Post Board Update Report

February 2016

The purpose of this report is to provide Sponsors and Stakeholders with a brief update on recent Programme progress and to summarise the activities in the next phase.

1 PROGRAMME DIRECTOR

Following Mike Sharon's appointment as Director of Strategy at the Royal Wolverhampton Hospital NHS Trust, as reported to the last Board meeting, Debbie Vogler has been appointed to fulfil this role going forward.

Debbie will provide continuity for the programme having been involved from the outset in her role as Director of Business and Enterprise at The Shrewsbury and Telford Hospital NHS Trust. Her appointment to the Programme Director role is on a secondment basis for two years and she will report to the joint Senior Responsible Owners for the NHS Future Fit Programme.

To have Debbie with her considerable skills and experience of 38 years in the NHS, and a decade of experience locally, is a huge bonus in this next critical phase of the NHS Future Fit programme.

2 PROGRAMME TIMELINE

In November 2015, we set out a new ambition to have identified a preferred option for acute services during Summer 2016, to move towards formal Public Consultation from end 2016 and to reach a final decision in Summer 2017. Progress continues to be made in line with this ambition.

The indicative critical path in Appendix One sets out a view of deadline dates by which key pieces of work must be completed in order to deliver our ambition. In addition to the work within the control of the programme, it will also be dependent on a range of external approval processes which may affect the timetable.

At the December Board meeting it was noted that 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.

Progress with these interdependencies and with other key programme workstreams is summarised below.

3 DEFICIT REDUCTION PLAN

This work commenced last year with a full day workshop for the Chief Officers and Finance Directors of all local NHS organisations. The day produced an initial view of the scale of the local financial challenge and a set of ideas for how that challenge could be addressed.

To further develop that work, expert external support has been commissioned from PwC under the leadership of Neil Nisbet, Director of Finance at SaTH. An initial high level plan has been drafted and was reviewed by the Finance Workstream in early February and, subsequently, by the Programme Board. This projects the scale of the health economy deficit going forward and sets out how a sustainable position could be reached. Local work on the projected deficit is now being validated by external consultants PwC.

The initial local plan will then be more fully developed by May, within the remit of the Sustainability and Transformation Plan.

4 SUSTAINABILITY AND TRANSFORMATION PLAN

All English health economies are required to produce a Sustainability and Transformation Plan (STP). The STP will be the vehicle through which local partners create a shared and ambitious blueprint for accelerating implementation of the *Forward View*. STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016.

It has been agreed locally that the 'transformation footprint' should be the area covered by Shropshire and Telford & Wrekin CCGs, and a Partnership Board has been formed involving all NHS organisations providing services in the area as well as both Local Authorities.

The Future Fit Board has agreed a variation to governance arrangements to ensure the alignment of plans and to avoid duplication (see Appendix Two). Martin Whittle has been appointed to coordinate this work

5 STRATEGIC OUTLINE CASE - SUSTAINABLE SERVICES PROJECT

SaTH is nearing completion of a revised SOC. This will reflect the brief it was given by the Programme Board in October of setting how it could address its most pressing clinical workforce challenges.

Once that work is completed the Programme will be able to set out a detailed plan leading to public consultation and a final decision.

6 RURAL URGENT CARE

Work remains on track for high-level proposals to be defined by end March.

Work with providers has enabled the collation of a lot of data on current activity. Working from the 'home is normal' principle set out in the Clinical Model, this work will confirm the services that patients can currently access across the county and it also aims to suggest potential enhancements to local services. This could include local diagnostics (e.g. point of care testing and X-ray) as well as greater consistency of minor injury services locally. Locality workshops will be held in early March.

This work has been characterised by very helpful collaboration between providers; an example of this is the work being done to map urgent care practitioner competencies. The workforce workstream is co-ordination an approach that will work towards the consistent adoption of an urgent care practitioner career ladder, underpinned by a common competency framework, to be consistently applied across the county.

7 COMMUNITY FIT

Following the initial collation of data from across health and care providers, the first data specific workshops have been held to discuss mental health, social care and community health data. These have been well attended and characterised by full engagement from across health and social care providers, as well as patient groups. A few gaps have been identified, as well as some data quality issues, and these are currently being resolved jointly with providers.

