University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper I

TRUST BOARD – 22 DECEMBER 2014

Better Care Together, Strategic Outline Case, Project Initiation Document – Key Issues for University Hospitals of Leicester NHS Trust

DIRECTOR:	John Adler, Chief Executive; Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Local Partnerships
DATE:	22 December, 2014
PURPOSE:	To present the Strategic Outline Case and Programme Implementation Plan (PID) for Leicester, Leicestershire and Rutland health and social care partners (LLRHSSC) and to highlight the implications for UHL.
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board, 9th December, 2014
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [x] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [x] 7. A clinically and financially sustainable NHS Foundation Trust [x] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient and public involvement has been an integral part of the development of the LLRHSC plans to date. This will continue on a project by project basis during implementation.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Once the overall plan has been agreed, an Equality Impact Assessment (EIA) will be undertaken on the whole plan. In addition to this an EIA will be integral to each individual business case.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED * For decision [X] For assurance [ ] For information [ ]	

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do ♦ We focus on what matters most ♦ We are one team and we are best when we work together♦ We are passionate and creative in our work* tick applicable box

Better Care Together
Strategic Outline Case (SOC) and Project Initiation Document (PID)

PURPOSE

1. The purpose of this paper is to seek approval for the Better Care Together Strategic Outline Case (SOC) and Programme Implementation Plan (PID) for Leicester, Leicestershire and Rutland health and social care partners.

2. The paper identifies key issues and mitigations that the Trust Board will want to be aware of and provides an opportunity for the Board to consider whether the governance arrangements and structures within UHL and external to it are sufficiently robust to oversee the transformation of local services and assure long-term clinical, operational and financial viability of the LLR system and UHL.

BACKGROUND

3. The SOC and PID are the key approval documents developed by the Better Care Together Partnership Board. These documents effectively form LLR's vison for the future of which an integral component is UHL's own 5-year plan. They align to the planning assumptions within our own 5 Year Plan and are completely compliant with the national policy direction set out in the 'NHS Five Year Forward View'.

4. There is nothing suggested in the SOC which is not included in our own 5-year plan.

5. The SOC is designed as a "wrapper" for all the future transformation business cases which will be required for the LLR system to achieve its five year vision.

6. The purpose of the SOC is to describe the case for change for service configuration across LLR and to describe a high level programme of work for making this happen.

7. The PID is essentially a programme management document. Amongst other things, it addresses the issues raised during the largely positive programme Gateway review. The Chief Executive has been involved in the development of the PID and related resourcing discussions in his role as joint Senior Responsible Owner of the BCT Programme. He is satisfied that the PID appropriately describes the structures and processes required to take forward the programme. The key policy issues therefore relate to the SOC rather than the PID.

KEY ISSUES AND DISCUSSION POINTS

7. **Vision for services in LLR**-The BCT vision for the future is one in which the community model of care is transformed, with a greater emphasis on prevention and far more provision of care taking place outside of hospital within primary, community and home care settings. The consequence of this will be less reliance on the acute sector. This aligns to the Trust's vision of becoming of "smaller and more specialised".

8. The case for a smaller acute hospital base is supported by several bed utilisation reviews and more recently by the detailed analysis undertaken to understand the likely cohorts of patients whose care could be contained or continued in alternative settings.

9. What will need to be very carefully managed is the transition from the current model of care to future models of care. **It is essential that beds are not removed from the system until the alternatives have sustainably reached scale and are delivering the level of care and outcomes anticipated**.

10. Eight clinical pathways have been described in the SOC and these set the vision for revised service models in the future. Examples include new models for urgent care, planned care, long term conditions and care of frail older people.

11. The vision for clinical services across LLR is completely compliant with the recently released national policy direction.

12. **Working in partnership to secure delivery**-Delivery of the new models of care will require health, social care and commissioners to work as a 'system' and to jointly design and safely deliver effective services that are tailored according to need.

13. It will require new pathways of care to be developed that have less reliance on acute and in patient models of care. This will require UHL to work in different ways both inside our organisation and outside it. It also creates a co-dependence between UHL and other health and social care partners – this represents a step change from current models of care and will require a cultural shift in practice and behaviours within and across organisations.

IMPLICATIONS FOR UHL

14. **Bed reductions**-The LLR strategy will realise a significant proportion of the health economy benefits through a reduction in the number of acute beds and the associated physical assets. The current bedded model of service provision across the LLR system includes 1773 acute beds across 3 acute hospital sites, 660 community and mental health beds in eight community hospitals and one mental health hospital. The shift of activity to community settings will involve UHL releasing a total of 571 acute beds (taking account of demographic growth), this equates to 462 physical beds. This is achieved through a combination of a) increases in internal productivity , b) provision of alternative services to avoid acute admission and c) earlier discharge to sub-acute services delivered in community hospitals or people's own homes.

15. **Workforce changes**-Workforce will be a key enabler to the delivery of the LLR strategy and will require a significant shift in skill mix from secondary to community care with new ways of working across organisational boundaries and traditional disciplines. The scale and pace of change required will create the greatest challenge to delivery.

16. **Transitional and transformational funding**-The financial case in the SOC sets out the need for external funding once existing sources of funding within the health economy have been exhausted.

17. The funding required is split between £255.8m of revenue (including deficit funding) and £430.3m of capital. Within this the funding for UHL is £175.2m to support the forecast deficit, £88.5m as transitional revenue funding and £286.3m capital resource. This temporary support will be required throughout the period to 2018/19.

18. Due to the forthcoming election in May 2015, it is very likely that the SOC will not be approved until after that.. This causes a tension with there being a growing need for some of UHL's major business cases to be delivered earlier than previously anticipated. It is intended that the SOC used as a "wrapper" for the UHL business cases and therefore any delay in the approval of the SOC may delay the progress of the business cases. This is an issue which is currently under discussion with the NTDA. In addition, there is likely to be a need to for transitional and transformational support prior to the approval of the SOC. How to resolve this timing conflict is being discussed with both the NTDA and NHS England.

19. The SOC is predominantly focused on additional revenue expenditure associated with the transformation programme e.g. major business case development, project management, capital charges, premium staffing and service transformation. It may not fully not reflect all of the income loss UHL is likely to experience before the Trust is in a position to take out fixed costs. This transitional income relief will need to be negotiated with LLR partners as part of contractual negotiation.

20. **Dependence on partners**-Delivery of the changes outlined in the SOC will only be achieved if all partners play their part; UHL will not be able to achieve the bed reductions identified without commissioners and primary care managing flow into UHL, with Leicester Partnership Trust and Social Care supporting timely egress from UHL. The Trust is critically dependent on all partners doing their part in order to secure our vision of moving from 3 acute sites to 2.

21. **Clinical and financial sustainability**-The SOC explored a number of alternative options for delivering the vision set out in the five year strategy including organisational efficiencies and ceasing delivery of non-agreed services. The outcome of the evaluation is that the BCT programme is the only viable option to deliver the qualitative benefits for patients and service users, in a way which is achievable and affordable. For UHL this means that the vision of moving from 3 acute sites to 2 and becoming smaller and more specialised is the only realistic option to secure clinical and financial sustainability.

KEY MITIGATIONS

22. There are a number of very significant implications for UHL in the BCT SOC. It is essential that we develop robust risk and mitigation plans. In summary these include:

23. **Contractual form and structure**-The current contracts in place between commissioner and provider will not support the necessary flow of funds to support and incentivise the transformation outlined. UHL require transitional funding to mitigate the impact of income loss whilst LPT and Social Care need to be incentivised to support early movement of patients out of UHL. Discussions are on-going to agree a more appropriate contractual form that will support and incentivise all partners to deliver their part of the change. These new models are intended to be in place for the 2015/16 contracting round.

24. **Clear metrics**-As the delivery of the plan requires all partners to deliver their part it is essential that there are clear metrics developed to show progress over time for all of the work streams identified. This will support and drive accountability between all partner organisations.

25. **Clinical leadership**-Clinical leadership will be critical to success. Active engagement of UHL clinicians in driving clinical change is essential and is already growing particularly is support of the out of hospital community shift between UHL and LPT.

26. **Governance**-A robust governance structure is already in place for the BCT programme and is aligned to our own governance structures and processes. This has been enhanced recently through the development of a UHL PMO for reconfiguration.

27. Organisational responsibilities – The NHS "Forward View" sets out a number of organisational models which could be used to effectively implement the kind of radical change described in the SOC. How best to use such models locally is the subject of ongoing discussion within the local health economy and will be further debated at a Trust Board Development session in the New Year.

RECOMMENDATIONS

27. The Trust Board is asked to:

- **RECEIVE** this paper;
- **DISCUSS** the issues and mitigations and confirm that they adequately address the key factors identified;
- **APPROVE** the Better Care Together SOC and PID**AUTHORISE** the Chief Executive to pursue the key actions set out in this paper in conjunction with partners

Better care together

A partnership of Leicester, Leicestershire and Rutland Health and Social Care

November 2014

Better Care Together

Strategic Outline Case

November 2014 v4.5

For discussion and review

Contents

List of Tables

Glossary of Terms

Term	Definition	Term	Definition
A&E	Accident and Emergency	LETC	Local Education and Training Council
ASC	Adult Social Care	LIFT	Local Improvement Finance Trust
BADS	British Association of Day Surgery	LLR	Leicester, Leicestershire and Rutland
BCBV	Better Care Better Value	LoS	Length of Stay
BCF	Better Care Fund	LPT	Leicester Partnership NHS Trust
BCT	Better Care Together Programme	LRI	Leicester Royal Infirmary
CAMHS	Child and Adolescent Mental Health Services	LTCs	Long Term Conditions
CCG	Clinical Commissioning Group	MH	Mental Health
CEO	Chief Executive Officer	MIU	Minor Injuries Unit
CFO	Chief Finance Officer	NEL	Non-Elective
CIP	Cost Improvement Programme	NPC	Net Present Cost
CQUIN	Commissioning for Quality and Innovation	OBC	Outline Business Case
CRL	Capital Resource Limit	OGC	Office of Government Commerce
CSF	Critical Success Factors	PDC	Public Dividend Capial
DMU	De Montfort University	PH	Public Health
DNA	Did Not Attend	PID	Programme Initiation Document
DTOCs	Delayed Transfers of Care	PMO	Project Management Office
EMAS	East Midlands Ambulance Service	PPI	Public and Patient Involvement
FBC	Full Business Case	QIPP	Quality, Innovation, Productivity & Prevention
GP	General Practitioner	RTT	Referral to Treatment
HEI	Higher Education Institution	SOC	Strategic Outline Case
HSCE	Health and Social Care Economy	TSA	Trust Special Administrator
IM&T	Information Management and Technology	UCC	Urgent Care Centre
IO	Investment Objectives	UHL	University Hospitals Leicester NHS Trust
LD	Learning Disabilities	WIC	Walk in Centre

1 Executive Summary

1.1 Introduction and scope of this document

In June 2014 the Local Health and Social Care Economy (LHSCE) developed a 5 year strategic plan setting out its ambition to transform local services in line with the models of care set out by the Better Care Together (BCT) programme.

BCT sets out a vision to improve health and social care services across LLR (Leicester, Leicestershire and Rutland), from prevention and primary care through to acute secondary and tertiary care. Successful delivery of this programme will result in greater independence and better outcomes for patients and service users, supporting people to live independently in their homes and out of acute care settings. The vision set out by the programme is in line with the strategic direction set out by NHSE's Five Year Forward View, and responds to the challenge set out more widely in A Call To Action, delivering sustainable clinical change at a time of growing financial pressure.

The purpose of this Strategic Outline Case (SOC) is to appraise whether the BCT programme is the best way of addressing the local case for change. In assessing the programme against a range of Critical Success Factors (CSF) it finds that the path laid out in the five year strategy is the only viable way of achieving clinical and financial sustainability in LLR. The document makes the case for the external funding that will be collectively required through the transition period from 2014/15-2018/19. It should be read in the context of BCT's Programme Initiation Document (PID) and the 5 year strategy which preceded it, both of which are key building blocks for this business case.

This document is the result of extensive collaboration and is jointly authored on behalf of East Leicestershire and Rutland Clinical Commissioning Group (CCG), Leicester City CCG, West Leicestershire CCG, Leicestershire County Council, Leicester City Council, Rutland County Council, Leicestershire Partnership NHS Trust (LTP) and University Hospitals of Leicester NHS Trust (UHL). A partnership approach is vital to the development and delivery of BCT as the problems faced by the LHSCE cannot be solved by any of these organisations working independently. EY have supported the development and compilation of the SOC in partnership with the Programme PMO and the organisations listed above. During this process all assumptions and figures have been signed off at regular stages with CFOs, COs and AOs to ensure clear oversight is maintained.

The SOC is designed to be a "wrapper" for all the future transformation business cases which will be required for the system to achieve its five year vision. The period of development has allowed local organisations to come together in the joint design of more detailed implementation plans, adding detail to the system projects set out in the 5 year strategy, and identifying the transitional support required to deliver these sustainably.

Further work will be required following the submission of this document to prepare for the series of organisational business cases that will need to be produced. These business cases will need plans to be worked through in granular detail, and the plans will need to be predominantly taken forward under the joint governance already established by BCT. This will help mitigate the risks posed by the interdependencies set out in the SOC, particularly in areas such as the beds reconfiguration, and a joint approach will help with the vital task of assessing the likely impact of NHS plans on local social care organisations, and conversely of the impact on the NHS of the significant efficiency savings required from local government over the same period.

1.2 Structure of this document

The SOC has been prepared using the Office of Government Commerce's (OGC's) Five Case Model to provide a structured approach in producing the SOC.

The five perspectives that the Five Case Model explores are set out below:

- **The Strategic Case** explores the case for change – exploring why the proposed investment is necessary in the LHSCE and how it fits with the overall local and national strategy
- **The Economic Case** asks whether the solution being offered represents value for money – it requires alternative solution options to be considered and evaluated
- **The Commercial Case** reviews the different approaches to funding the programme and also reviews the relevant commercial arrangements to the decision making process.
- **The Financial Case** asks whether the financial implication of the proposed investment is affordable and sets out the requirements for Non-Recurrent funding to support the developments described
- **The Management Case** highlights implementation issues and demonstrates that the LHSCE is capable of delivering the proposed solution

1.3 Strategic case

The strategic case builds on the models of care developed in the 5 year strategy, and sets out how the BCT vision will be achieved. This vision is:

> *'…to maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings'.*

The vision for the LHSCE is to improve outcomes for patients and service users whilst maintaining an affordable system which can be safe for future generations. It sets out a case for change for the health economy which requires broad changes to models of care to change the traditional reliance on acute-based care, develop more services in the community, and improve primary prevention and identification of people at risk of significant deterioration in their health and quality of life earlier than ever before.

The financial challenge set out in this document is significant. Modelling conducted during the development of the 5 year strategy shows that the total gap between income and expenditure for the NHS element of the LHSCE in 2018/19 is £398m before any CIP/QIPP or other projects are modelled. This was in the context of virtually no anticipated increases to real terms funding over the 5 years, and anticipated increases in the forecast demand brought about by the ageing population and greater numbers of people living with multiple long term conditions. In addition to this, cuts to local government funding have been even more severe, with councils under pressure to radically change the provision of adult social

care over the next 5 years. The overall impact of this funding shortfall in local government is not yet fully known as it is dependent upon political decisions at both a national and local level and the impact of the recent Care Bill is yet to be fully assessed, however it is clear that the way we currently deliver services will not be sustainable in the future.

The strategic case develops a vision for the future in which the community model of care is transformed, with far more provision of care taking place outside hospital in primary, community and home care settings. Reviews which have taken place at UHL suggest that a significant number of patients currently in acute beds do not require this enhanced level of care, and that patients can often deteriorate, with increasing levels of dependency the longer they stay in hospital. The plans set out in the strategic case, if fully enacted, will see a significant "left-shift" of care out of acute settings, allowing UHL to concentrate on providing care to complex patients and improving the provision of sub-acute services in community hospitals, and the development of greater capacity in community teams allowing patients to live more independently in their homes. This "left shift" is planned across the spectrum of prevention and care, supporting as many people as possible to live independently through better education and preventative programmes.

The drive to improve health and social care integration has begun. The Better Care Fund (BCF) will begin to support independent living for patients and service users and the LHSCE will look to develop this model further. The joint health and social care fund has been introduced in 2014/15 and will be expanded in 2015/16 to cover a range of health and social care projects. Many of these changes to services will be targeted at the frail older population and therefore a number of the initiatives are captured in the section of the strategic case which describes the frail older people (FOP) workstream. The BCF is a key enabler to change and represents the co-dependence of NHS and adult social care services. The 5 year strategy modelling recognised this importance by assuming that the funding associated with the BCF would be continued through the latter years of the plan, however further work is required to ensure that sufficient support is available to social care over the period of transformation.

It is anticipated that these changes will lead to the reduction of 427 beds at UHL, and allow the organisation to achieve its vision of moving from 3 to 2 acute sites by 2018/19, a core strategic objective. However, these changes will require a significant increase in capacity in primary care, social care and community care, and in order to affect these changes at a time when services will necessarily be undergoing disruption requires that plans are put in place during this transition period to allow the changes to the model of care to be made safely and sustainably.

Local estates, IM&T and workforce across health and social care will undergo significant changes over the 5 years of the plan with opportunities for greater sharing of resources including the estate. Some of these have already formed the basis of detailed plans, such as the series of estates changes planned across the UHL sites (e.g. the new emergency floor), however a number of stages of new community estates development are now captured in the SOC to ensure existing facilities are fit for purpose. This is particularly the case for primary care, where CCGs will transform the current offer to improve access for the most complex patients, with some services developed at a locality or "health neighbourhood" level to improve quality.

