Health Gateway Review 0: Strategic Assessment
Programme Title: Brighton and Sussex 3Ts Programme.
Health Gateway ID: DH 393

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Health Gateway Review
Review 0: Strategic Assessment

Version number: Final Report

Date of issue to SRO: 17 June 2008

SRO: Amanda Philpott

Organisation: Brighton and Sussex University Hospital NHS Trust

Health Gateway Review dates: 9 to 12 June 2008

Health Gateway Review Team Leader:
David Carr

Health Gateway Review Team Members:
Frank Johnston
Harold Caldwell
Tim Ainger

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Background

The aims of the programme:

1. Over the past few years, Brighton and Sussex University Hospitals Trust (BSUH) and the local Primary Care Trusts (PCTs) have undertaken significant work in preparing strategic outline cases (SOCs) for the development of specialist and acute services. This has run alongside a reconfiguration of the local PCTs and the Sussex-wide "Fit for the Future" (FfF) review of acute services.

2. To this end, BSUH has established the 3Ts Programme to enhance the Trust's role as the regional centre for Teaching, Trauma and Tertiary Care.

3. The 3Ts Programme is a key objective for the Trust and it is currently anticipated that it will run up to 2012, replacing and improving out-dated building stock with state of the art accommodation for clinical and associated services on the Brighton and Hayward Heath Sites.

4. The Programme consists of four key elements:

- An expansion of the Cancer Centre on the Brighton site
- The relocation and expansion of the Neurosciences Centre from Haywards Heath to Brighton
- Critical Care / Trauma Centre enhancements on the Brighton site with the development of a Level 1 Trauma Unit.
- Replacement of existing aged estate with fit for purpose improvements

The driving forces for the programme:

5. The Sussex Cancer Network faces a number of challenges in implementing the NHS Cancer Reform Strategy and the 3Ts Programme is, in part, designed to address these needs in terms of diagnostic and treatment capability and the quality of clinical accommodation for patients with cancer.

6. In the 2004 *Best Care, Best Place* review stakeholders were consulted on the future of Neurosciences within Sussex and the relocation of the Regional Centre from the Princess Royal Hospital (PRH) to the Royal Sussex County Hospital (RSCH) campus. The conclusion was to keep neurosciences in Sussex and move over time to a new department at the RSCH. This proposal was agreed by stakeholders and commissioners.

7. Nearly 30 years after the Osmond-Clark report recommended a tripartite scheme of peripheral casualty units, District General Hospital (DGH) accident centres and regional major injury units, the Royal College of Surgeons highlighted significant deficiencies in the management of seriously injured patients.

8. Subsequent reports, including *Better Care for the Severely Injured* and *Trauma: Who Cares?* (2007) have drawn similar conclusions: that there should be a National Trauma Service based upon geographical trauma systems for England, Wales and Northern Ireland and that improved care for the severely injured will create an opportunity for reducing the cost of avoidable death and unnecessary morbidity.

9. The Trust has reconfigured services to separate emergency and elective care and ensure that training posts retain Royal College accreditation. These changes have improved the safety and quality of services. However the design, layout and location of some services limit the Trust's ability to deliver modern, high quality care.

The procurement/delivery status:

10. The Programme Team's current preferred option is to deliver the Programme using ProCure21 (P21) and exchequer funding. To this end they have recently completed a Principal Supply Chain Partner (PSCP) selection process reducing a list of 8 interested potential suppliers to a short list of 3 from which they have recently selected their preferred partner. They anticipate signing a formal contract by the end of July 2008 for the provision of Phase 2 Services to deliver the Outline Business Case (OBC) for the Programme.

11. A Strategic Outline Case (SOC) for the Programme was adopted by the BSUH Trust Board in June 2008 and is now with the SEC SHA for approval.