A second round of meetings in early March will preview the linked data sets. Primary care data will not be included in phase one output and we are agreeing a proxy measure for this. Significant progress has been made with the primary care data and we are working with the Board of the GP Federation - aiming to get an at scale extract of data from GP practices to support a future phase of work.

Work with the Private, Independent and Voluntary sectors is continuing and the existing and potential contribution from these important groups will form part of the output of phase one. The work remains on track to have a final output from phase one at the end of March. Further phases will be outlined before that time.

8 CLINICAL DESIGN

The Clinical Leaders' group has continued to meet to ensure the development of plans in line with the Clinical Model.

It has recently published a blog summarising key evidence in relation to the impact of patient travel times.

It is currently planning a further meeting of the wider Clinical Reference Group in April to review and inform emerging proposals.

9 WORKFORCE

At the last Board meeting, the workstream presented a wider view of the workforce challenges across the health and social care economy.

The workstream has since held a workshop to explore what a whole-system workforce plan might look like and how it could be developed. That work is now underway. As well as supporting Future Fit proposals it will also be a key enabler of the STP.

The workstream is also supporting the review of urgent care competencies.

10 ENGAGEMENT AND COMMUNICATIONS

The Communications and Engagement team are striving to ensure that our stakeholders and public are reassured that the programme is progressing forward and remains on focus.

Campaigns underway include a series of engagement pop up events in local centres and community hospitals, with people invited to give their views and comments on the clinical model, shortlisted options, their health concerns as well as ask questions. The recent Radio Shropshire 'hot seat' programme also supported the aim of keeping NHS Future Fit in the public domain and allowed listeners the opportunity to ask questions on key hot topics, including the wider CCG pressures.

As part of the ongoing equalities outreach work, an initial report has been received of outcomes of work with traditionally 'hard to reach' groups. The team is exploring ways to expand on this useful piece of work, reaching more localities and approaching a wider range of these groups. Engagement work also continues with a series of conversations/ presentations with stakeholders and community groups, with recent updates to the Telford & Wrekin Parish Council Forum and further meetings planned in with Members in Powys and in Shropshire, Local Joint Committees, community groups, Patient groups and GP surgeries.

In the coming weeks the promotion and delivery of a number of 'pop up' stands will continue. In addition, a high-level workshop is being delivered to confirm the key messages

going forward over the next few months and further ahead as the programme continues to develop.

11 FINAL DECISION MAKING

In order to agree the process which leads to a final decision being reached by commissioners next Summer, a workshop for members of both CCG Boards will be held in the next two months in advance of the identification of a preferred option.

12 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.