Workforce remains the single biggest challenge for the transformation of services. New community facilities, services and teams will require significant recruitment and much of this will need to come from the existing workforce as more services are provided outside of an acute setting. The emerging models of care will require a review of both generalist and specialist skill balance; the need to ensure a supply of nurses becoming community focused

over time; and the need to ensure more social care staff are available to support people at home.

1.4 Economic case

The economic case explores the potential alternative options for delivering the vision set out in the five year strategy. Three alternatives are considered:

i) Delivery through the BCT strategy;
ii) Delivery of financial balance through organisational efficiency alone (do minimum option); or
iii) Ceasing delivery of non-agreed services to regain financial balance.

It finds that when set against the CSF adopted by the programme and set out in the PID, the BCT programme option is the most able to deliver the qualitative benefits for patients and service users, in a way which is achievable and affordable. Delivery of financial balance through organisational efficiency alone, without working as part of system, would require internal organisational savings programmes well above the level deemed sustainable, and in addition would pose significant risks to the integrated working which has underpinned the programme so far. An alternative option of ceasing delivery of non-agreed services was also considered, however the impact on patient safety and the risks posed by an uncertain legal process were considered to be too great for the LHSCE to take on.

Given this qualitative discussion, the BCT programme was economically assessed against the "do minimum" option. The do minimum option assumed that organisations attempted to make savings until such point as they were deemed to be unsustainable, at which point it was probable that an external party would place one or both local providers into an administration process, adding further cost and delay to the decision to find a sustainable solution. The anticipated impact of this delay and additional uncertainty has been calculated in the economic case and the net present cost was compared against the BCT option, as below:

Costs/(Benefits)	RANK	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total (£m)
BCT Option	1	(31,580)	74,785	93,990	103,778	19,166	(78,422)	(66,711)	115,007
Do Minimum Option	2	(29,878)	84,079	101,808	106,918	16,677	(62,014)	(84,946)	132,644

The conclusion of the economic case is therefore that the LHSCE should support the BCT programme as the only viable way of achieving quality and financial sustainability across LLR.

1.5 Commercial case

At this stage the commercial case has been limited to a discussion of potential options for financing the transition support set out by the programme. The most likely procurement route to be followed for this scheme is through a combination of existing Capital Resource Limited (CRL) funds and additional Public Dividend Capital (PDC) loans. This offers flexibility to organisations within LLR around fully shaping the design of services and assuring a focus on quality. Utilisation of internal NHS funds has the benefit of being the cheapest form of long term capital likely to be available for such projects.

1.6 Financial case

The financial case sets out how the BCT programme will allow the health economy to respond to the £398m identified gap by 2018/19. It is vital that this challenge is understood

as one which is owned by all organisations. The approach to modelling has been to formulate a single health economy wide understanding, based upon agreed assumptions concerning demographic growth and known funding levels. The interrelationship between the work being taken forward within each clinical workstream and the significant savings required from each organisation is key. The NHS organisations cannot achieve collective financial surplus without working closely together.

Although in the financial breakdown the majority of savings that need to be delivered are shown against UHL and LPT, in reality these organisations will not be able to achieve this without the system projects which are being led by each of the 8 clinical workstreams. The workstreams' impact feeds into the beds reconfiguration programme which allows UHL to consolidate from 3 to 2 acute sites and therefore make a significant recurrent saving by 2019/20.

The financial case sets out the case for external funding required, split between **£255.8m** of revenue (including deficit funding), and **£430.3m** of capital, once existing sources of funding within the health economy have been exhausted. This temporary support will be required throughout the period to 2018/19 where the health economy will reach recurrent surplus.

It is important to note that the projected gap of £398m only reflects the NHS impact of the changes that are taking place. Further work is needed to understand the implications of this programme on local government budgets, and in addition to understand the future impact of significant changes to social care services on corresponding health services. This will be the subject of an ongoing joint programme of work.

1.7 Management case

The management case sets out the importance of managing the BCT programme in a joined up and inter-dependent way. The joint health and social care governance structure establishes the importance of the clinical workstreams as the drivers of change across the health economy, and represents the significance of their role in enabling the major changes to take place at UHL and LPT.

The programme will be overseen by the BCT Partnership Board, overseen by the joint SROs who have been in place since July 2014. A joint approach to risk and benefits management has been developed and the jointly funded PMO established to ensure that the complexities and interdependencies of the programme are appropriately managed.

1.8 Conclusion

The conclusion of this SOC is that after a qualitative and quantitative assessment of viable alternatives, the BCT programme represents the only viable way of ensuring the clinical and financial sustainability of services across LLR. Further work must now be completed on individual business cases and detailed organisational and workstream plans, to ensure a collaborative and coordinated approach is taken to the redesign of the health and social care system.

2 Strategic Case

2.1 Introduction to the strategic case

This section of the business case sets out the strategic context across the LLR LHSCE and makes the case for transformational changes to models of care. The new models proposed are then fully described before setting out the investment objectives, risks, constraints and dependencies associated with the BCT programme.

2.2 National strategic context

Health and social care services in England are at a seminal point in their history. The combined pressures of a growing and ageing population, rising public expectations and the ongoing squeeze on public finances mean that commissioners and providers must cooperate to commission and provide different service models.

The Keogh urgent and emergency care review[1]

Demand for health and social care services has been rising year on year – the following quotes are taken from the recent Keogh review into emergency and urgent care services:

- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008, indicating greater demand and complexity in primary care;
- There were 6.8 million attendances at walk-in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since data was first recorded a decade ago;
- Attendances at hospital A&E departments have increased by more than 2 million over the last decade to 16 million;
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million; and
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13.

Growth in demand is set to continue as people live longer with increasingly complex, and often multiple, long term conditions (LTCs). This will have a profound impact on both NHS and social care budgets.

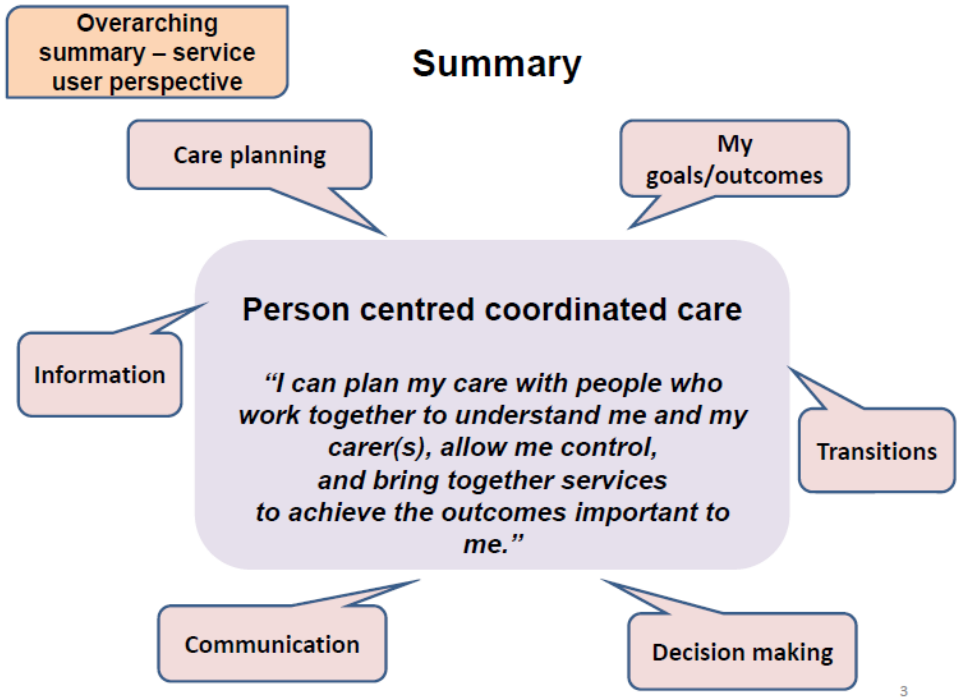
People's expectations are also rising. The NHS Constitution, a consumerist society and scandals such as Mid Staffordshire have created an environment in which the public rightly expect an NHS that can deliver world class services, with minimal delay in a setting the patient chooses. It is acknowledged that citizens want to; be fully engaged in making positive choices about their own health; participate in the shaping of health and social care services; have access to reliable data and advice about health and care services; and be able to choose which services they can use and how to access them.

[1] http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx

Person centred coordinated care

The public expect health and care services to be joined-up, but the system is fragmented between different commissioners and different providers. Work by National Voices on a "narrative for person-centred co-ordinated care"[2] demonstrates that this lack of integration and co-ordination is unacceptable to the public: instead people want co-ordinated care as summarised below.

Figure 1: Person centred co-ordinated care summary



Source: A Narrative for Person-Centred Coordinated Care, NHS England, 2013

National financial challenge

The government's deficit reduction plan involves significant cuts in public spending. The 2010 Government Spending Review[3] set out plans to reduce government funding for councils by 26% by 2014/15, whilst the 2013 Spending Round resulted in council resources being cut by a further 10% in 2015/16. Adult social care accounts for 18% of local authority spending, meaning that the pressure to reduce costs will inevitably impact on social care.

The settlement for the NHS has been more generous with the NHS budget being ring-fenced. However, the growing and ageing population, and rising expectations have resulted in demand for health services increasing by up to 5% each year. If demand continues to rise at historic rates, the NHS will face a growing budgetary shortfall despite its budget being protected. The 2011 "Nicholson Challenge"[4] represented the initial response with £20bn

[2] http://www.nationalvoices.org.uk/defining-integrated-care
[3] https://www.gov.uk/government/publications/spending-review-2010
[4] http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51208.htm

being targeted from a budget of circa £110bn. The NHS is on track to deliver against the challenge by March 2015 but is now faced with the need to make further savings.

The government's response to these pressures has been a series of reforms to the public sector coalescing around the Health and Social Care Act (2012) and The Care Act (2014). Key points impacting on this business case are:

- The creation of the BCF bringing together elements of health and local authority funds, aimed at promoting integrated care;
- The promotion of joined-up commissioning;
- The introduction of a standard minimum eligibility threshold for social care;
- The introduction of a legal right to have a personal budget;
- Placing a legal responsibility of local authorities to issue a care and support plan to everyone receiving care, and a support plan for all carers; and
- Introducing a responsibility on local authorities to assess carer needs.

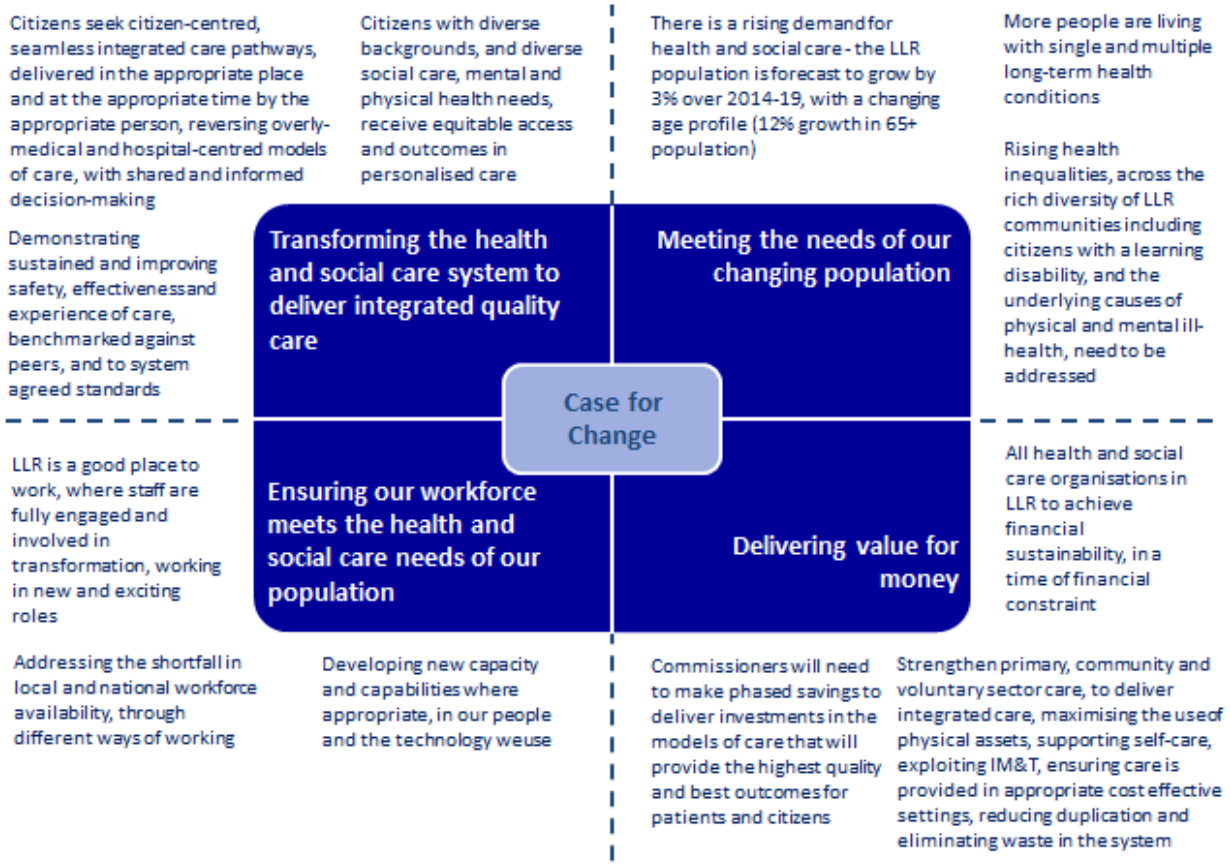
In NHS England's recently released Five Year Forward View[5], it is stated that "a combination of a) growing demand, b) no further annual efficiencies, and c) flat terms real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30bn a year". This requires organisations to find different ways of working to address these growing pressures and sets out a call for action on demand, efficiency and funding.

2.3 Local strategic context

The section above set out the national context. In this section the local case for change is set out. The following diagram provides a summary of the reasons the LLR system must change – each quadrant of the diagram is discussed in more detail below.

[5] NHS England 5 year view, October 2014, http://www.england.nhs.uk/ourwork/futurenhs/

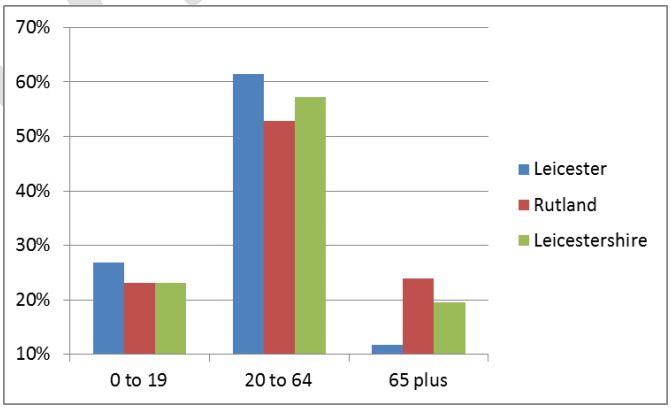
Figure 2: Summary case for change



2.4 Meeting the needs of our population

LLR has a population of 1.03 million with 32% of people living in the city, 64% in Leicestershire and 4% in Rutland. There are important differences between Leicester City, Leicestershire and Rutland – firstly the City of Leicester has a younger population; the county areas are markedly older.

Figure 3: Age breakdown of population, 2014[6]



[6] 2012 population estimates, Office of National Statistics

Secondly, the city of Leicester has a much more ethnically diverse population than county areas.

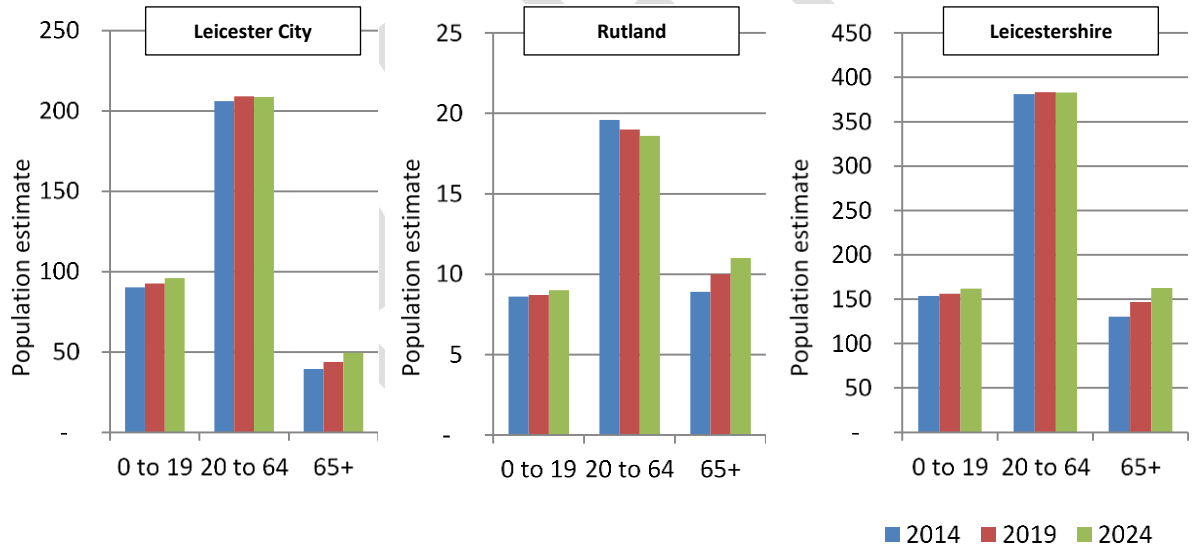
Figure 4: Ethnicity[7]

	White	Gypsy / Traveller / Irish Traveller	Mixed / Multiple Ethnic Groups	Asian / Asian British: Indian	Asian / Asian British: Pakistani	Asian / Asian British: Bangladeshi	Asian / Asian British: Chinese	Asian / Asian British: Other Asian	Black / African / Caribbean / Black British	Other
Leicester	50.4%	0.1%	3.5%	28.3%	2.4%	1.1%	1.3%	4.0%	6.2%	2.6%
Rutland	97.0%	0.2%	1.0%	0.3%	0.1%	0.0%	0.3%	0.2%	0.7%	0.2%
Leicestershire	91.4%	0.1%	1.3%	4.4%	0.3%	0.4%	0.5%	0.7%	0.6%	0.4%

Service design and delivery must respond to these important differences particularly in terms of access to services – culture and language being potential barriers amongst minority ethnic communities in the city; poor access to transport being a potential barrier for older people living in Leicestershire and Rutland.