Current position regarding Health Gateway Reviews:

12. This is the first Health Gateway Review of this Programme.

Purposes and conduct of the Health Gateway Review

Purposes of the Health Gateway Review

13. The primary purposes of a Health Gateway Review 0: Strategic assessment, are to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

14. Appendix A gives the full purposes statement for a Health Gateway Review 0.

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Conduct of the Health Gateway Review

15. This Health Gateway Review was carried out from 9 June 2008 to 12 June 2008 at Audrey Emerton Building, Eastern Road, Brighton. The team members are listed on the front cover.

16. The people interviewed are listed in Appendix B.

17. The Review Team would like to thank the SRO and her Programme Team and the many people from the Trust, PCTs and other NHS and local organisations for their valuable time, support and openness, which contributed to the Review Team's understanding of the Programme and the outcome of this review. We would also like to thank Joanne Floyd who made all the arrangements for the interviews and accommodation, the efficiency of which helped us to carry out the review smoothly and comfortably.

Conclusion

18. The Trust began work on the 3Ts Programme Strategic Outline Case (SOC) in Autumn 2007. The SOC was approved by the BSUH Trust Board in June 2008 and is now with the SEC SHA for final approval following approval by all the relevant PCTs. During this period the Trust has established significant momentum in the scheme through the work of a small and committed Programme Team and strong senior management and Trust Board support and leadership.

19. The Review Team has found wide support in the Local Health Community (LHC) for the 3Ts Programme and its decision to use a ProCure21 approach for the delivery of the Outline Business Case (OBC).

20. Through the effective use of clinical champions and a series of successful, well attended workshops the Programme has generated strong clinical engagement. A critical output from the clinical workshops, when integrated with work undertaken in key specialist departments, will be a clinical brief to inform the design solutions in the OBC. Opinions amongst senior clinicians as to when this brief will be completed and available for input into the OBC vary from one to four months. We have seen no evidence of a plan to conclude this work and to gain formal approval of the design brief.

21. The Programme Team has successfully identified a preferred ProCure21 partner to assist in the development of the OBC. The Team hope to be in a position to sign a formal contract with the Principle Supply Chain Partner (PSCP) in mid July 2008, a month ahead of target. The Programme however, does not yet have in place either a protocol detailing the governance arrangements for managing their new partner or a Programme Director and strengthened Programme Team.

22. The Review Team believes the Programme should consider deferring signing any formal contract with the PSCP until the Programme Director is appointed, the protocol for managing the PSCP is agreed and the clinical design brief has been approved.

23. It is clear from our interviews that the OBC will now need to include full financial modelling of both PFI and public exchequer funded delivery mechanisms to Treasury Green Book Standards. We believe there should be early formal contact with the Capital Investment Unit in the DH.

24. The OBC will need to demonstrate the scale of benefits to be achieved by the Programme. In a climate of tight exchequer finances, high quality benefit realisation plans may be one area in which projects can distinguish themselves from potential competitors. We recommend that this aspect of the OBC is given special attention.

25. Whilst there is much to commend the challenging target dates the Trust has set for the Programme we believe the current Programme delivery plan does not support these ambitious dates and should be revisited. Our interviews, the experience of the Review Team and the issues now facing the Programme suggest that it is unlikely to successfully deliver a draft OBC by the end of 2008.

26. The Programme does not have a Risk Management system in place. We understand one is under development. This work needs to be completed and the agreed system implemented. More fundamentally the Programme does not have a Programme Execution Plan (PEP) detailing all of the key project management protocols to be used to control the development.

27. Existing governance arrangements are seen by those affected to have worked well in the development of the SOC and merely need to be revisited as the Programme moves into the development of the OBC to ensure they remain fit for purpose. We believe it will be timely to consider reallocating the role of SRO to the Trust CEO to reflect the increasing profile of the development.

28. Because of the relatively small size of the Programme Team and the need to generate the SOC to a challenging target date, not unnaturally there has been less focus on preparing for the next phase to develop the OBC and consequently the majority of our recommendations relate to this issue.