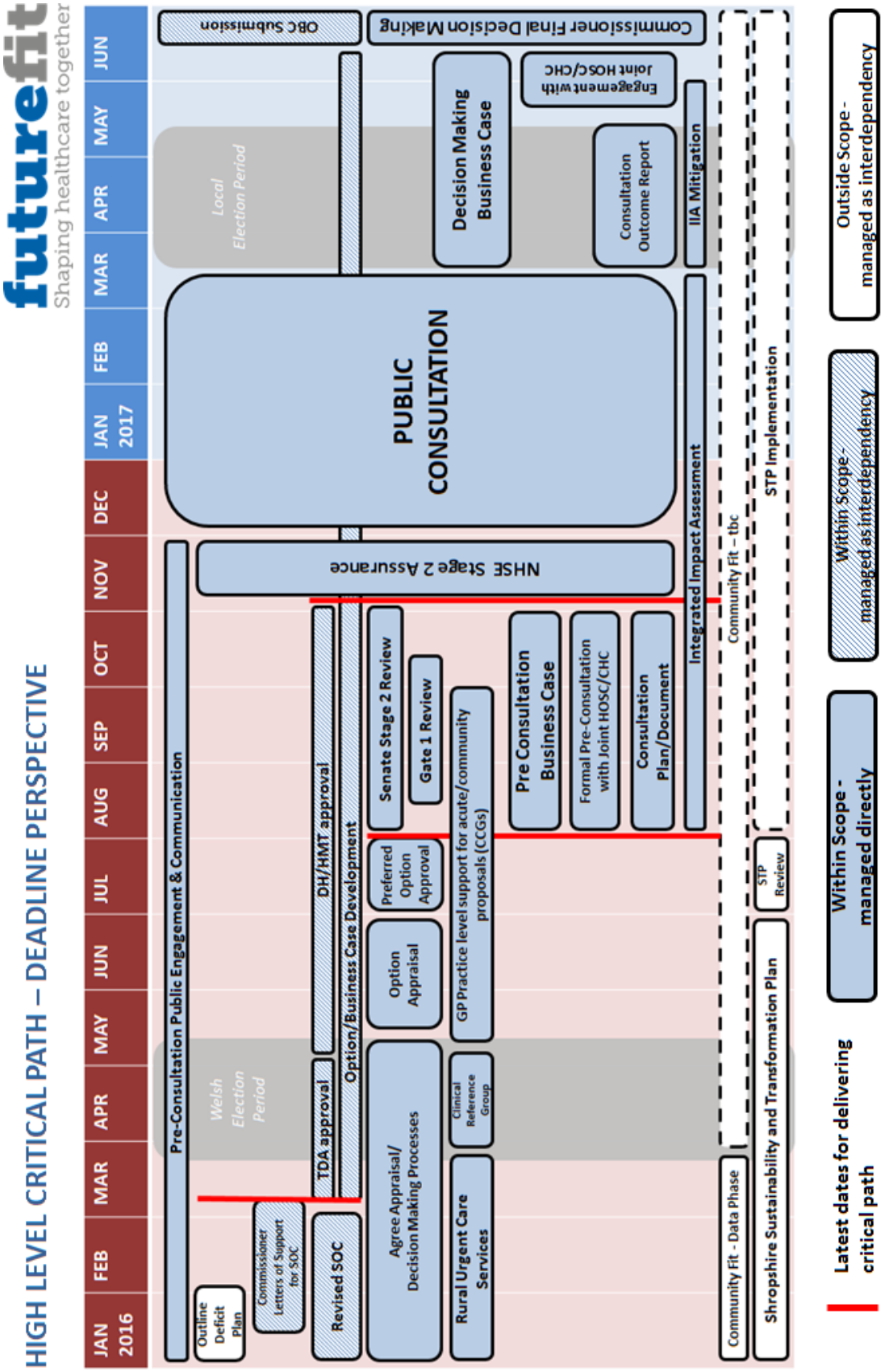
The Board has previously agreed that all red-rated risks (both pre- and post-mitigation) should be reported to it. The current list of red-rated risks is attached to this report (see Appendix Three).

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.