The population is also changing. The LLR population is forecast to grow by 32,100 (3%) by 2019. Expected growth rates vary marginally between the three local authority areas and more materially between different age groups.

Figure 5: actual forecast population change[8]



Relative demand for different health and social care services will be affected by these varying rates of demographic change. Whilst population growth is not particularly high overall, factors of more importance to note are as follows:

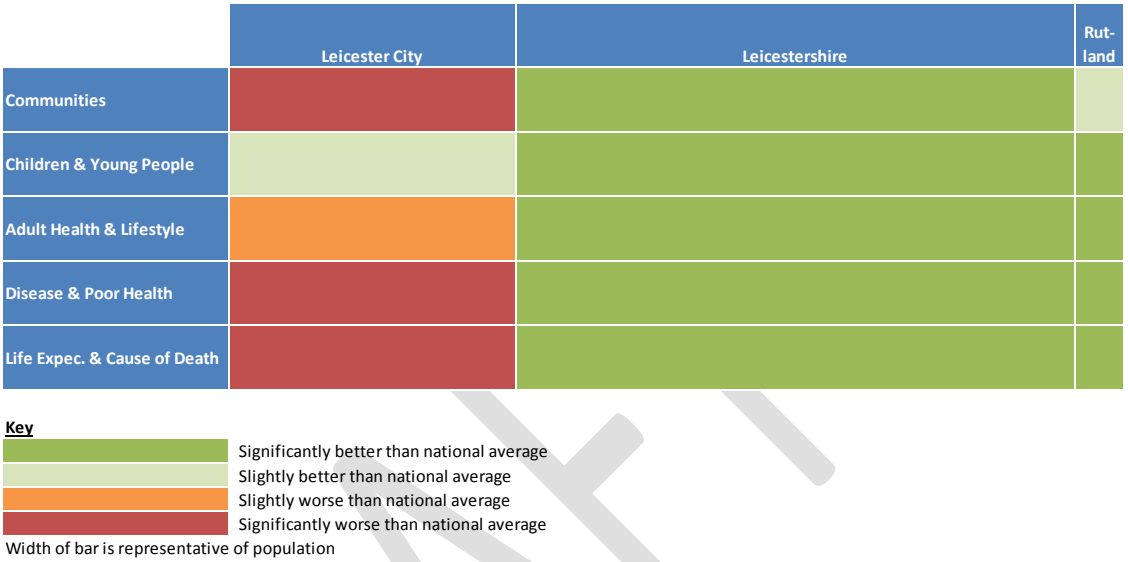
- A much higher percentage growth rate amongst the over 65s who are disproportionately represented in both NHS and local authority services;
- A faster rate of growth amongst young people in the city than elsewhere, which will impact upon services such as school nursing and paediatrics; and

[7] 2011 Census, Office for National Statistics
[8] Subnational population forecast 2012, Office for National Statistics

- Almost no growth in working age adult population, which suggests providers will need to look outside of LLR when recruiting the extra staff needed to cope with rising demand.

The relative demand for health and social care services, and the relative mix of service provided is also affected by underlying health of different populations. The diagram below provides a visual representation of which areas experience better or worse overall health compared to the national average.

Figure 6: Health profile 'heat map' of LLR[9]



Key underlying themes are summarised below.

Leicester city:

- 75 per cent of people are classified as living in deprived areas;
- There are significant problems with poverty, homelessness, low educational achievement, violent crime, long-term unemployment, poor diet, lack of exercise, alcohol and drug misuse, diabetes and tuberculosis;
- People suffer from both physical and mental ill health, and die much younger than the national average. Mortality rates are particularly high for heart disease and stroke: there is also a high level of infant deaths; and
- Barriers to people accessing services are primarily cultural.

Leicestershire:

- Just over 70 per cent of people are classified as living in non-deprived areas, although there are pockets of deprivation particularly in the north-west of the county;
- There are moderate concerns over educational achievement, increased and higher-risk drinking, incidence of malignant melanoma and excess winter deaths;
- There is resultant high life expectancy for males and females and low level of infant deaths; and

[9] NHS England health profiles, 2013

- Barriers to people accessing services are low, with the exception of some of the more rural areas to the east of the county.

Rutland:

- Over 90 per cent of people are classified as living in non-deprived areas;
- There are moderate concerns over educational achievement, malignant melanoma, excess winter deaths and road injuries/deaths;
- There is resultant high life expectancy for males and females and low level of infant deaths; and
- Barriers to accessing services are associated with the rural nature of the area.

Demographic and socio-economic differences manifest themselves as inequalities, which appear to be rising despite recent attempts at their reduction. Inequalities are recorded in:

- Differing access rates between different ethnic communities;
- Accessibility between people living in rural areas, particularly the rural poor, and those living in urban areas;
- Outcomes between city and county (life expectancy in the city is 5.6 years less than in Rutland amongst men and 2.5 years less amongst women; years of 'healthy life' show similar variation);
- Outcomes between different localities within both the city and the county (within Leicester life expectancy is 9.4 years lower for men and 5.0 years lower for women in the most deprived areas of Leicester than in the least deprived areas); and
- Outcomes between vulnerable groups and the wider population (people with enduring mental illness are likely to have worse general health and to die over 10 years earlier).

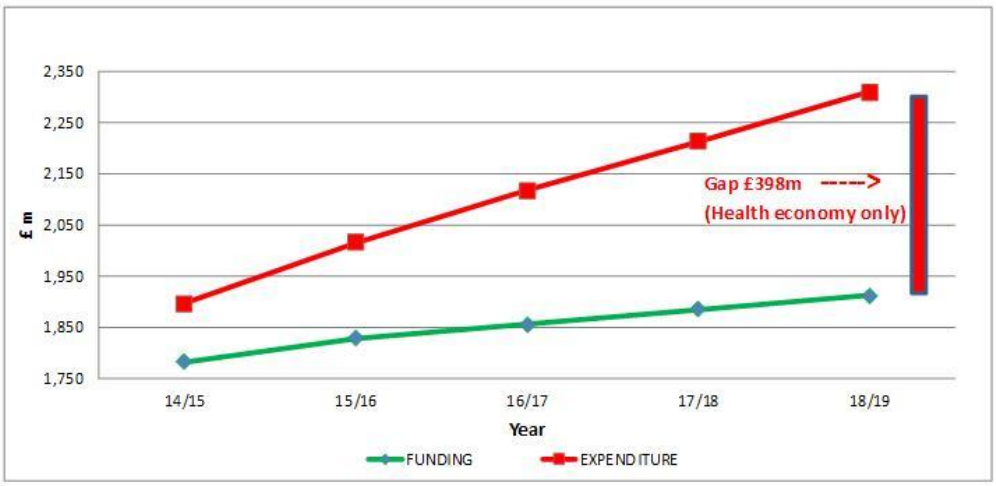
2.4.1 Delivering value for money

The local health and social care system is already facing financial pressures – the health economy is one of eleven "financially challenged" economies identified by NHS England with current financial pressures manifesting themselves particularly clearly in a deficit at UHL.

Since formation, UHL has narrowly broken even every year with the exception of 2013/14 when it posted a £39.7m deficit. The Trust's financial recovery plan requires moving from 3 to 2 acute sites by 2018/19, and to do this will require both system led change around a joint beds reconfiguration programme, and internal efficiencies such as reducing length of stay, increasing day case rates, standardising clinical protocols and rapid turnaround of tests.

Modelling has been undertaken to articulate what would happen to the finances of the LLR health system (UHL, LPT, Leicester City CCG, East Leicestershire and Rutland CCG, West Leicestershire CCG and Leicestershire and Lincolnshire Area Team (direct commissioning of primary care and specialised services)). If no action were to be taken to improve the quality, outcomes and value for money of services currently provided to patients a financial gap of £398m has been identified by 2018/19.

Figure 7: "Do nothing" financial gap 2014 - 2019



	£ m				
INCOME & EXPENDITURE	14/15	15/16	16/17	17/18	18/19
FUNDING	1,783	1,829	1,856	1,885	1,912
EXPENDITURE	1,896	2,016	2,117	2,213	2,310
"DO NOTHING" GAP	(113)	(187)	(261)	(328)	(398)

The local authorities in the LLR system also face very significant financial pressures to the extent that by 2018/19 a collective savings requirement of £177m is predicted (Leicester City Council £64m, Leicestershire County Council £110m, Rutland County Council £3m). The broader cuts to local government funding will inevitably have an impact on adult social care, which currently constitutes between 33-42% of expenditure. The savings figures above also exclude any pressures from the Care Act 2014. These are currently being assessed.

Local authorities have been engaged throughout the development of the 5 year strategy. The organisations are represented in all key programme governance groups and have been actively involved in developing and challenging new models of care.

In identifying the potential to deliver health economy efficiencies, the Better Care Better Value (BCBV) and Commissioning for Value indicators were used to benchmark LLR organisations against peers. BCBV indicators suggest that if UHL and commissioners performed at upper quartile, there would be a total annual saving of £86m, and if these organisations performed at best decile there would be an annual saving of £104m. The Commissioning for Value data packs provide an alternative view of potential commissioner savings by focusing on disease groups rather than settings of care. Nevertheless, the results triangulate with the BVBC indicators and suggest commissioner LLR wide savings of £47m are possible based on achieving the average of the best 5 of 10 peer CCGs.

The scale of the financial gap facing LLR emphasises the need to move to a sustainable model of care.

2.4.2 Ensuring our workforce meets the health and social care needs of our local population

The combined NHS and social care workforce is one of the largest groups of employees across LLR. Organisations struggle to recruit to some key posts and agency staff use is higher than expected. There is also too much silo working which can result in less than optimal communication between teams, as well as duplication of roles and effort. Looking ahead there are a number of workforce challenges that will have a local LLR impact:

- The health care workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. However, those placing the greatest demand on services are older people with multiple conditions who require support from a range of services;
- An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad;
- By 2021 there will be a national shortfall of between 40,000 and 100,000 nurses and there could be 16,000 fewer GPs than needed;
- The ageing population means that by 2025 the national social care workforce will need to increase from 1.6 million to 2.6 million; and
- The nature of work undertaken by staff is changing. As the population ages, our staff will need to care for more people with complex needs and multiple co-morbidities.

LLR recognise that in future they could face shortages of staff in some key disciplines and that staff currently employed will need to work differently. They will need to work much more in multi-disciplinary teams that treat the “whole person” and not just the presenting condition; they will need to have more generic skills; and they will need to be more productive, partly through use of new technologies.

In addition to the challenges in recruiting the right numbers of key staff the BCT strategy requires a significant “left shift” in activity from acute settings into the community. This will entail a similar transfer of staff so that more nurses and other professionals are working outside of a hospital setting. This in itself will pose a major workforce challenge to the health economy. Social Care will face a similar challenge to recruit and train the additional staff to provide support in the community.

2.4.3 Transforming the health and social care system through quality integrated care

While the health and social care services within LLR are currently meeting the needs of most people most of the time quickly, efficiently and effectively, there are times when performance falls below the desired standards.

On a range of quality measures from various sources, there is evidence of mixed performance across LLR. Some of the more notable results are as follows:

- UHL performed low on the NHS staff survey on standards of care;
- Emergency readmissions are at or below average across the 3 CCGs; and
- Below average patient experience of GP out of hours services in both Leicester city and East Leicestershire and Rutland

In some cases performance should be improved, and for indicators such as admission and readmission rates LLR aspire to performance in the top decile. The relatively poor results relating to primary care indicate that LLR need to pay particular attention to making improvements here.

Local performance against key operational measures, such as the 4 hour wait in A&E and referral to treatment (RTT), needs to be improved. Performance against the A&E target at UHL has improved through 2013/14 but remains well below the national target. Waiting times are also above required levels in many community and mental health services, for example tier 3 child and adolescent mental health services (CAMHS).

BCBV national benchmarks show that UHL is ranked 57th in terms of performance on length of stay. Length of stay has continued to rise at a rate of 19% in the last financial year for patients staying 11 days or more, with the majority of these patients aged over 65. Critically, a hospital stay of 11 days or more is detrimental to frail older people in terms of increasing their levels of dependency while in hospital; reducing their potential to return to their usual place of residence and reducing their potential to maintain their previous baseline of functioning. Long stays are often linked to delayed transfers of care and the local health and care economy's performance on delayed transfers of care has deteriorated in quarter one 2014/15.

There is both national and local evidence to suggest patients are using acute services inappropriately. The Keogh Urgent and Emergency Care Review[10] found that 40 per cent of patients who attend an A&E department are discharged requiring no treatment, and could have been helped closer to home. In addition, the results of 2 bed utilisation reviews of unscheduled care patients admitted to medical wards in UHL showed that many inpatients did not require acute care.

In summary, there is a clear case for change for a transformative programme to put in place new models of care to improve outcomes and ensure the financial and clinical sustainability of healthcare in LLR.

[10] http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx

2.5 Vision, values and system objectives

LLR have developed a vision to:

> ***…maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings.***

This vision has been agreed across all partners on the BCT Partnership Board. The partner organisations recognise the scale of the challenge that lies ahead for this health and social care economy. The Board is committed to delivering the transformative system reform required without compromising on the outcomes for LLR citizens or the quality of services that are available.

LLR recognise that transformative change is required and this will need organisations to work together in new ways. In order to reflect this, the following value and principles have been agreed and offer a consistent approach to developing new models of care:

- Work together as one system to realise our vision;
- Citizen participation and empowerment at the heart of decision making;
- Commitment to addressing the inequality between mental health and physical health services;
- Improve outcomes and reduce inequalities for our citizens by striving to be 'best in class', using evidence-based models which comply with our equality principles; and
- Maximise value for our citizens by rigorously assessing how we allocate and use our resources.

In line with these values and principles, and to achieve the vision, a number of system objectives have been developed:

- **System objective one** – to deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital.
- **System objective two** – to reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions.
- **System objective three** – to increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings.
- **System objective four** – to optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system.
- **System objective five** – all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate.

- **System objective six** – to improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

The following section describes the proposed new models of care, detailing the changes that will be made and how they will support delivery of the over-arching programme objectives.

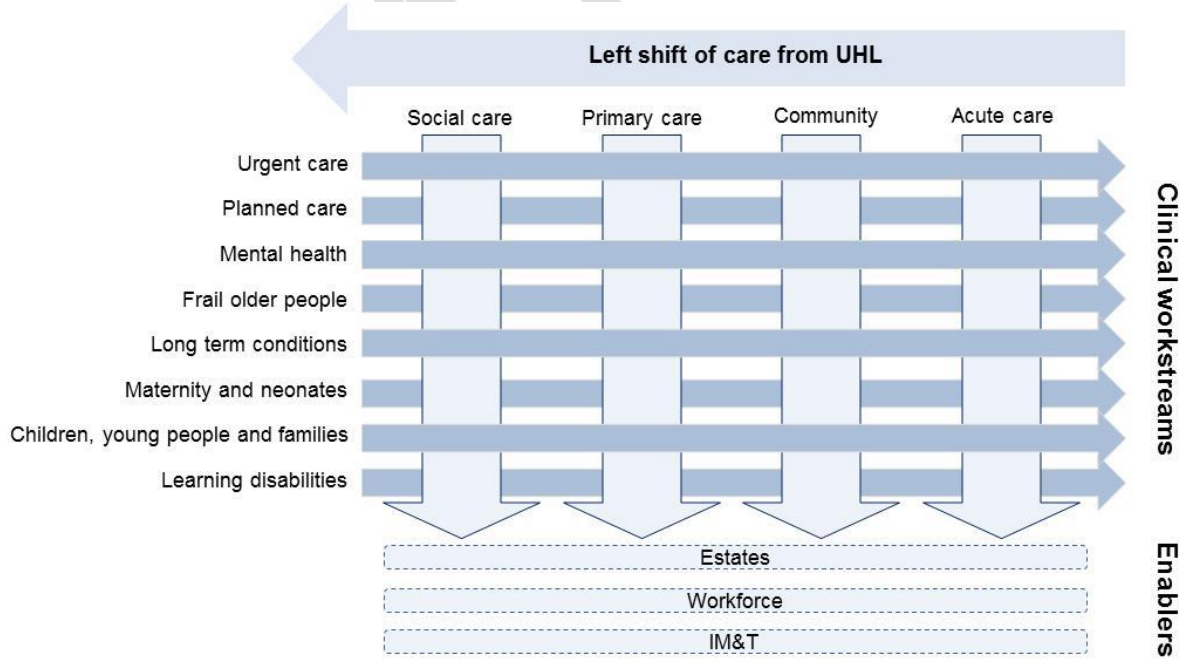
2.6 Health economy strategy – new models of care

2.6.1 High level description of new model

The previous section described the case for change in LLR. It articulated the national and local context for the programme and some of the demographic and social-economic characteristics of the LLR population. It also highlighted the significant financial pressures facing the health and social care system and potential opportunities to ensure services deliver value for money in the future.