29. A summary of recommendations can be found in Appendix C.

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Health Gateway Review RAG Status

30. The overall RAG status of the programme is **Red** -as defined below.

31. RED – To achieve success the programme should take remedial action immediately, ie within two to three weeks.

32. AMBER – The programme should go forward with actions on recommendations to be carried out within two to three months or before the next key decision point or by a specified date.

33. GREEN – The programme is on target to succeed but may benefit from the uptake of the recommendations.

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Findings and recommendations

1: Policy and business context

34. The final version of the SOC put before the Trust Board for approval sets a clear direction for the Programme which has universal support from all key stakeholders in the Local Health Community (LHC). It clearly articulates that the proposed Regional Centre for Teaching, Trauma and Tertiary Care (3Ts) is affordable and is consistent with plans for services such as cancer care and critical care networks. It is also in line with commissioners' plans including Fit for the Future (FfF) which proposes reconfiguration of acute services across West Sussex.

35. FfF confirmed the RSCH's role as the critical care hospital for the South East coast and the Trust has the vision that by 2012 it will be one of the UK's leading teaching hospitals providing specialist and tertiary care services as well as excellent local general hospital services.. This includes the move of Regional Centre for Neurosciences onto the RSCH site (agreed in 2004), expanding the Sussex Cancer Centre and developing a Level One Trauma Centre. The Programme therefore seeks to address shortcomings in the Trust's ability to respond to national initiatives including *"Our NHS, Our Future"* which identified shortcomings in hi-tech emergency interventions. The Programme also needs to ensure the continuation of high quality secondary care to the local population delivered in high quality accommodation.

36. The Review Team found wide support both from the SHA and the local PCTs. There is an expectation within both BSUH and the PCTs that the SOC will be approved by the SHA at its meeting in July 2008 thus allowing the Programme Team to proceed to OBC approval, the targeted date for which is May 2009. A letter sent to the CEO of BSUH by the CEO of the lead PCT (BHCPCT) dated 2 June 2008 evidenced this wide support.

37. The Trust has now implemented a robust financial recovery plan to address a longstanding recurring deficit and has successfully turned a £4.5M deficit into a £100K surplus in the last financial year (2007/08). This has enabled the Trust (with transitional help from the local PCTs) to start to repay the accumulated debt to an agreed timescale.

38. The Review Team was informed that all of the three Sussex PCTs have very good financial control and this situation has undoubtedly led to them being able to give such strong support to the 3Ts Programme.

39. The Programme will allow the Trust to deal with some very long standing issues with the quality of patient accommodation, some of which pre-dates Florence Nightingale and is clearly not fit for purpose. This includes the Barry building which was built in 1828 and would fail most of the current measures applied today to assess the overall performance of health buildings under *NHS Estatecode.*

40. The NHS Estatecode assessment covers privacy and dignity, control of infection (bed spacing and cleaning), energy performance and cumulative backlog maintenance. The expectation is that any capital investment will significantly reduce the levels of backlog maintenance costs at the Trust (currently estimated to be £16M).

2: Business case and stakeholders

Business Case

41. The Trust began work on the 3Ts Programme SOC in Autumn 2007. A first draft of the SOC was completed in March 2008 and forwarded to the SEC SHA for review. The SHA had a number of comments on this initial draft. A final document responding to these comments and to issues raised by the PCTs in the LHC was approved by the BSUH Trust Board in June 2008. This final document is now with the SEC SHA for approval following approval by the relevant PCTs.

42. We have seen evidence of good working relationships between the Programme and the LHC throughout the development of the SOC. All of the relevant critical assumptions in the document have been shared with the LHC and agreed wherever appropriate. Corporately, the PCTs have confirmed their support for the strategic vision described in the SOC and the high level activity and financial assumptions underpinning the capital requirements subject to some specific caveats.

43. During this period the Trust has established significant momentum through the work of a small, committed Programme Team, strong senior management leadership and Trust Board support.

