FI	**SaTH Affordability**	Financial analysis demonstrates that one or more shortlisted options are not affordable, potentially leading to reconsidering shortlisting decision and significant delay.	NN	4	5	**20**	Phase 2 assumptions agreed by SaTH. Financial costs and benefits of options to be set out by Technical Team. A number of options excluded on affordability grounds. Remaining options potentially affordable to SaTH.	4	4	**16**	Option costs to be reassessed as revised SOC developed, and scope of SOC to be confirmed.	4	2	**8**
38	27/03/2014	27/07/2015	Y	FI	**Capital Availability**	Lack of availability of capital to fund preferred option delays implementation	AN	4	5	**20**	Discussion with TDA/DH re: availability of funding. PF2 to be explored if necessary.	4	4	**16**	Phased approach to implementation could be considered, and potential sources of funding clarified.	4	2	**8**
39	29/05/2014	05/11/2015	Y	FI	**Commissioner Affordability**	Lack of revenue affordability to Local Health Economy of capital requirement and of whole system change adversely impacts identification of the preferred option	AN	5	5 ↑	**25**	Affordability assessments to form part of appraisal processes. Extensive work undertaken to reconcile 5 year plans with Phase 2 assumptions and to allow for community investment.	5	5 ↑	**25**	5 year plans to be kept under review. CCGs to develop community investment plans. Impact of deficit reduction plans to be assessed.	5	2	**10**
40	05/11/2015	05/11/2015	Y	FI	**Local Health Economy Deficit**	LHE deficit undermines viability of business cases	SROs	4	5	**20**	Commissioners and providers to set out nature and scale of deficit and to develop a deficit reduction plan acceptable to regulators.	4	4	**16**	FDs scoping scale of challenge. FDs/CEOs to participate in planning workshop in early December.	4	3	**12**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
42	23/03/2015	09/06/2015	Y	WF FI	**Dual Workforce Costs**	Sufficient resources are not available to support double-running costs associated with introducing new roles, leading to delayed implementation	VM	4	4	**16**	Workforce workstream to set out requirements and to liaise with Finance workstream on resourcing.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
45	27/03/2014	29/01/2015	Y	FI	**Programme Resources**	Programme resources / staffing inadequate leading to difficulties in running Programme to agreed timelines	SROs	4	4	**16**	CoreProgramme Budget agreed. Additional requirements for each phase to be identified. Budget for 2015-16 agreed.	4	2	**8**	No further action required.	4	2	**8**
49	27/03/2014	09/06/2015	Y	AS	**NHS Approvals**	Failure to secure necessary NHS approvals at key milestones delays the programme	MS	4	4	**16**	Engagement with NHSTDA, NHSE Project Appraisal Unit and NHSE Regional Team to clarify requirements and duration of approval processes. Sense Check Action Plan monitored monthly by Programme Team and evidence against the Four Tests being assembled. Stage 2 assurance being planned.	4	3	**12**	NHSE/TDA to provide common view on pre-consultation approval requirements.	4	2	**8**
50	09/03/2015	05/11/2015	Y	AS	**Government Approvals**	Uncertainty about timescales for DH/HMT approvals leads to flawed assumptions being made in the Programme Plan and to delay (including to the start of consultation).	MS	4	5	**20**	Programme Plan contains estimated approval periods for DH/HMT. Advice sought from NHSE Project Appraisal Unit.	4	4	**16**	Revised plan to take account of advice from Project Appraisal Unit, NHSE & TDA.	4	2	**8**
51	09/03/2015	05/11/2015	Y	AS	**Decision making**	Lack of an agreed process for reaching a final commissioner decision (including clarifying the role of Powys tHB) prevents a final decision being agreed	SROs	5	4	**20**	Commissioners to agree approach to final decision making in advance of Stage 2 Assurance. Proposal draft for CCG boards. Legal advice received.	5	3	**15**	All relevant commisioners to agree process. SROs to arrange Board-to-Board.	5	2	**10**