In response to this case for change, the BCT programme developed a model based on settings of care and service pathways. Settings of care range from self-care, prevention through to acute hospital based services. The simplified diagram below shows the interaction between workstreams and settings of care, with workstreams responsible for the whole patient pathway from public health through to hospital based services:

Figure 8: Aligning service pathways to settings of care



This section of the strategic case describes the proposed changes to service delivery for each pathway. It begins by outlining the financial benefits that the programme will deliver before articulating the key changes that will be made in the service pathways over the next five years to deliver these. It describes some of the specific projects that have been developed by the programme's clinical workstreams, to provide a clear view of some of the proposed pathway changes.

The section then moves on to describe the changes that will take place in LLR's settings of care over the next five years; in UHL, LPT, primary care and social care. These changes are required for successful implementation of the proposed service pathways, and to ensure high quality and sustainable care can be developed in the future.

Finally, the section describes how the 3 enabling workstreams - estates, workforce, and IM&T – will support delivery of these changes. Without these enabling groups, the programme will not be able to implement these transformational changes.

2.7 Clinical models of care driving delivery

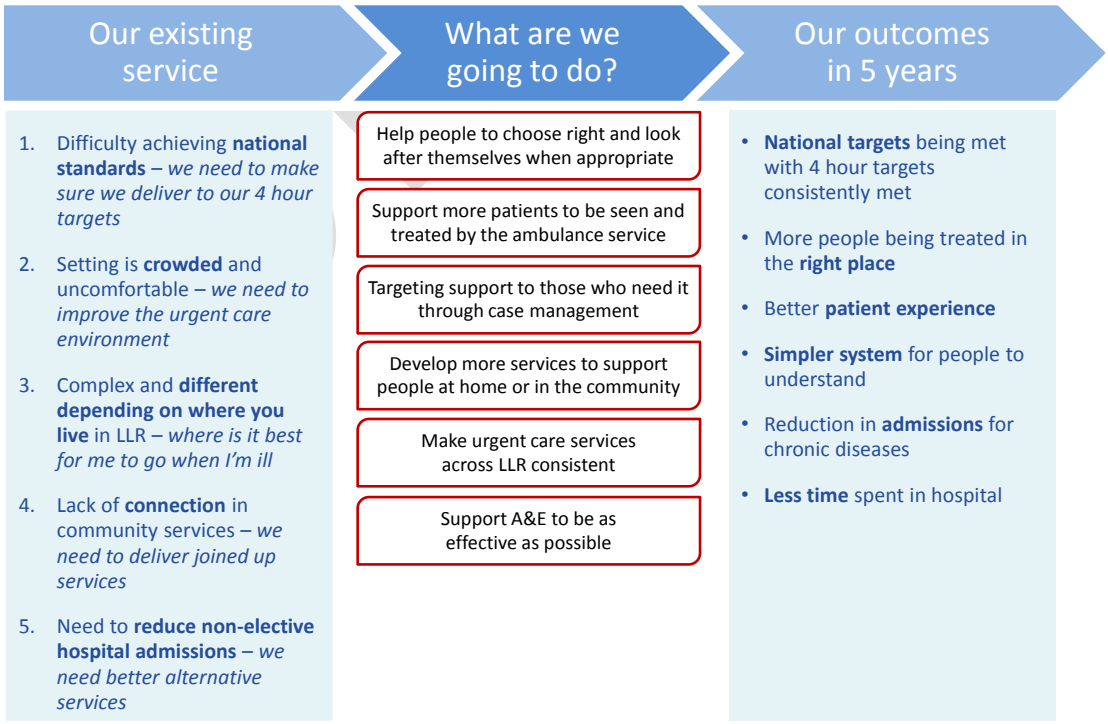
The new models of care will deliver significant benefits to local people and to health and social care commissioners and providers. As explained further in the economic and financial cases, the health economy needs to close a projected financial gap of £398m across the 5 years of the plan. If all of the elements of the strategy are delivered the health economy will achieve a surplus of £1.88m by 2018/19. Further efficiencies delivered by the UHL reduction in overhead from moving to 2 acute sites will release a further £30.8m of recurrent savings for the trust which will be realised in 2019/20.

Each workstream that will support delivery of the new model of care is described in detail below:

2.7.1 Urgent care

Urgent care refers to the range of services under non-elective medicine and emergency surgery for adults. Areas in scope include System Navigation, EMAS, the single point of access, NHS 111 and the out of hours service.

Figure 9: Urgent care summary



Objectives

There are many interdependencies between the urgent care workstream, and the long term care and frail older people workstream. These 3 groups have worked together closely to ensure the individual plans are coordinated and aligned, and come together to form a coherent model of care. This has been achieved by using an overarching model which is based on ten key components of care[11]. Research has identified these areas as central to designing health and care systems for this cohort of people:

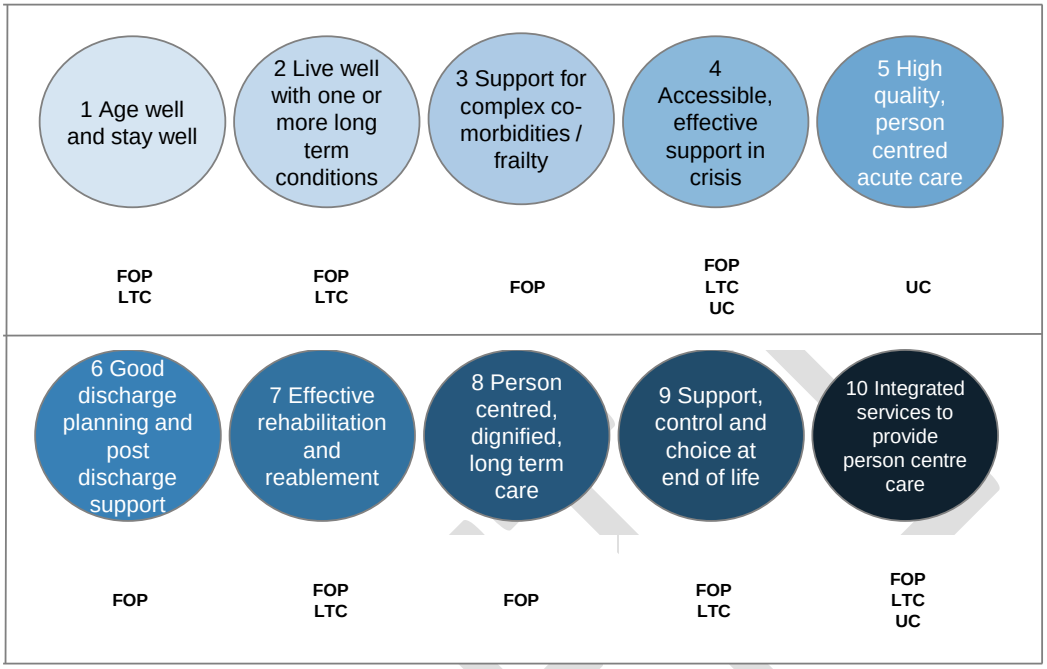
- Age well and stay well, which is linked to Public Health outcomes;
- Live well with one or more long term conditions;
- Support for complex co-morbidities/frailty;
- Accessible effective support in crisis for patients and carers;
- High quality person-centred acute care;
- Good discharge and post discharge support;
- Effective rehabilitation and re-ablement;
- Person centred, dignified long-term care;
- Support control and choice at end of life;
- The tenth component is “integration”. The BCF will be vehicle used to help drive local integration across the system and this workstream is strategically aligned to Leicestershire county, Leicester city and Rutland BCF plans.

Figure 10: Ten components of care

[11] http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population, March 2014

The diagram below shows how the 3 workstreams have worked together to deliver these 10 components:

Figure 11: Ten components of care – urgent care



The urgent care workstream is focussed on delivering component 5 of the model "high quality person centred acute care". The objectives for urgent care are:

- To deliver the highest quality safe urgent care service for the population of LLR with the resources that are available, within a five year timeframe;
- To make that urgent care offer understandable, accessible, consistent and measurable by using best practice and common frameworks in settings that the public find easy to get to and use;
- To maximise the benefits of integrating primary and secondary urgent care to ensure that best experience and quality of care is offered to patients whilst best value is extracted and duplications of resource are removed;
- To reduce the proportion of beds dedicated to the delivery of urgent care.

<u>What will happen across LLR to deliver these objectives</u>

Treating more people in the right place with the right offer will ensure LLR meets its objectives of delivering a better patient experience and improving outcomes. Key changes that will take place in the urgent care system are:

- Reconfiguring the emergency floor at LRI to ensure there is sufficient space to support the flow of "majors", offer dignified care and create a positive working environment;
- Improving system navigation by boosting NHS111, out of hours medical cover, local single point of access triage;
- Increasing the availability of ambulatory care options i.e. alternatives to admission;

- Introducing ambulatory care pathways for the conditions listed in the directory of ambulatory and emergency care medicine for adults[12];
- Boosting the urgent out of hospital options for at risk patients;
- Increasing seven day coverage in primary and community urgent care services;
- Increasing the use of a "see and treat" approach by the ambulance service to treat people on site when conveyance to hospital will not improve care outcomes;
- A "Choose Well" public campaign to help people to make the right urgent care choices.

Detailed projects developed by the BCT Urgent Care workstream

The following project has been developed by the urgent care workstream to support the changes to urgent care:

Figure 12: Urgent care – projects

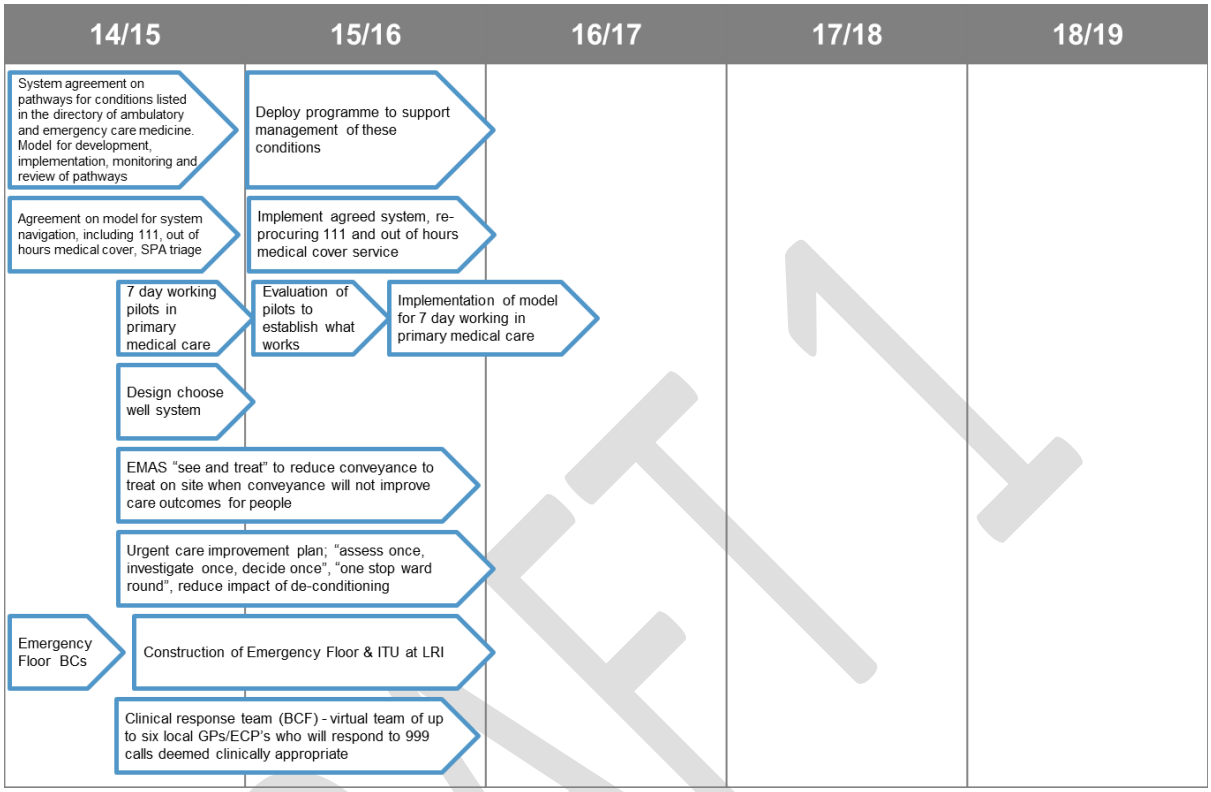
Project	Description	Net annual saving
Ambulatory care sensitive conditions	A full programme to support the management of Ambulatory Care Sensitive Conditions will be deployed in line with the handbook guidelines.[13] This will provide the system with a baseline of resilient preventative primary medical care interventions for at risk patients, and the delivery of 'home first' principles for all people who are safe to be treated in the community in line with best practice. This will increase the amount of ambulatory care we deliver and shorten the length of stay for this cohort of patients.	£1,000,000 (due to reduced admissions for ACS conditions and reduction of 26 beds)
Directory of Ambulatory and Emergency Care Medicine for Adults	The second system wide project focuses on ensuring that system navigation in LLR is effective and safe, directing people to the most appropriate setting for their care. The most appropriate model for system navigation is currently under consideration, but through this programme we aim to maximise the benefits of enhanced clinical triage at the point of first contact. The project will smooth patient journeys, ensuring that people have every opportunity to avoid attending A&E if it is not beneficial for them to do so, but also ensuring that people who need an emergency intervention get rapid and timely access to emergency support.	This will enable the reconfiguration of services that needs to take place within UHL
	Total	£1,000,000

[12] http://www.ambulatoryemergencycare.org.uk/Directory
[13] http://www.ambulatoryemergencycare.org.uk/Directory

Timeline for delivery

The diagram below sets out the timeline for delivering the proposed changes to urgent care:

Figure 13: Urgent care timelines



Outcomes

The resulting benefits to patients and professionals will be; urgent care interventions available closer to home; an improved fit for purpose emergency care environment; fewer admissions and better outcomes for patients with ambulatory care sensitivity conditions; easier system navigation; shorter waiting times in emergency departments; and shorter lengths of stay for people still requiring acute hospital intervention. This will support the system to:

- Reduce beds needed for non-elective patients;
- Improve mortality rates and treatment outcomes;
- Resource switch from unplanned to planned care.

The table below shows how these benefits support delivery of the overall BCT objectives:

Figure 14: Urgent care – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Urgent care	• Easier access to urgent GP appointments • More attendances at UCC/WIC • Community alternatives to A&E integrated with community services • EMAS aware of alternatives to A&E	• Urgent care available more locally in county and Rutland	• System easier to understand and navigate • Less pressure on A&E	• Improved use of community hospitals e.g. UCC/WIC	• Fewer admissions saving CCGs money • Reduced non-elective LoS saving UHL money • Fewer residential admissions saving local authorities money (may be offset by increased support required in the community)	• Enhanced skills in primary care • A&E staff able to focus on more serious cases • Integration of IT

Enablers

The urgent care plans rely on changes in a number of enabling areas:

- IM&T – electronic directory of services to support the single point of access; mobile devices to support mobile working; and the ability to share information;
- Estate – LRI emergency department floor scheme and changes to the community estate to support the shift of activity out of acute settings;
- Workforce – recruiting sufficient staff to deliver 7 day services and to expand community and primary care alternatives. There will also be a likely social care impact which will need to be managed.

2.7.2 Frail older people

Frail Older People covers community based frail older people services, dementia services and end of life care (including palliative and continuing care for adults, and hospice care). It has not sought to address hospital-based care (covered in urgent/planned care as appropriate) or end of life hospital episodes.

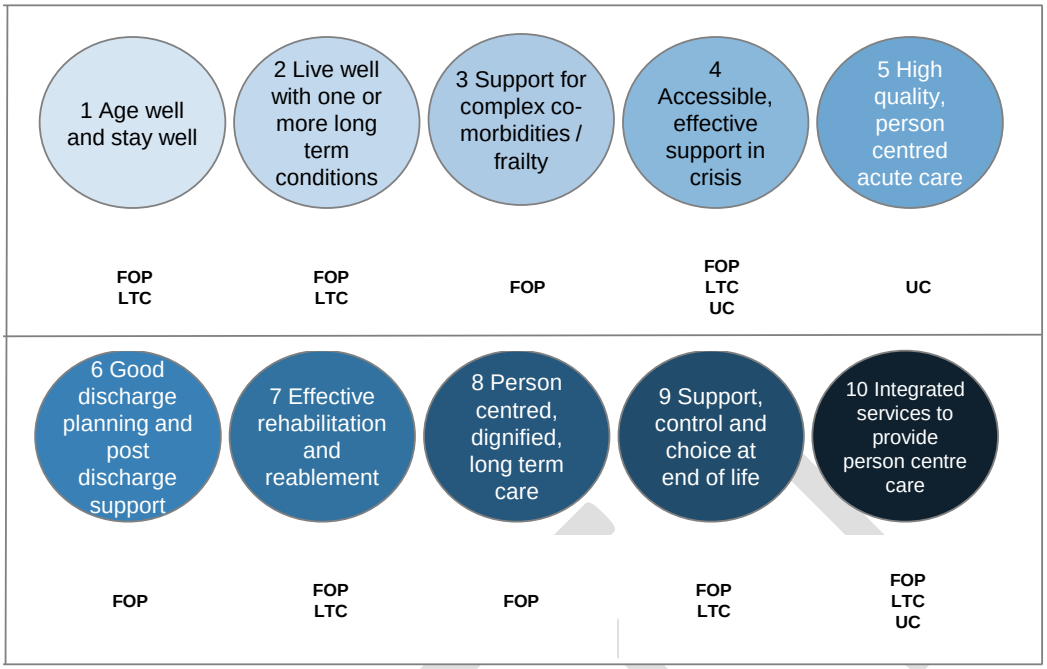
Figure 15: Frail older people – summary

Objectives

Health and social care organisations across LLR must work in partnership to change the way services for older people are delivered to address the threat of destabilisation posed by the ageing population. Too many people are admitted to hospital and care homes, often because services are fragmented, which also means that older people remain in hospital too long with implications for their overall outcomes. In addition, at the current estimated rate of prevalence, there will be 850,000 people with dementia in the UK in 2015. The current economic and political climate puts those delivering dementia services under very significant pressure to reduce costs and develop a sustainable pathway which is fit for the future.