Stakeholders

44. The Review Team found wide support in the LHC for the 3Ts Programme and its decision to use a P21 approach for the delivery of the OBC.

45. It is well understood by the PCTs that the 3Ts Programme is the cornerstone of a wider programme to deliver improved healthcare across the whole of the LHC. The PCTs recognise the need to deliver their own primary care components to ensure the success of the overall LHC programme. Underpinning this is their proposal to establish shared governance arrangements to ensure that the LHC elements of the overall programme effectively mesh with the 3Ts activities. We can see much merit in the creation of an LHC Strategic Executive Group and an LHC Programme Board.

46. Whilst the Review Team supports this approach, we endorse the view held by the 3Ts Programme that they need to retain prime control over the BSUH based activities. The 3Ts Programme should have its own Programme Director and Programme Office. Appropriate governance arrangements should be jointly agreed as to how the 3Ts Programme Team will interface with the LHC Programme Board and the proposed shared LHC Programme Office.

3: Management of intended outcomes (benefits realisation)

47. Based on the Programme objectives, the SOC used six key benefits criteria to appraise the shorlisted development options. A benefits workshop applied these criteria to each option to provide a crude comparative appraisal.

48. Whilst the evaluation team deemed this to be a useful process to distinguish between options, no activity appears to have been undertaken to capture and quantify fully the specific whole life benefits that will accrue from the proposed investment in the preferred option. Consequently the SOC contains no reference to fully define and deliver a benefits realisation management process which can be carried forward into the OBC, the Full Business Case and beyond.

49. Given the level of estimated capital investment (circa £389m) there is an imperative to ensure that the OBC emphasises the key measurable benefits to be delivered by the preferred option.

50. It is also clear that in a climate of tight exchequer finances high quality benefit realisation plans may be one area in which projects can distinguish themselves from potential competitors especially when judged on the basis of national priorities. We recommend that this aspect of the OBC be given special attention.

Recommendation 1

51. The Programme Team should ensure that the OBC contains a comprehensive benefits management process.

4: Risk management

52. The SOC outlines the perceived key risks faced by the Programme and how they can be mitigated and managed.

53. The areas covered are:

- Clinical model changes
- Changes in demand
- Design development
- Planning approvals
- NHS approval process
- Procurement of supply chain partners
- Construction
- Operational service and performance
- Termination and decommissioning

54. The Programme does not however have in place a comprehensive risk management system.

55. We understand that such a process is currently under development. It is important that this work is concluded and that the system is fully implemented and integrated into all programme activity. The Programme must have in place a rigorous method for identifying, quantifying, owning, mitigating and reporting the risks that it faces along with the ability to highlight the most critical risks and escalate them to the 3Ts Programme Board.

56. During the course of our interviews it became clear that a number of people were concerned with a similar range of key risks. These need to be actively managed and their existence underpins the need for a rigorous and robust risk management process. Quoted examples which would need to be incorporated into a risk register and management process include:

1. Timescale of P21 Framework at national level. The current Framework is scheduled to end in 2010. This could impact on the proposed PSCP approach as currently envisaged.
2. There is a level of ambiguity at national level as to whether P21 is an acceptable procurement solution for a development of this magnitude.
3. There is a potential for costs to escalate given the demands placed on the local construction economy with other major construction projects being planned in Brighton e.g. football stadium, tower and marina extension along with the national impact of the Olympics in East London.

4. The potential conflict of interest associated with the Trust Cost Advisor and the PSCP.
5. Town and Country Planning approval – whilst high-level engagement with the City Planners has already commenced there are risks associated with decant plans, traffic, travel, the Listed Chapel.

Recommendation 2

57. The Programme Team should establish a robust risk management process.

5: Review of current outcomes

58. The current phase of the 3Ts Programme to generate the SOC has been effectively executed with good Programme Board and associated governance arrangements.