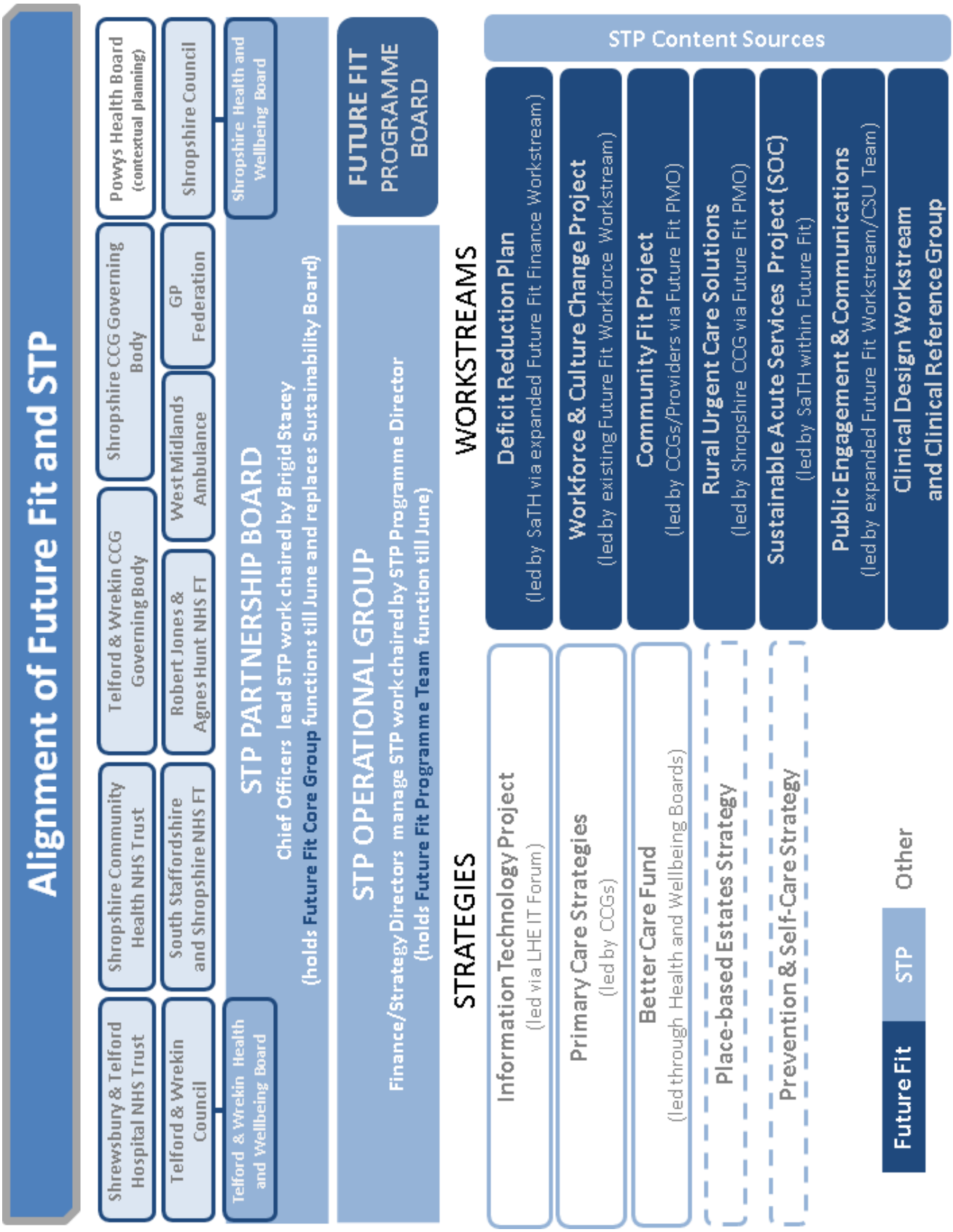
David Evans & Brigid Stacey

Senior Responsible Officers

APPENDIX ONE – 'DEADLINE' CRITICAL PATH



APPENDIX TWO – RATIONALISING GOVERNANCE STRUCTURES