The frail older people workstream contributes to delivery of all the components of the overarching model of care, except component five which will be delivered by the urgent care workstream.

Figure 16: Ten components of care – frail older people



The objectives of this workstream are to:

- Deliver high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person;
- Improve care outside of hospitals to the extent that we can reduce the time frail older people spend in hospital;
- Reduce existing inequalities in accessing care for older people;
- Help increase the number of people with a positive experience of physical health, mental health (dementia) and social care services;
- Improve the use of physical assets by co-locating different services to enable integration;
- Integrate health and social care services thereby eliminating duplication such as repeat assessments;
- Reduce urgent care costs to health and social care commissioners;
- Develop new capacity and capabilities amongst our workforce.

<u>What will happen across LLR to deliver these objectives</u>

The Better Care Fund (BCF) is a primary driver of projects to address the frail older population. The fund is a single pooled health and social care budget to incentivise the NHS and local government to work more closely together, bringing improved integration to existing services. People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. The workstream will coordinate the existing BCF plans to provide information, services and support in a coordinated way across different teams and organisations. The plans being developed will need to link in with public health, for example through the Age Well and Stay Well project.

A number of projects to improve services for frail older people have already been developed outside of the BCT programme e.g. through commissioner QIPP plans and the BCF plans that have been developed by each Health and Wellbeing Board in LLR.

As an example, “Accessible effective support in crisis” will be delivered through a number of BCF projects. The City plan will fund and drive the implementation of an Unscheduled Care Team and the County plan includes provision for an Integrated Crisis Response Service. These services are tailored to support the needs of the differing populations they will serve, but both focus on supporting frail older people in crisis in the community, to achieve a 3.5% reduction in total hospital admissions and a 15% reduction in hospital admissions for older people.

The table below shows how existing plans will deliver the components of care:

Figure 17: Frail older people – delivering components of care

Project	Description	Net annual saving
Age Well and Stay Well	The Age Well and Stay Well project has numerous associated programmes/projects which are themes within the BCF. Unified Prevention Offer is a theme and within this are various projects a) First Contact and the new b) Local Area Co-ordination, which focuses on improving self-care, education and prevention, the savings associated with this project will be achieved by improving independence and well being amongst frail older people.	BCF Initiative and Public Health budgets being better targeted
Live well with one or more LTC	The initiatives that are associated with the Live Well with one or more LTC are the Carers service, Risk Stratification, Early diagnosis and referral, and the increase in the number of quality care plans for the 65 and over or those who are at high risk of admission.	BCF Initiative
Support for complex co-morbidities/frailty	The initiatives that support complex co-morbidities/frailty are the Care Navigators, Local Area co-ordinators and the development of integrated pathways for dementia. The dementia pathway will be redesigned to ensure that diagnosis, care, monitoring and support for people with dementia is provided in the most appropriate setting and support for carers is improved.	BCF Initiative
Accessible effective support in Crisis	The BCF projects that will assist in the development of support Frail Older People in a crisis are the Unscheduled Care Team the Clinical Response Team, the Falls service, the Integrated Crisis response service along with the development of 24/7 coverage in the community linked to assistive technology. LLR will work alongside EMAS and community services to reduce the number of people accessing secondary care.	BCF Initiative
Good discharge planning and post discharge support	To achieve good discharge planning and post discharge support there is a need across LLR to maximise the use of assistive technology. Within BCF the development of Intensive Community Support services and Planned care teams will assist patients back into the community once they no longer	BCF Initiative

	require specialist services.	
Effective rehabilitation and reablement	Leicestershire and Rutland are developing a “help to live at home" programme which forms part of the reablement and rehabilitation programme across LLR.	BCF Initiative
Person-centres dignified long term care	Though some people make a positive choice to enter long-term care, older people should only generally move into nursing and residential care when treatment, rehabilitation and other alternatives have been exhausted. New discharge to assess pathways will ensure that older people receive high quality rehabilitation and reablement on discharge prior to making a decision about long term care arrangements.	BCF Initiative
Support control and choice at end of life;	LLR will deliver projects outlined in the Learning the Lessons action plan	BCF Initiative
	Total	Financial benefits already contained within existing BCF plans, forming part of CCG QIPP

The new model of care will also offer people choice at the end of life, working with people and their families to develop end of life care plans that reflect their wishes. There is a recognition across LLR that end of life care is not just applicable to frail older people. As a result, the programme is going to develop a new and separate workstream to focus on developing and implementing changes to the way end of life services are delivered in LLR.

Detailed projects developed by the BCT Frail Older People workstream

As described, a number of the projects to deliver the objectives of this workstream are already in place through existing BCF plans, with other projects phased to commence during 2014/15. The Frail Older People workstream has therefore not focussed on developing new projects. The group has instead consolidated this work and aligned it to an overarching model of care.

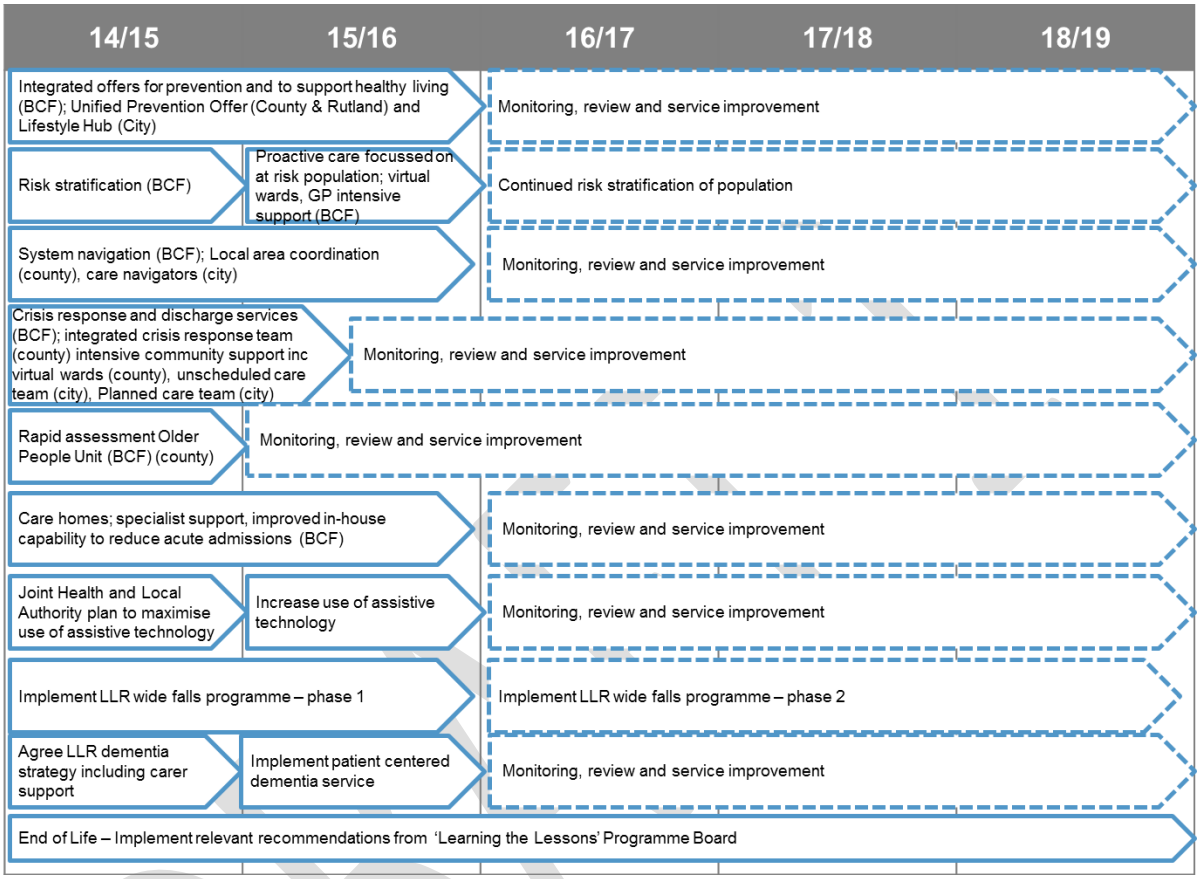
However, in gathering information on existing plans, the workstream identified a system gap around dementia services. This will be taken forward over the next few months and the workstream will develop an LLR wide approach to dementia care. This will include:

- Increasing the number of people who are diagnosed with dementia;
- Early and on-going support for those diagnosed with dementia;
- Increasing the number of people who have a positive experience of care;
- Support for dementia carers.

Timeline for delivery

The diagram below sets out the timeline for delivering the proposed changes to frail older people services:

Figure 18: Frail older people timelines



Outcomes

The benefits these changes will deliver are:

- Improved independence and wellbeing, as measured by fewer care home admissions and a 15% reduction in hospital admissions;
- Increase in dementia diagnosis rates;
- Shorter stays for those who do require hospital admission and fewer readmissions, reducing likelihood of functional decline and institutionalisation;
- A reduction in acute hospital bed numbers which will contribute towards UHL's plans to reduce from three to two sites;
- A reduction in the cost of care home placements, which will support local authorities in meeting their financial challenge;
- Improved patient and service user experience;
- A reduction in inequalities relating to access to care;
- An increase in life expectancy and "years of healthy life".

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 19: Frail older people – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustain-ability	Objective six Workforce & IT capability and capacity
Frail older people	• One anticipatory care plan • Joined-up delivery across health & social care (planned care) • Urgent care services aware of care plan	• More care delivered closer to where people live • Targeted proactive delivery of services based on risk stratification	• Personalised care plans co-designed with people & their carers	• Improved use of community hospitals • Less duplication between different teams e.g. trusted single assessment • Standardised care pathways	• Fewer admissions saving CCGs money • Reduced non-elective LoS saving UHL money • Fewer residential admissions saving LAs money	• Enhanced skills amongst primary and community care staff • Integration of IT across primary, community, secondary and social care sectors

The frail older people workstream overlaps with some of the changes that will be implemented by the LTCs and urgent care workstreams. In developing the specific workstream projects these three groups have worked together closely to ensure projects are coordinated and aligned, and that there is no double count of financial savings. Each workstream will continue to work closely together to ensure that changes are effectively planned and implemented.

Enablers

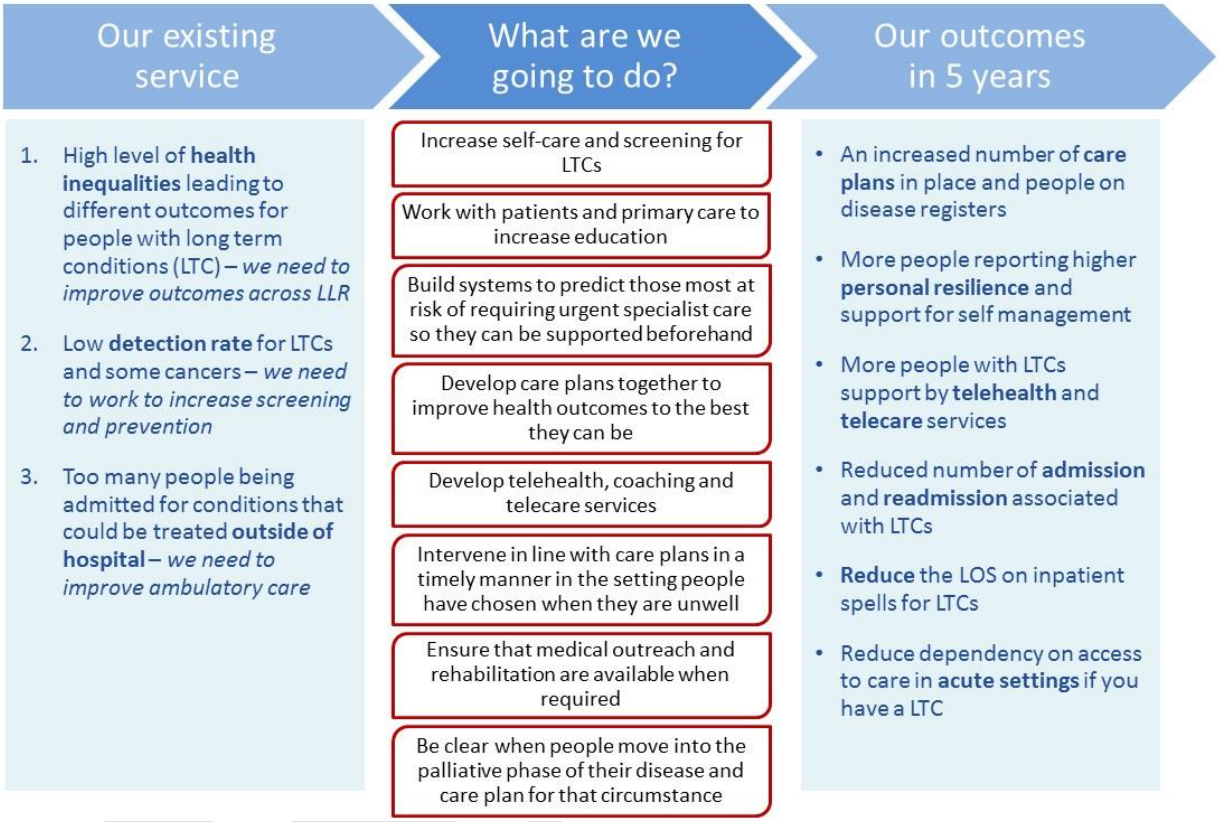
The changes to frail older people services require changes in a number of enabling areas.

- IM&T – electronic directory of services to support the single point of access; the ability to share information; tele-health and tele-care developments; and mobile devices;
- Estate – changes to the community estate to support the shift of activity out of acute settings, for example the co-location of teams in community hubs to support integrated working;
- Workforce – recruiting sufficient staff to deliver seven day services and to expand community and primary care support for older people, the development of new roles and consideration of joint appointments or “system wide appointments” for certain roles. There will also need to be a focus on enhanced support for carers who are a core element of the initiatives being described above.

2.7.3 Long term conditions

Long term conditions covers patients requiring long term care for chronic illnesses, such as Respiratory Disease (Includes asthma, COPD and pneumonia), cardiovascular disease (Includes heart failure, angina and atrial fibrillation), diabetes, stroke, neurology and cancer.

Figure 20: Long term conditions summary

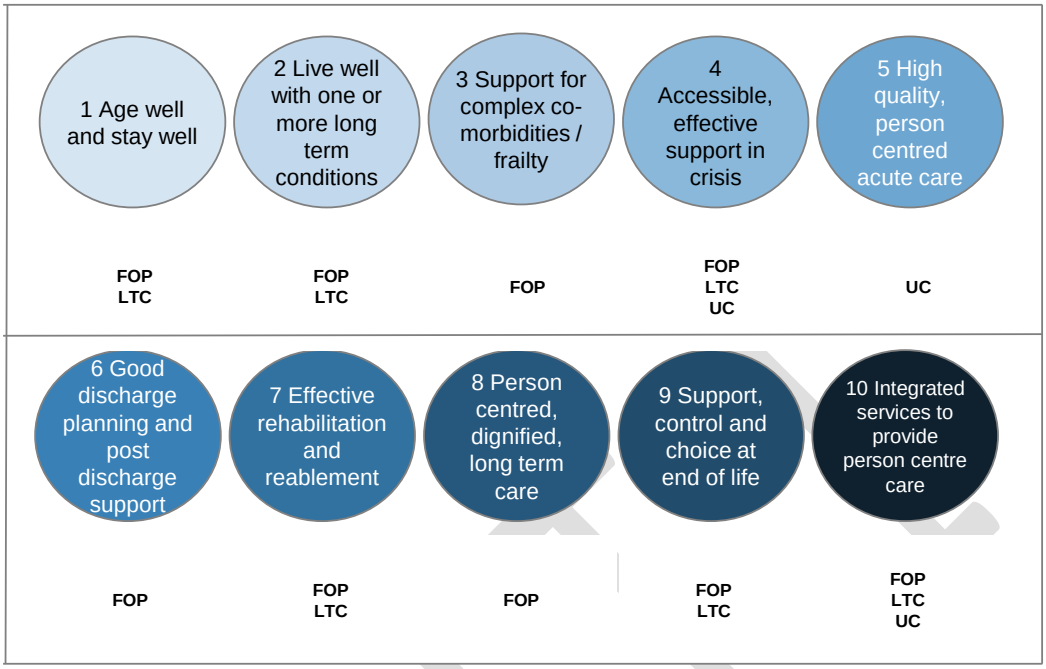


Objectives

Demographic change means that the number of people with LTCs will increase over the next ten years. A more sustainable model of care for people with LTCs is needed because “no change” is unsustainable. There is also a high level of inequality between different areas which leads to different outcomes. In part this reflects the need for better screening and prevention, but also the fact that too many people are being admitted for conditions that could be treated outside of hospital.