59. The Programme Team has engaged well with clinicians and stakeholders as evidenced by the clinical workshops and their high attendance. The workshops exposed a myriad of issues and ideas and these have been well tracked and recorded by the Programme Team and taken forward into a planned series of further, focussed workshops.

60. The Programme Team will have to actively work to plan and maintain an appropriate level of clinical engagement during the course of the development of the OBC but we found no resistance from clinicians to continue to support the Programme in any way they can. This commitment strongly reflects their belief in the opportunity the Programme represents to deliver the improvements in service they desperately believe are necessary for the Trust.

61. Outside of the clinical input we found there were encouraging signs of wider corporate Trust support for the Programme Team. We understand that the finance department believe that the financial control of the programme to date has been acceptable and have dedicated resource committed to the control of day-to-day project expenditures. We also understand that the HR department have identified an HR lead for the programme and we have seen a 'Rolling 3-Month Communication Plan for the BSUH 3T Strategy' generated by the Head of Communications.

62. The models of care being considered within the 3Ts Programme are complex. This complexity is compounded by the relatively poor nature of parts of the current Acute Hospital estate intertwined with some relatively new facilities and built assets. The mixed and relatively congested nature of the estate and the proposed models of care mean that any further major development of the site will involve a complicated decant programme and the need for significant resource and effort to maintain business as usual. An early outline decant programme has been developed which will be reviewed with the support and involvement of the PSCP.

6: Readiness for the next phase: Delivery of outcomes

63. The Programme Team and its associated governance have worked well to date to deliver a completed SOC. The next phase of the 3Ts Programme is to prepare and deliver an OBC by February 2009 for subsequent approval by the SHA and DH in May 2009.

64. Because of the relatively small size of the Programme Team and the need to generate the SOC to a challenging target date, not unnaturally there has been less focus on preparing for the next phase to develop the OBC. Consequently the majority of our recommendations appear in this section of the report.

65. Given the imminent departure of the current SRO, the importance of the Programme to the business of BSUH and the intensity of activity that will be required to deliver the OBC, the Review Team believes that now is the time to reallocate responsibilities to a new SRO.

66. The Chief Executive of BSUH should now become the SRO of the BSUH 3Ts Programme to drive the development of the OBC (and subsequent phases) and to reinforce the importance of the 3Ts Programme as a key component of the wider Local Health Community Programme of Change. This appointment will further strengthen the existing Programme governance arrangements.

Recommendation 3

67. The BSUH Trust Board should appoint their Chief Executive as the 3Ts Programme SRO.

68. Existing governance arrangements involving the 3Ts Programme Board supported by the Core Team are seen by those affected to have worked well in the development of the SOC and merely need to be revisited as the Programme moves into the development of the OBC to ensure they remain fit for purpose.

69. To move effectively into the development of the OBC the Programme Team needs to be led by an experienced full time Programme Director who has a proven track record in delivering a programme of this magnitude. One who can manage the key workstreams, the associated internal (BSUH) resources and the PSCP along with the interfaces with the LHC and other key stakeholders. Such an appointment was identified in the draft SOC dated 1st April 2008 and now needs to be made as soon as is practically possible.

70. The Programme Team also identified in the first draft of the SOC the need for additional managerial and technical support and these should also be sourced as soon as is practically possible. We would encourage BSUH to supplement the Programme Team using resources that are completely independent of the, soon to be appointed, PSCP and not simply seconded from the new partner.

Recommendation 4

71. The BSUH Trust Board should appoint an experienced Programme Director and relevant team resources as soon as possible to provide an effective client team to manage the PSCP and delivery of the OBC.

72. The co-ordination and management of the Programme Team and the PSCP will be greatly enhanced with the use of an integrated Programme Control Office. The process to deliver a comprehensive OBC (and subsequent phases) must be defined by a comprehensive Project Execution Plan (PEP) which acts as a "live" project manual for existing and future Programme Team members and which defines all key project management processes (including risk, benefits, change control, cost, value, quality and communications management), milestones, activities, resources and associated delegated authorities, outputs, governance and organisation.