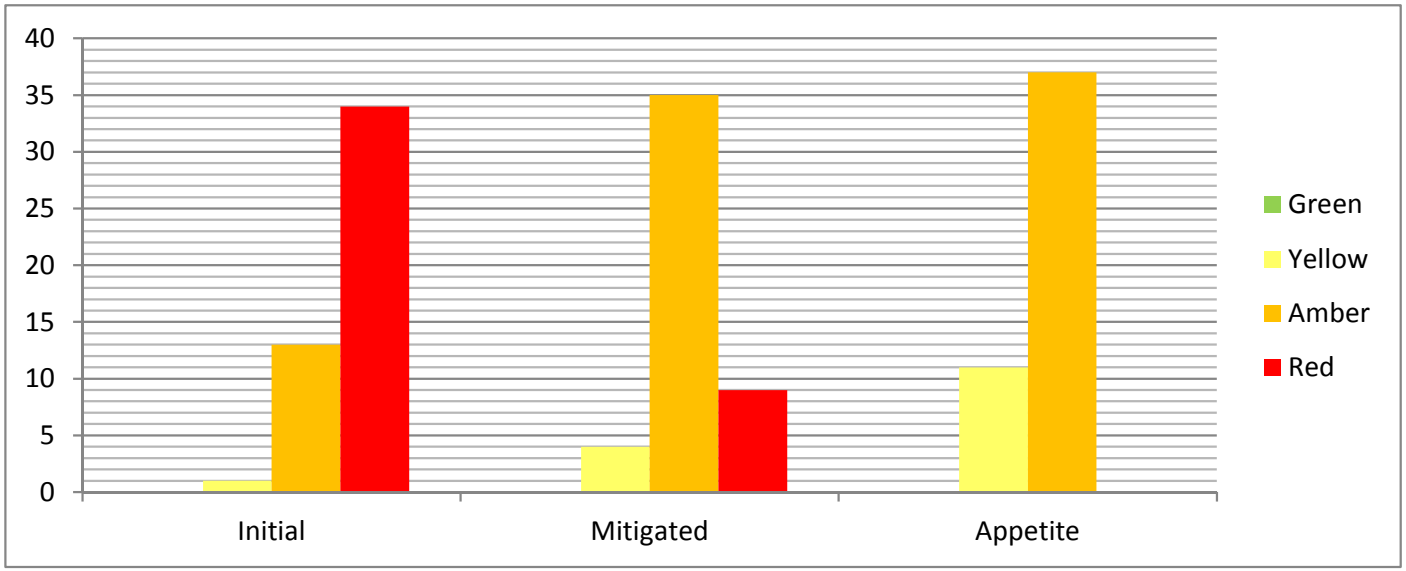
APPENDIX THREE – RED RATED RISKS

futurefit
Shaping healthcare together

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	11
Amber	13	35	37
Red	34	9	0
Totals	**48**	**48**	**48**