The LTC workstream contributes to six of the components of care, as shown below;

Figure 21: Ten components of care – long term conditions



The objective of this workstream is to create a system that delivers high quality safe care for people with LTCs based on best practice, using a service model spanning health and social care and which is easily accessible (both geographically and at different times of the day/week). Our projects will contribute towards delivering the LLR strategic objectives by:

- Delivering high quality, citizen centred, integrated health and social care pathways, delivered in the right place at the right time by the right person; including ensuring that healthy lifestyles and self care become a common feature of all treatment;
- Improving care outside of hospitals to the extent that we can reduce the time spent in hospital by people with LTCs;
- Reducing the inequalities in accessing care currently experienced by people with LTCs;
- Helping to increase the number of people with a positive experience of physical health and social care services;
- Improving the use of physical assets by co-locating different services to enable integration;
- Integrating health and social care services thereby eliminating duplication such as repeat assessments;
- Reducing costs to health and social care commissioners;
- Developing new capacity and capabilities amongst our workforce.

<u>What will happen across LLR to deliver these objectives</u>

The things that will change to deliver these objectives across LLR are:

- “Education” – working with patients and primary care to increase education around risk factors associated with LTCs and strategies to support self-care;

- "Prediction" – building systems, including screening programmes, to predict those most at risk of developing or accelerating the onset of LTCs. These will include health checks; and screening for chronic obstructive pulmonary disease (COPD), atrial fibrillation (AF), heart failure (HF) and cancer;
- "Care planning" – jointly developing care plans with patients and carers to improve health outcomes to the best they can be. Delivery of the care plan will be through a system-wide multi-disciplinary team approach;
- "Ambulatory pathways" – efficient pathways for ambulatory care-sensitive conditions based on treating people in the right care setting and avoiding hospital admission wherever possible (see urgent care above);
- "Innovation" – using new technologies such as tele-health and tele-care as well as techniques such as coaching to support people with LTCs;
- "Services available when required" – ensuring that medical outreach and rehabilitation are available when required';
- "Choices and plans at the end of life" – being clear when people move into the palliative phase of their disease and plan for that circumstance. LLR recognises that end of life is not just applicable to those with LTCs. As a result, the programme is going to implement a new and separate workstream to focus on developing and implementing changes to the way end of life services are delivered in LLR.

The LTC workstream will also take forward and coordinate ongoing work to redesign pathways for three key clinical areas identified at the Health Summit event in January 2014; respiratory disease, cardiovascular disease (including stroke) and cancer. Bringing this work into the programme will ensure that LLR develops a robust and effective overall approach to managing LTCs. The ongoing work will be complemented by the specific projects developed by this workstream, which are described in the next section. The two other areas identified at the Health Summit were dementia and mental health. These are being taken forward by the frail older people and mental health workstreams, respectively.

Detailed projects developed by the LTC workstream

The LTC workstream has developed a number of plans for system wide projects related to LTCs:

Figure 22: Long term conditions – system wide projects

Project	Description	Net annual saving
Integrated COPD team	This team will cover primary, community and acute care and will deliver care for patients with COPD in the community wherever possible, avoiding hospital admissions, including ambulatory care wherever possible. This will contribute towards UHL's bed reduction plans and the move from three sites to two; by tackling out of hospital care, in hospital processes and efficient discharge this project will deliver a reduction of approximately 49 beds.	£240,000 (excludes bed saving)
Exercise medicine	There is a strong evidence base that improving levels of activity, giving people access to integrated reablement services and encouraging them to exercise leads to improved health outcomes and savings for health economies.	£975,000
Workplace Wellness	Supporting NHS employees with LTCs to reduce absenteeism and presenteeism and the associated spend on agency cover (proof of concept in UHL).	£138,000
Specialist oxygen review and prescription services	Reviewing specialist oxygen and prescription services to ensure patients are receiving an appropriate level of care.	£111,000
Stratified cancer pathways	Redesigning services and end to end care pathways for those living with or beyond cancer.	£12,000
Remote monitoring of cardiac devices	Community based monitoring of appropriately risk stratified patients with cardiac devices, reducing the need for out-patient appointments.	£2,000
Home administration of intravenous diuretics to heart failure patients	Implementing community based resources to deliver intravenous diuretics for heart failure patients.	£38,000
Evidence based cardiovascular disease screening and treatment	Increasing capacity of screening for cardiovascular disease leading to increased early diagnosis, supporting better outcomes for patients and reducing high cost treatments associated with late diagnosis	£50,000
NICE Hypertension guidelines	Ensuring LLR is compliant with new NICE guidelines for the management of hypertension (a risk factor for stroke), improving outcomes for patients and financial savings through effective management of the condition.	£118,000
	Total	£1,684,000

Timeline for delivery

The diagram below sets out the timeline for delivering the proposed changes to long term condition services:

Figure 23: Long term conditions – timeline 1/2

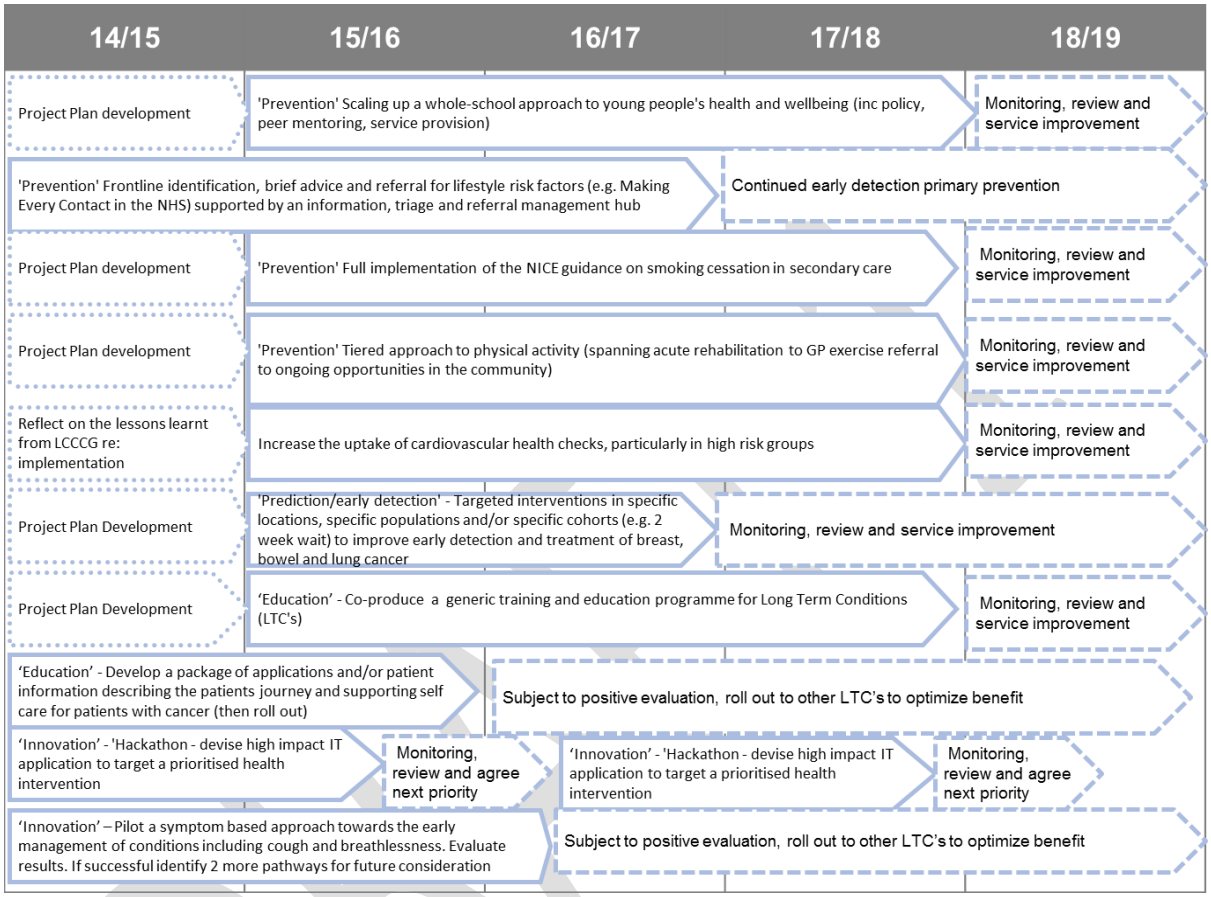
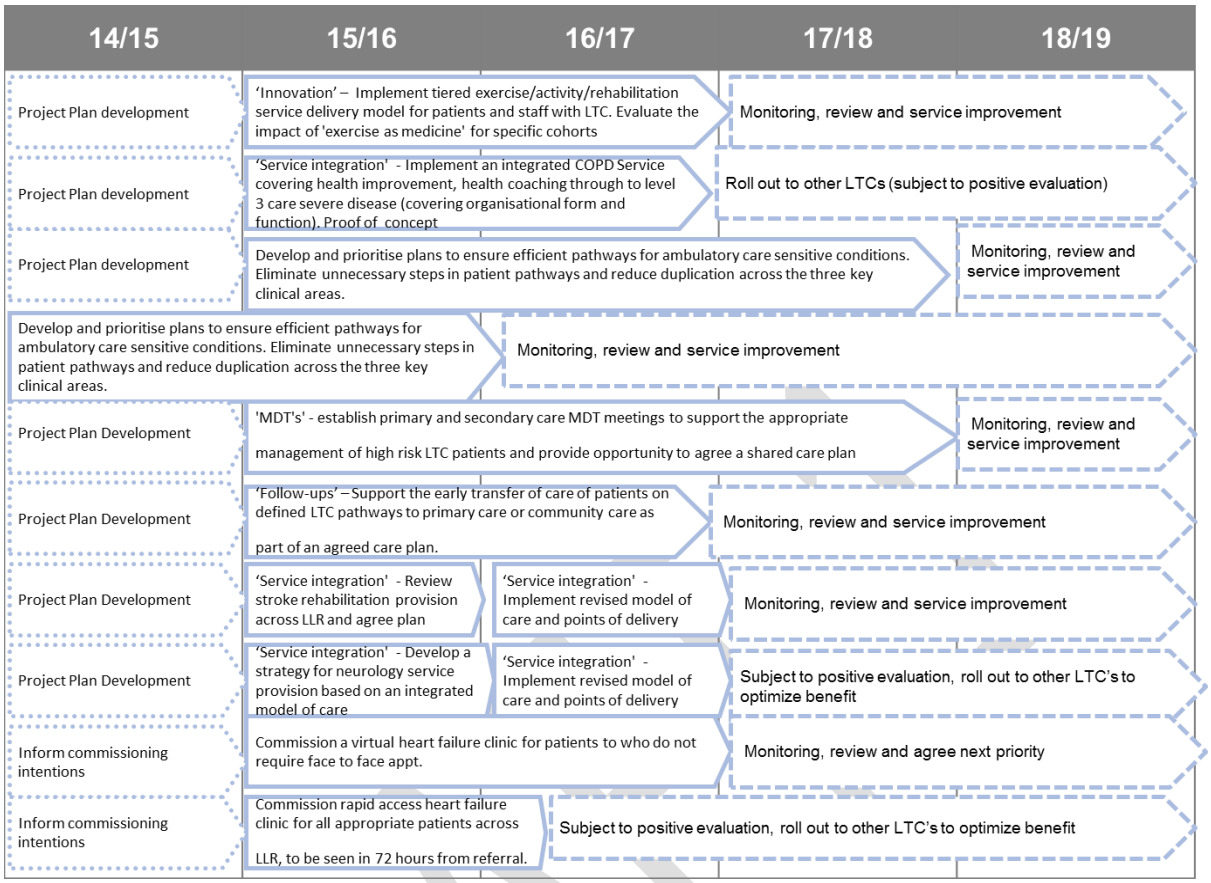


Figure 24: Long term conditions – timeline 2/2



Outcomes

The benefits for local people with LTCs will be an increase in the number of people with co-designed care plans in place and who are listed on primary care disease registers. We expect that more people will report higher personal resilience and that they feel supported to self-manage their condition.

The system benefits resulting from our projects will be a reduction in the number of admissions and readmissions associated with LTCs, and shorter inpatient stays for those people who still require admission. Together with changes in frail older people's pathways this will equate to 30% reduction in bed days for a length of stay of greater than 15 days – as a direct result UHL will be better placed to deliver its ambition to collocate clinical services and thereby reduce from three sites to two sites.

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 25: Long term conditions – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Long-term conditions	• One anticipatory care plan • Joined-up delivery across health & social care (planned care) • Urgent care services aware of care plan	• More care delivered closer to where people live • Targeted proactive delivery of services based on risk stratification	• Personalised care plans co-designed with people & their carers	• Improved use of community hospitals • Less duplication between different teams e.g. trusted single assessment • Standardised care pathways	• Fewer admissions saving CCGs money • Reduced non-elective LoS saving UHL money • Fewer residential admissions saving LAs money (possibly offset by increased cost of provision within the community)	• Enhanced skills amongst primary and community care staff • Integration of IT across primary, community, secondary and social care sectors

The LTC workstream overlaps with some of the changes that will be implemented by the frail older people and urgent care workstreams. Each workstream will work together closely to ensure that changes are effectively planned and implemented, and that financial savings are not double-counted.

Enablers

The plans for LTC rely on changes in a number of enabling areas.

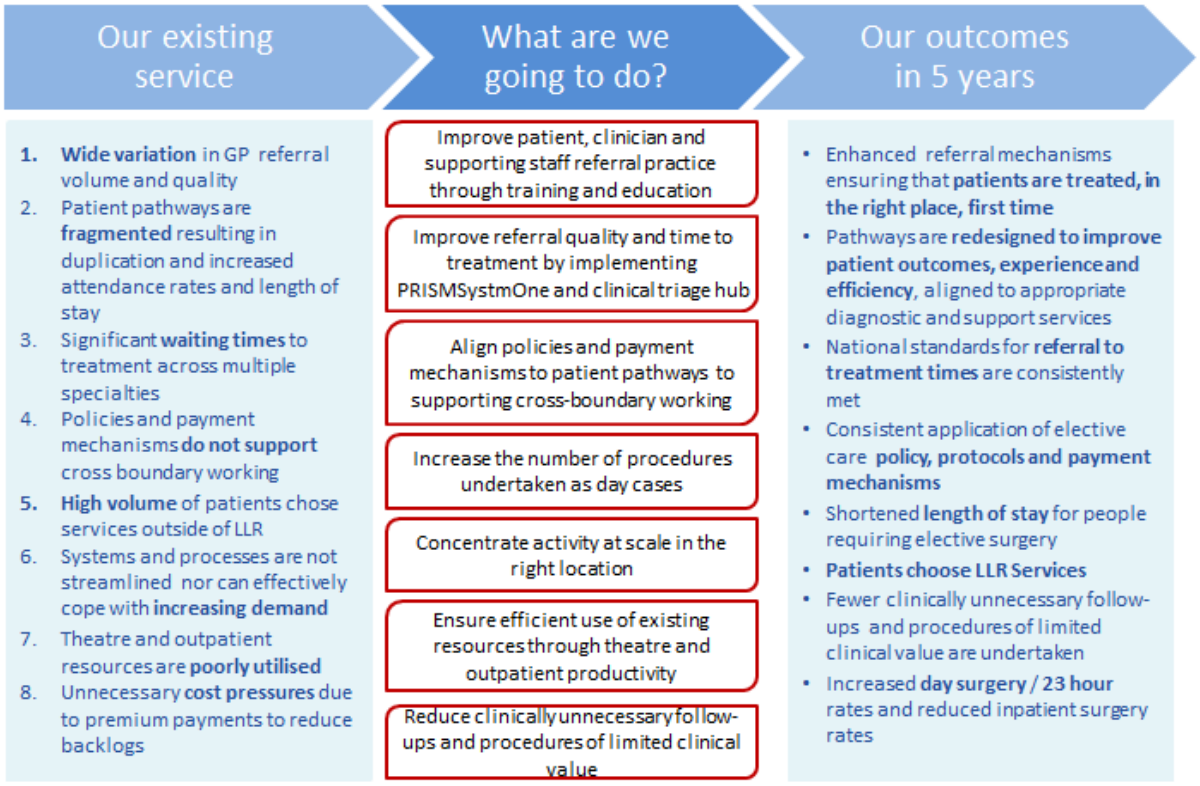
- IM&T – electronic directory of services to support the single point of access; the ability to share information e.g. real-time data on admission and a single dataset on discharge; telehealth and telecare developments; and mobile devices;
- Estate – changes to the community estate to support the shift of activity out of acute settings, for example the co-location of teams in community hubs to promote integrated working;

- Workforce – recruiting sufficient staff to deliver seven day services and to expand community and primary care support for patients with long term conditions and consideration of joint appointments or "system wide appointments" and generic workers across health and social care for certain roles.
- Community ambassadors – many of the projects proposed will be focused on those areas where health inequality is greatest. To support this we intend to work with community leaders and 'community ambassadors' to ensure that a sustainable community infrastructure is established.

2.7.4 Planned care

Planned Care seeks to improve care pathways across a range of 18 specific specialties. It covers improved access to diagnostics, development and implementation of referral policy, establishment of a pathway management service, training and education for referrers, patients and support staff, commissioning of community based care provision and support provider implementation of enhanced recovery and improved productivity and efficiency in secondary care. The workstream does not cover planned paediatric services (covered in children's services) or existing provider CIP initiatives.

Figure 26: Planned care summary



Objectives

Transformational change is required within planned care to ensure that patient experience and outcomes can be enhanced. Patient pathways, systems and protocols must be redesigned to ensure that key performance measures, such as referral to treatment time and length of stay can be significantly improved. The planned projects will ensure that treatment

is delivered in the right place, by the right clinician, first time without the requirement for unnecessary appointments and hospital visits, while reducing costs and driving improvements in quailty and patient outcomes. These significant improvements will encourage patients to make LLR their first choice when accessing healthcare and support the repatriation of activity back into the local health economy. In addition, the successful delivery of the planned care workstream will contribute signficantly to UHL's strategy to move from three site to two by shifting acute activity into community settings.