Recommendation 5

73. The Programme Team should prepare and publish a comprehensive Project Execution Plan.

74. During the course of our interviews we found almost universal acceptance that the target timeframe to prepare and submit the OBC for approval was "extremely challenging". Everyone recognises the need, as does the Review Team, to maintain a high degree of momentum and energy to continue the good work undertaken to date.

75. The Programme Team should consider delaying the formal 'Phase 2' contracted appointment of the PSCP until the BSUH Trust are absolutely clear about and have approved the clinical brief. The expected deliverables from the PSCP also need to be fully understood.

76. We believe from our interviews, that a co-ordinated and integrated clinical brief may be anything between 1 to 4 months away from being complete and that a formal activity plan to conclude this important work does not exist. The Review Team recommends that a detailed plan is developed to deliver a robust clinical brief.

Recommendation 6

77. The Programme Team should prepare a robust plan to deliver and gain approval for the clinical design brief.

78. The Review Team also believes that the Programme Director and robust project protocols for the management of the PSCP should be in place before formally engaging the PSCP and embarking on the programme for completion of the OBC.

Recommendation 7

79. The SRO should consider the deferment of the formal 'Phase 2' appointment of the PSCP until such time as the clinical brief, the 3Ts Programme Director and the protocols to manage the PSCP are in place.

80. Whilst there is much to commend the challenging target dates the Trust has set for the Programme we believe the current Programme delivery plan is insufficiently rigorous to support these ambitious dates and should be revisited. Our interviews, the experience in the Review Team and the current issues as listed above suggest that the Programme is unlikely to successfully deliver a draft OBC by the end of 2008.

81. The Programme Team should therefore review the current programme and generate, agree and publish a fully resourced, robust programme plan to secure a comprehensive OBC and its associated consultations and approvals.

82. The programme plan will have to recognise a number of key issues that the OBC must address. These include:

- the SOC approval conditions that were placed by the PCTs (and any that may be placed by the SHA).
- the full exploration of all procurement options including HM Treasury Green Book analysis and comprehensive financial modelling (including sensitivity analysis) for both a Private Finance Initiative and a P21 procurement for the preferred scheme.
- sufficient time to start and continue an active discussion with the Capital Investment Unit of DH to explore the funding options and the appropriateness of the P21 procurement model for a construction project of this magnitude (we believe that such discussions will be welcomed by DH).
- to fully explore, develop and quantify the anticipated benefits arising from the Programme across whole health community.

Recommendation 8

83. The Programme Team should prepare and publish a comprehensive programme plan of activities and associated resource to deliver a robust OBC.

84. The next Health Gateway Review is expected immediately prior to the approval of the OBC.

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APPENDIX A

Purposes of Health Gateway Project Review 0: Strategic assessment

- Review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to the overall strategy of the organisation and its senior management.
- Ensure that the programme is supported by key stakeholders.
- Confirm that the programme's potential to succeed has been considered in the wider context of the organisation's delivery plans and change programmes, and any interdependencies with other programmes or projects in the organisation's portfolio and, where relevant, those of other organisations.
- Review the arrangements for leading, managing and monitoring the programme as a whole and the links to individual parts of it (e.g. to any existing projects in the programme's portfolio).
- Review the arrangements for identifying and managing the main programme risks (and the individual project risks), including external risks such as changing business priorities.
- Check that provision for financial and other resources has been made for the programme (initially identified at programme initiation and committed later) and that plans for the work to be done through to the next stage are realistic, properly resourced with sufficient people of appropriate experience, and authorised.
- After the initial review, check progress against plans and the expected achievement of outcomes.
- Check that there is engagement with the market as appropriate on the feasibility of achieving the required outcome.
- Where relevant, check that the programme takes account of joining up with other programmes, internal and external.