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	10/02/2016	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**	Frequency and scope of meetings to be reviewed to reflect needs of STP work until June 2016.	4	2	**8**
2	27/03/2014	28/01/2016	Y	CD WF	**Clinical Engagement**	Inadequate clinical engagement leads to lack of support for clinical model	MI	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 in April to consider latest work on acute SOC, rural urgent care and Community Fit.	5	1	**5**
4	27/03/2014	16/01/2028	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 & communications strategy and plans developed and being implemented. Ongoing support from Consultation Institute. Activity log to be shared every quarter with work stream 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 work stream and PtHB E&C leads have met and agreed plan of action including tactics to clarify FF Powys engagement plans. E&C work stream 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 WF	**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	Capacity to be reviewed once requirement of STP work known.	5	2	10
19	24/11/2014	04/08/2015	Y	EC WF	**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 work stream.	4	3	12	No further action proposed.	4	3	12
21	30/10/2014	28/01/2016	Y		**Approval Requirements**	Lack of clarity about the nature and alignment of external approval processes prevents agreement of a robust timetable.	DV	4	5	20	NHSE/TDA proactively engaged re: approval process requirements and interrelationships. NHSE/TDA confirmed reasonableness of revised timeline. New guidance noted.	4	2	8	No further action required.	4	2	8
23	27/03/2014	28/01/2016	Y	AS	**Stakeholder Strategies**	Development of stakeholder strategies and plans constrains or conflicts with the Programme	SROs	4	4	16	Programme to inform development of whole system Sustainability and Transformation Plan, and ensure alignment.	4	2	8	No further action proposed.	4	2	8
24	29/05/2014	28/01/2016	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 plans. Deficit reduction work initiated by programme.	4	3	12	CCG Boards to reconsider SOC activity implications in March (in light of high level deficit reduction plan). Ensure alignment between programme proposals and development of STP.	4	2	8
25	27/03/2014	28/01/2016	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	Regular briefings of key stakeholders to continue. New phase of engagement to focus on clarifying urgent care offer and clinical model.	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	17/12/2015	Y	WF	**Interim A&E Plans (SaTH Risk Register)**	Insufficient consultant capacity in Emergency Department which adversely affects patients safety and patient flow.	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.	5	1	**5**
27	04/08/2015	17/12/2015	Y	WF	**Non compliance with Critical Care Standards for Intensivist Cover within ITU (SaTH Risk Register)**	Non compliance with Critical Care Standards for Intensivist Cover within ITU: 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**	Recruit to the 4WTE at PRH and 2 WTE at RSH substantive vacancies and additional 3 WTE at PRH and 1 additional WTE at RSH new posts.	5	1	**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
28	27/03/2014	28/01/2016	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	10/02/2016	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 work stream. 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. STP will have coordinating oversight of all programmes.	4	2	**8**
30	26/02/2015	28/01/2016	Y	EC	**Urgent Care Offer**	Inability to adequately define urgent care offer leads to lack of support for single Emergency Centre.	DV	4	4	**16**	Workshops held and initial report completed in September. Additional workshop held re: urban UCCs. Process in place for engaging localities in defining rural urgent care offer by end March.	4	3	**12**	Locality proposals to be finalised. Key public messages to support understanding of urgent care system.	4	2	**8**
31	23/02/2015	28/01/2016	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. Updates reports provided at Board.	4	3	**12**	Plans for next stage of Community Fit work to be established via STP process.	4	2	**8**
32	23/03/2015	28/01/2016	Y	WF	**Workforce Deliverability**	Difficulties in recruiting in line with workforce plan (including new roles) adversely impacts implementation of programme proposals	VM	4	4	**16**	Workforce work stream 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**	Whole system workforce plan to be developed.	4	2	**8**
33	23/03/2015	28/01/2016	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	VM	4	4	**16**	Workforce work stream 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**
34	27/03/2014	28/01/2016	Y		**Option Appraisal**	The number and/or complexity of shortlisted options identified for appraisal delays the Programme	DV	4	4	**16**	Shortlist of 6 agreed in line with national guidance. Number of options reduced on affordability grounds. Revised SOC exploring different ways of delivering the options.	4	4	**16**	Options to be reviewed in light of work in revised SOC.	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
35	26/02/2015	28/01/2016	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.	4	2	**8**
37	27/03/2014	28/01/2016	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**	Capital requirement to be discussed with NHSE/TDA in light of revised SOC and deficit reduction plan.	4	2	**8**
38	29/05/2014	28/01/2016	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**	Revised SOC to maintain Phase 2 financial implications. Commissioner affordability to be reviewed in light if high level deficit reduction plan and final STP.	5	2	**10**
39	05/11/2015	10/02/2016	Y	FI	**Local Health Economy Deficit**	LHE deficit undermines viability of business cases or other proposals	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**	High level deficit reduction plan to be completed alongside revised SOC. Full sustainability plan to follow in June.	4	3	**12**
41	23/03/2015	28/01/2016	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 work stream to set out requirements and to liaise with Finance work stream on resourcing.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
44	27/03/2014	28/01/2016	Y	FI	**Programme Resources**	Programme resources / staffing inadequate leading to difficulties in running Programme to agreed timelines	SROs	4	4	**16**	Core Programme Budget agreed. Additional requirements for each phase to be identified. Resourcing for 2016/17 to be agreed.	4	3	**12**	Resourcing for 2016/17 to be agreed including completing in-sourcing of PMO function and clarifying CSU support requirements.	4	2	**8**
47	27/03/2014	28/01/2016	Y		**Loss of Key Personnel**	Loss of Sponsor/Programme personnel leads to disruption and/or delay	DV	4	5	**20**	New Chief Officers provided with programme briefings. Close involvement of wider CSU team throughout Programme to ensure ability to provide backup. New programme director involved from outset.	4	3	**12**	Ongoing CSU support to be confirmed.	4	2	**8**
48	27/03/2014	28/01/2016	Y	AS	**NHS Approvals**	Failure to secure necessary NHS approvals at key milestones delays the programme	DV	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. New guidance received and factored in to plans.	4	3	**12**	Programme to continue developing business cases in line with regulator requirements.	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
49	09/03/2015	28/01/2016	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).	DV	4	5	**20**	Programme Plan contains estimated approval periods for DH/HMT. Advice received from NHSE/TDA. Reasonableness of timetable confirmed. Uncertainty around duration of higher approvals is beyond Programme control.	4	3	**12**	Ensure completion of local approvals in line with the timetable.	4	2	**8**
50	09/03/2015	28/01/2016	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 commissioners to agree process. Strategy Unit to arrange Board-to-Board workshop in March for CCG governing bodies.	5	2	**10**