The planned care workstream will:

- Deliver high quality, patient centered, integrated care pathways, delivered in the appropriate place at the appropriate time by the appropriate person, supported by staff/patients, resulting in a reduction in time spent avoidably in hospital;
- Increase the number of patients reporting a positive experience when accessing planned care services across all pathways and provider organisations;
- Optimise opportunities for intergration and use of physical assets across the health and social care economy, ensuring care is provided in the most appropriate cost effective setting, reducing duplication and eliminating waste in the system;
- Improve the utilisation of the workforce and the development of new capacity and capabilities where appropriate, in our people and the technology used;
- Ensure that patient pathways, systems and protocols are patient focused, aligned/integrated and support cross-boundary working and payment mechanisms;
- Support the consistent achievement of all associated targets and quality indicators, with a particular emphasis on referral to treatments time;
- Make LLR planned care service provision attractive to patients to support the repatriation of activity and income from patients who currently chose services outside of LLR.

<u>What will happen across LLR to deliver these objectives</u>

The following changes across LLR will enable the delivery of these objectives.

- Implementation of PRISMSystmOne to improve referral quality by providing GPs with comprehensive referral guidelines and training to facilitate standardisation and reduction in variation;
- The establishment of a Clinical Triage Hub to support "better referrals" by eliminating unnecessary referrals, pathway steps and increase the timeliness to referral;
- Working with patients, clinicians and supporting staff, in conjunction with public health, to devise and implement a comprehensive training and education programme;
- Review and redesign patient pathways within eighteen clinical specialties to eliminate unnecessary steps, reduce duplication and ensure integration/alignment of services and payment mechanisms;
- Introduce a range of alternative community-based services to support the shift away from acute based care and ensure activity is provided in the most appropriate setting based on clinical need, access and cost effectiveness;
- Provide non face-to-face follow-ups where appropriate, for example open access, virtual and remote follow ups, to reduce unnecessary patient attendances and DNAs;

- Review and redesign systems and protocols, where appropriate, to support the sharing of information between primary, community, acute and social care services to support effective decision making;
- Enhance health and social care integration linked to pre-assessment prior to surgery;
- Development of locally agreed tariffs for treatments, procedures and care pathways to support integrated cross-boundary working and cost reduction for activity
- Full compliance with BADS;
- Establish an outpatient and daycase elective care hub to increase ambulatory elective work undertaken;
- Support the introduction of an enhanced recovery programme to facilitate a timely and quality discharge;
- Support the improved productivity in secondary care; outpatients and theatre utilisation, reduced length of stay, DNA and cancellation rates;
- Develop and implement comprehensive evaluation mechanisms to measure Workstream impact and support learning and dissemination to stakeholders.

This programme will have a significant impact upon and facilitate the successful delivery of provider efficiencies which will be supported by the Alliance. The Alliance Partners (UHL, LPT & LLR PCL) were commissioned to re-provide outpatient, day case and clean room service in community hospitals around LLR. This will support significant shifts in elective services to lower acuity and lower cost settings closer to the patient's homes. Priorities for the Alliance include pain management, general surgery, ophthalmology, gastroenterology and dermatology.

Detailed projects developed by the BCT Planned Care workstream

The following projects have been developed in detail by the planned care workstream:

Figure 27: Planned Care – system wide projects

Project	Description	Net annual saving
10% reduction in outpatient appointments	The reduction in outpatient appointments across 18 specialties will be delivered through the integration of PRISMSystmOne and a clinical triage hub that will ensure patients are seen in the right place first time and support referral to treatment times. This combined with pathway redesign within the 18 specialties and the implementation of enhanced referral management policies will also reduce unnecessary referrals and reduce steps in patient pathways. The implementation of this work will commence in year 1 and be phased across years 2 and 3.	£2,863,000 (based on reduction in activity: 5% reduction in 6 specialities in Q1 2015/16, 10% reduction in Q2 2015/16; 5% reduction in a further 6 specialities y Q3 2015/16 and 10% reduction by Q4 2015/16)
Repatriate 50% of outpatient and daycase activity	Whilst acknowledging that some patients will chose to access services across borders, this targeted activity spans 18 specialties and consists of non-specialised procedures only. The redesign of these pathways will focus on providing accessible services as close to the	£2,602,000 (based activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond and 50% repatriation of day case activity by 2018 and beyond)

	patient's home as possible, improving waiting times and reducing unnecessary steps in pathways, which is in direct response to patient feedback in relation to what can improve the attractiveness of LLR service provision to patients. An analysis of current waiting times confirmed that average waiting times within LLR are longer than those within surrounding areas. For example, the non-admitted waiting time in gastroenterology at UHL is 11 weeks compared to only 6 weeks in surrounding areas including Derby, Nottingham, Kettering, Lincolnshire, Coventry and Warwickshire.	
40% left shift into community and primary care	The left shift of outpatient activity is a key enabler to UHL reducing its footprint from three sites to two as it will facilitate the reduction of outpatient space required within an acute setting, allowing the transfer of services from the closing site. This shift will also contribute to the increased utilisation of community hospitals, making them more cost effective and supporting the care closer to home agenda and the delivery of repatriation described above.	There is no financial saving, but it is a key enabler of UHL reducing their sites.
Reduction in procedures of limited clinical value.	Reduction of £5k per quarter for 18 months - procedures currently under review	£30,000 (based on a reduction of £5k per quarter for 18 months)
	Total	£5,495,000

Timeline for delivery

The planned care workstream will be delivered in three phases as shown below:

Phase one – to March 2015:

- Re-design pathways for 6 specialities by March 2015;
- Establishment of pathway management service – pilot 2 specialties by March 2015;
- Development and Implementation of LLR Education Programme by March 2015;
- Development and implementation of PRISM across primary care services by March15;
- Implementation of enhanced referral management policies by March 2015.

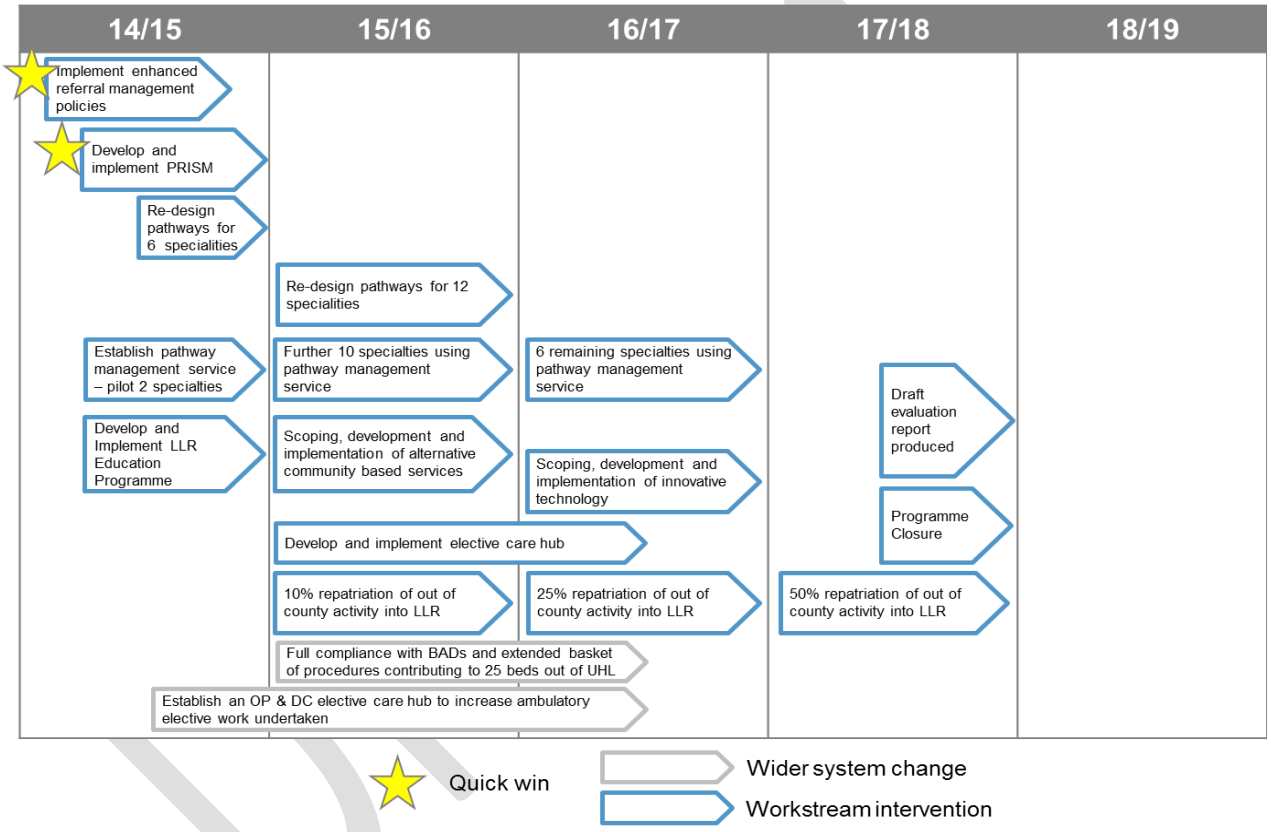
Phase two – April 2015 to March 2016:

- Re-design pathways for remaining 12 specialities by March 2016;
- Further 10 specialties using of pathway management service by March 2016;
- Scoping, development and implementation of alternative community based provision by March 16;
- 10% repatriation of out of county activity into LLR by March 16.

Phase three – April 2016 to March 2017 (and beyond):

- 6 additional specialties using pathway management service by March 2017;
- Support the scoping, development and implementation of innovative technology by March 17;
- Support the review and implementation of improvements to utilisation of secondary care, outpatients and theatres by March 17;
- 25% repatriation of out of county activity into LLR by March 17 and 50% by March 18;
- Draft evaluation report produced by March 18.

Figure 28: Planned care – timeline



Outcomes

This progamme of work will focus on redesigning care pathways to eliminate unnecessary step, standardising protocols to reduce variation and improving efficiency to increase capacity and ensure key performance indicators are consistantly achieved. The planned projects will ensure that treatment is delivered in the right place, by the right clinician, first time without the requirement for unnecessary appointments and hospital visits, driving improvements in quailty, patient outcomes and experience, and achieve significnat cost savings. This range of improvements will encourage patients to make LLR their first choice when accessing healthcare and support the repatriation of activity back into the local health economy. Both county CCGs expect a 40% “left shift” of acute activity into community settings as a result of the planned projects which will help improve the utilisation of the community estate and will contribute towards UHL’s goal of reducing its estate footprint in

Leicester. UHL will also benefit from efficiencies such as higher day case rates and fewer outpatient DNAs.

The table below shows how these benefits support delivery of the overall programme objectives;

Figure 29: Planned care – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Planned care	• Integrated pathways between GPs, diagnostics, community services and UHL • Health and social care integration linked to pre-assessment prior to surgery	• Less unjustified variation in referral rates and quality • Consistent application of protocol	• Shorter waiting times • More appropriate follow-up methods • Reduced steps in patient pathways	• Greater use of community hospitals resulting from pathway redesign and reprovision of services (clinics & diagnostics) • Adherence to NICE/ RCS pathways reduce waste • Supports reduction of UHL, three sites to two • Support the improved productivity in secondary care; outpatients and theatre utilisation, reduced length of stay, DNA and cancellation rates	• Higher day case rate saving UHL money • More procedures in primary care saving CCGs money • Reduced tariffs resulting from renegotiation and new payment models • Utilisation of existing resources for clinical triage hub once established	• Enhanced skills in primary care • Roll out and further development of PRISMSystm One • Establishment of Clinical Triage Hub

Enablers

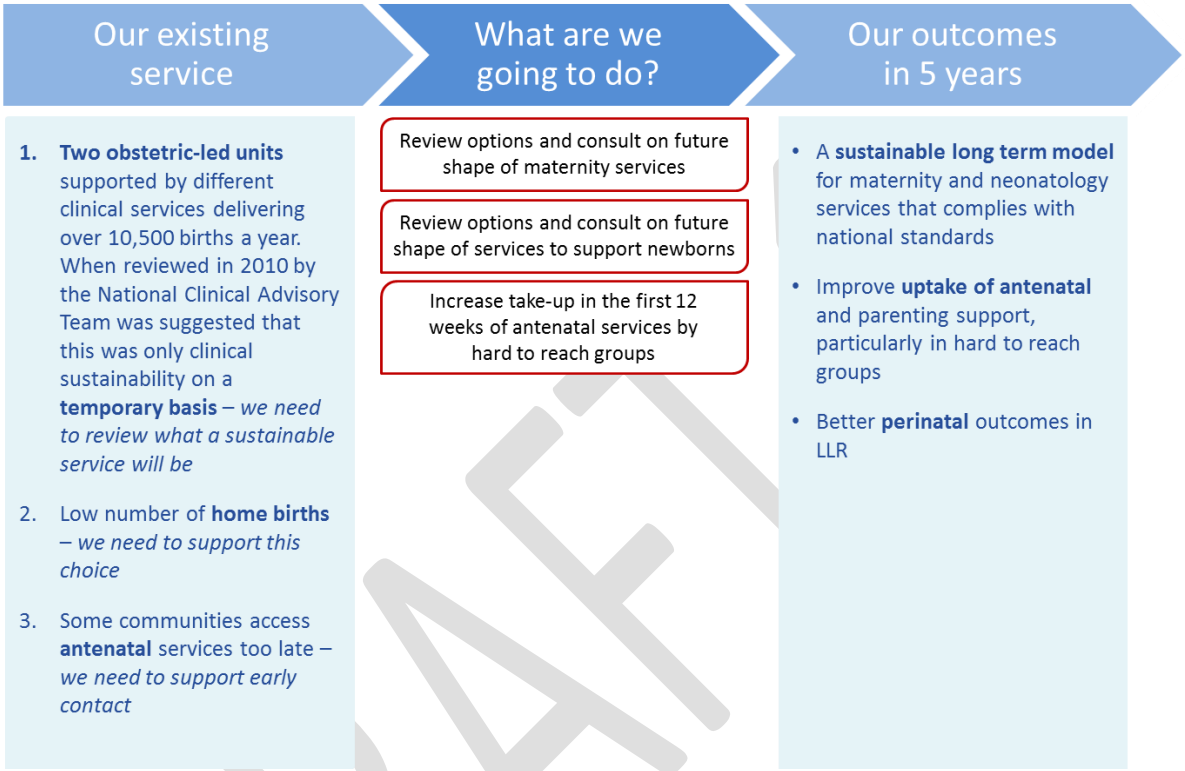
These plans rely on changes in a number of enabling areas.

- IM&T - real time data on admissions and discharge; shared information systems; technology assisted virtual interactions; and increased use of booking services;
- Estate - ensuring the community estate can support the “left shift” out of acute setting;
- Workforce – significant workforce implications will result from the 40% left shift of elements of planned care into community settings. This will require clinical staff to work from different locations and in a more integrated with community colleagues.

2.7.5 Maternity and neonates

The work stream addresses antenatal, intrapartum, neonatal and infant care (birth up to and including the immediate postpartum period) as well as post-natal care both routine and specialist. Pre-conception is not addressed.

Figure 30: Maternity and neonates – summary



Objectives

The case for changing maternity and neonates services is that LLR is currently not providing expectant mothers with as much choice as some other areas, and too many mothers are presenting to services late in their pregnancy. There are also concerns about the sustainability of running two obstetric-led maternity units in the city and concerns about the sustainability of the St Mary's Birthing Centre.

The aims for this service pathway are to:

- Maximise access to services to ensure all mothers are seen by a midwife at an early stage in their pregnancy;
- Improve the identification of babies at risk of poor perinatal outcomes will be developed;
- Offer personalised holistic care that is integrated between primary and secondary services;
- Ensure that babies needing specialist neonatal care continue to be treated at the right level;
- Work with partners across the East Midlands Neonatal Network to ensure adequate cot capacity;

- Expand neonatal outreach services to enhance the support to paediatric wards and to parents at home;
- In the context of wider UHL site reconfiguration plans, develop plans to consider consolidating all women's and neonatal services on a single site.

6What will happen across LLR to deliver these objectives

These objectives will be delivered by:

- Engaging with local people to review and consult on future shape of maternity and neonatal services as part of the acute site review;
- Maximising the uptake of midwifery led care options by promoting home births and midwife-led provision;
- Continuing with the multi-agency programme of work to improve perinatal outcomes in Leicester city;
- Working in partnership across health and social care to reduce perinatal and infant mortality;
- Promoting the importance of healthy lifestyle and early access to achieving a healthy baby;
- Providing targeted support for teenage mums and assist other services in reducing under 18 conception rates;
- Working with health and social care to support women and families with the transition to parenthood, particularly hard to reach groups;
- Working with adult mental health to develop an integrated maternal mental health pathway for mothers and families;
- Working with regional providers to develop networks for tertiary provision;
- Building the skills and capacity of the workforce to meet the needs of the local population;
- Rationalising the number of health and social care staff that women and their family have contact with, reducing handoff's and improving patient experience.