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APPENDIX B

Interviewees

Name	Role
Duncan Selbie	Chief Executive, BSUH
Amanda Philpott	SRO, Director of Strategy BSUH
Glynn Jones	Chair, BSUH
Steve Gallagher	Assistant Director Capital Development, BSUH
Gary Speirs	Capital Project Manager, BSUH
Jon Cohen	Dean, BSMS
Michael Wilson	COO, BSUH
Dr Nigel Marchbank	Lead Sussex Cancer Network
Neil McMullen	Regional Director, Nisbetts
Michael Postle	Business Support Consultant, SEC SHA
Richard Lavine	Nightingale Architects
Christian Walch	Nightingale Architects
Amanda Fadero	Director of Strategy, Brighton & Hove PCT
Ray Stevenson	Programme Manager ProCure21
Rob Smith	National Director ProCure21
Peter Finn	East Sussex Downs and Weald PCT
Ken Ellis	East Sussex Downs and Weald PCT
Paul Richards	Estates, SEC SHA
Colin Gentile	Director of Finance, BSUH
Chris Adcock	Deputy Director of Finance, BSUH
Ian Tait	Director of Facilities & Estates, BSUH
Nick Groves	Interim Assistant Director – Strategy, BSUH
Jan Nawrocki	Director of Medical Education, BSUH
Alison Robertson	Chief Nurse, BSUH
Julie Nerney	Non Executive Director, BSUH
John Hartley	Divisional Clinical Director, BSUH
Ben Masterson	DH Capital Investment Unit
Geoff Newman	Clinical Oncologist, BSUH
Phil Thomas	Divisional Clinical Director, BSUH
Matthew Fletcher	Medical Director, BSUH
Carry de Ridder	Sussex Critical Care Network Manager
Ali Mohammed	HR Director, BSUH
Andy Cashman	Service Development Manager, SEC Ambulance Service

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Richard Eager	Laing O'Rourke
Karen Hicks	Laing O'Rourke
Michael Schofield	Director of Finance, Brighton & Hove PCT
Peter Hale	3Ts Clinical Lead
Robert Gregory	Capital Development Manager, SEC SHA

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APPENDIX C

Summary of recommendations

Red – Take action immediately, 2-3 weeks.

Amber – Take action within 2-3 months or take action within an agreed timeline

Green – Take action as required.

		Status	Status July 2014	
Ref. No.	**Recommendation**	**R/A/G**	**R/A/G**	**Comment**
1.	**The Programme Team should ensure that the OBC contains a comprehensive benefits management process.**	**Amber**	**Green**	**Included in FBC**
2.	**The Programme Team should establish a robust risk management process.**	**Amber**	**Green**	**See Management case for further details**
3.	**The BSUH Trust Board should appoint their Chief Executive as the 3Ts Programme SRO.**	**Amber**	**Amber**	**SRO now Programme Director as per Selim governance review**
4.	**The BSUH Trust Board should appoint an experienced Programme Director and relevant team resources as soon as possible to provide an effective client team to manage the PSCP and delivery of the OBC.**	**Red**	**Green**	**Action complete**
5.	**The Programme Team should prepare and publish a comprehensive Project Execution Plan.**	**Amber**	**Green**	**See FBC appendices**

6.	**The Programme Team should prepare a robust plan to deliver and gain approval for the clinical design brief.**	**Red**	**Green**	**Complete**
7.	**The SRO should consider the deferment of the formal 'Phase 2' appointment of the PSCP until such time as the clinical brief, the 3Ts Programme Director and the protocols to manage the PSCP are in place.**	**Red**	**Green**	**Complete**
8.	**The Programme Team should prepare and publish a comprehensive programme plan of activities and associated resource to deliver a robust OBC.**	**Amber**	**Green**	**Complete**

NB: Full RAG definitions can be found in the 'Health Gateway Review RAG status' section.