Detailed projects developed by the BCT Maternity and Neonates workstream

The maternity and neonates workstream has developed the following specific projects:

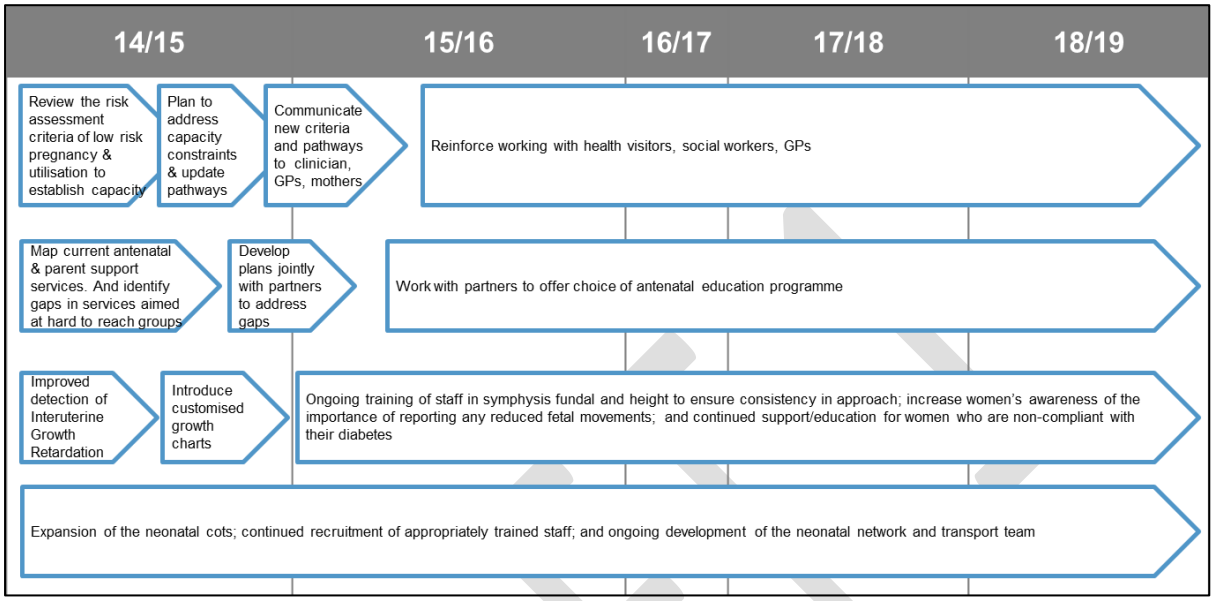
Figure 31: Maternity and neonates – system wide projects

Project	Description	Net annual saving
Changes to community based midwife led services	Redesigning how community based midwife led services are develivered to ensure that there is a sustainable model for community based delivery of midwife led care, which offers women in LLR real choice and access to high quality and sustainbale services.	£378,000
	Total	£378,000

Timeline for Delivery

The diagram below shows the timeline for delivering the proposed changes to maternity and neonatal services:

Figure 32: Maternity and neonates – timeline



The maternity and neonates plan has some interdependencies with plans for elective and emergency gynaecology which sits with the urgent care and the planned care workstreams, and links into the mental health workstream. These workstreams will work together closely as plans are finalised and implemented to ensure a joined up and coordinated approach.

Outcomes

These changes will deliver greater choice for mothers in LLR about how they deliver their babies. Some groups will also receive targeted support, for example teenage mums and other hard to reach groups who may need help making the transition to parenthood. Ensuring services are accessible and mothers access services at an appropriate point, and working in partnership with agencies across LLR will improve perinatal outcomes, particularly in hard to reach groups. The changes will also deliver a sustainable long-term model for maternity and neonatology services in LLR that complies with national standards

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 33: Maternity and neonates – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Maternity and neonates	• Improved links between neonatal services and paediatrics	• Targeted support for hard to reach groups to reduce late presentations	• More choice of high quality services for expectant mothers	• Consider consolidation of estates to ensure future sustainability of services	• Consider consolidation of estates to ensure future sustainability of services	• Greater resilience in community midwifery team

Enablers

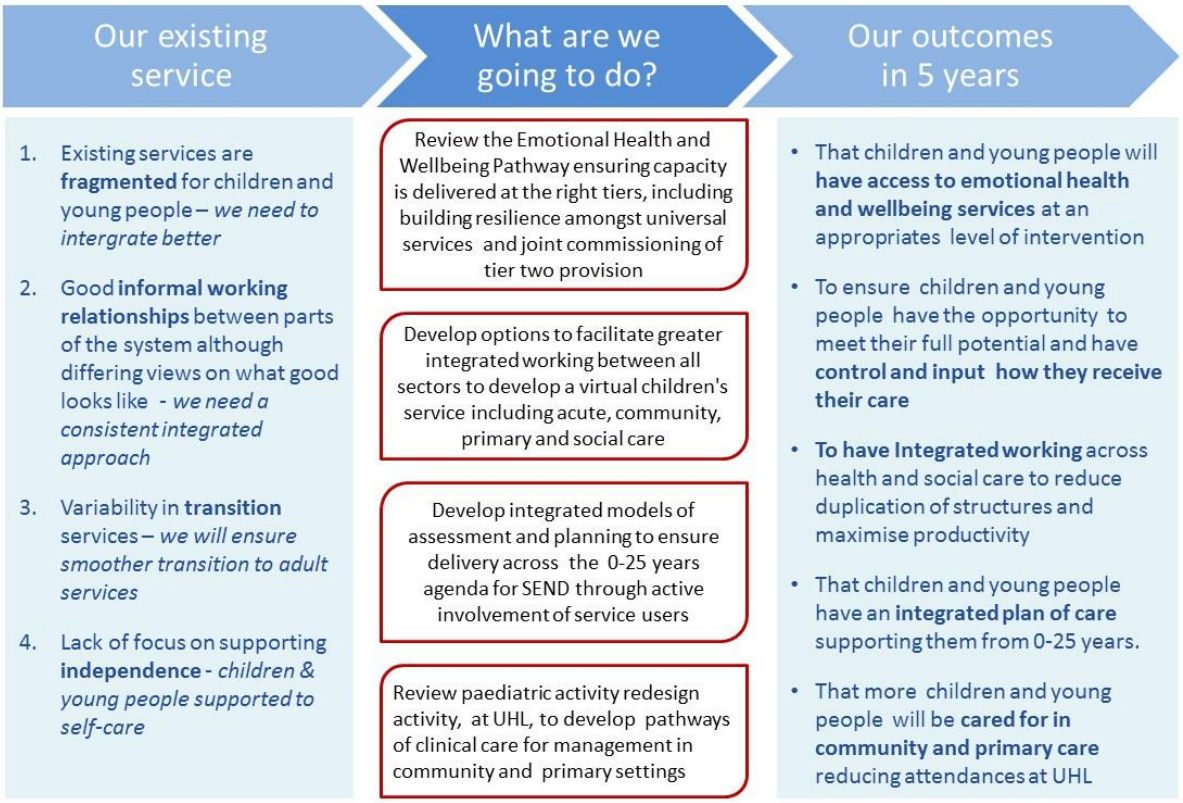
Implementing our plans for these services is dependent upon work of the estates enabling group to support potential consolidation of sites, subject to public engagement and consultation.

The workstream will also work alongside the workforce group to build the skills and capacity of the workforce to meet the needs of the local population.

2.7.6 Children, young people and families

The work stream covers all children and young people up to the age of 18 and in specific circumstances to the age of 25 years who reside in Leicester, Leicestershire and Rutland. It looks at paediatric primary care services (including urgent/unscheduled and planned/routine), Health Visitors and Early Years Providers (Children's Centres), Community paediatrics and children's community nursing care (including those receiving social care) and educational for children with long term health needs (including physical disabilities). Urgent and Planned and outpatient paediatric care are covered alongside emotional health and well-being.

Figure 34: Children's services – summary



Objectives

The child health agenda is vast and complicated and the current health care system is not designed to adequately address the unique needs of children. The needs of children are dealt with by a range of organisations including health, social services, education and the voluntary sector. These services need to change because current services are fragmented, and suffer from poor coordination across teams and organisations. The service model varies across LLR and whilst some local variation will always be needed, greater consistency is essential to reduce duplication. Current services lack a focus on supporting independence: children and young people need to be supported to self-care. The workstream aims are:

- Establish integrated pathways across primary and secondary care thereby reducing duplication and maximising productivity;
- Reduce inpatient activity and hospital-based outpatient contacts;
- Children and young people have an integrated plan of care supporting them from 0-25 years;
- Continue to work together to fulfil our responsibilities under the Children and Families Act 2014;
- Enable all children and young people to maximise their capabilities and have control over their lives;
- Children and young people will have access to emotional health and wellbeing services at an appropriate level of intervention.

What will happen across LLR to deliver these objectives

These aims will be delivered through the following programme of work:

- Facilitation of self-care, by empowering individuals and family capacity through patient education and community support by offering personal health budgets to eligible individuals;
- Increase access to tier two emotional health and wellbeing services which will be jointly commissioned to reduce the need for access to tier three CAMHS;
- Reduce out of area placements by developing sustainable specialised children's and young people's services within LLR, for example complex eating disorders and perinatal mental health;
- Improve delivery of planned care through redesign of pathways to reduce activity in an acute setting;
- Develop options to deliver integrated provision across all children's service providers;
- Develop a joint framework for assessment, planning and commissioning across agencies;
- Merger of Children's Emergency Department and Children's Assessment Unit to become a single Ambulatory care unit and deliver Children's acute care provision from a single site;
- Deliver Local Authorities requirement to deliver targeted early help to prevent the need for specialist services.

Detailed projects developed by the BCT Children's workstream

The following projects have been developed by the children's workstream:

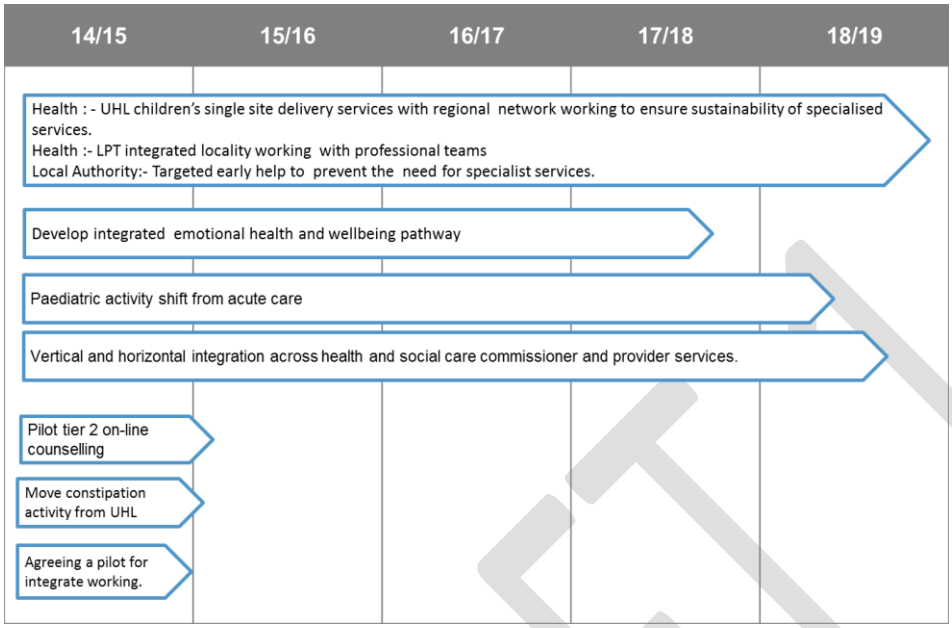
Figure 35: Children's services – system wide projects

Project	Description	Net annual saving
CAMHS	Increasing the provision of counselling and emotional health and wellbeing services to reduce the number of children escalating to tier 3 CAMHS serivces.	£73,000 (saving based on reducing referrals by 40 people at a cost of £2,333 per person and reducing the CAMHS tier three generic team caseload by 2.2%. Saving is net of costs of implementing improved counselling services.)
Hepatitis B ward attenders	Redesigning the hepatitis B pathway to shift 100% of activity from UHL and to primary care, so that in the future vaccinations are delivered by GPs	£3,000 (based on 100% activity moving out of UHL into primary care)
Eating disorders	Implementing a community based eating disorders team with capacity to support 120 children and their families each year. This will significantly improve the quality of care these children receive and reduce the number of children sent out of the county to receive inpatient care.	£60,000 (based on reducing admissions for patients with eating disorders by 50% and length of stay by 30%.
Bowel management services	Redesign the outpatient pathway for bowel management to increase the number of nurse led appointments by 50%, reducing the number of appointments that are consultant led.	£13,000 (based on reducing consultant led provision by 50% and increase nurse led provision by 50%)
Provider integration	The workstream will continue to engage with stakeholders and partners across LLR to increase the integration of children's services. This will focus on integrated working and joint commissioning by developing an overarching joint commissioning strategy across LLR, and this plan will be taken forward over the next couple of years.	£100,000 (based on savings due to rationalisation of management posts across LPT & UHL to reduce two band 7 posts costed at £46,346 plus £3,500 non pay costs)
Health and social care integration	Increased integrated working between health and social care providers to reduce the duplication of activity.	£50,000 (based on savings of 2 band 3 HCAs costed at £21,977 plus £3,500 non pay costs)
	Total	£299,000

Timeline for Delivery

The timeline for making these changes is set out below:

Figure 36: Children's services – timeline



Outcomes

These changes will improve health and wellbeing for children, leading to improved life expectancy and independence, and more children and young people will benefit from joined-up personalised care. There will be reduced duplication in the system, greater productivity, reduced inpatient admissions and less hospital-based outpatient activity.

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 37: Children's services – meeting system objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Children, young people & families	• Joined-up delivery across health & social care	• More support for carers • Services targeted at areas of most need	• Services more joined-up	• Less duplication between different teams • Standardised care pathways	• Reduced variation leads to savings amongst providers	• More partnership working across health & social care • More generic workers

Enablers

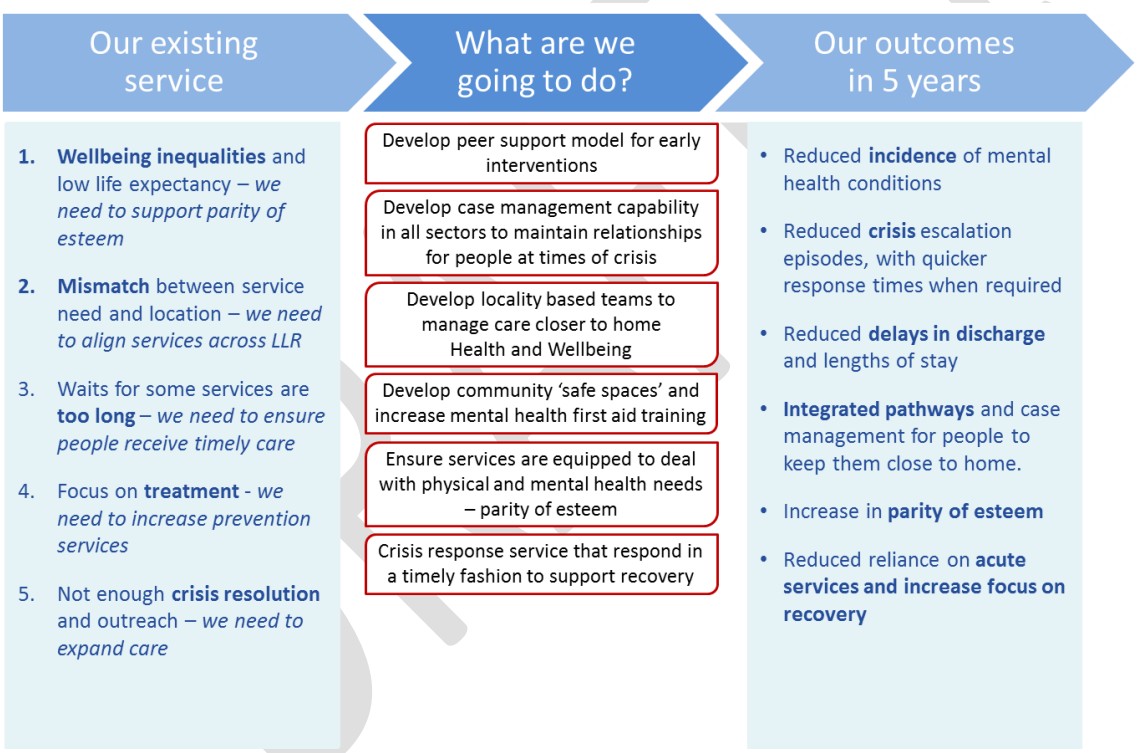
Implementing these proposed changes is dependent upon supporting changes in enabling areas:

- IM&T – technology to support a single point of access; mobile working devices; and the ability to share electronic records between providers;
- Estate – teams will need to be co-located in community settings to encourage integrated working;
- Workforce – developing new roles across health and social care; recruiting enough paediatricians to deliver 24/7 standards; consideration of joint appointments or "system wide appointments" for certain roles; and new roles and associated training.

2.7.7 Mental health

The mental health workstream addresses adult mental health services (primary, community and acute) and Liaison psychiatry and acute hospital In-reach. It does not cover dementia (part of the frail older people workstream), substance misuse or children's mental health services.

Figure 38: Mental health – summary



Objectives

The mental health service case for change is built around the need to achieve a "left shift" by moving activity from secondary care to community and primary care services. Central to this aim is a need to refocus on prevention and early diagnosis. When people need help from specialist services waiting times can be too long and those in crisis cannot always access services as quickly as they would like. Alternatives to hospital admission will also be provided to ensure people are treated in the least restrictive environment.

What will happen across LLR to deliver these objectives

The aims for mental health services are very similar to those for physical health services, and are focussed on delivering equal health status for people with mental health problems. The programme aims to deliver high quality safe mental health services; more joined-up across the primary care and secondary care interface; based on best practice; are easily accessible to those in need; reduce duplication and maximise productivity. The aims will be achieved by:

- Improving resilience within the population and individuals by strengthening prevention and self-help services;
- Enabling earlier intervention and more timely support in the event of crisis, through enhanced primary care capacity, backed-up by excellent acute care services;
- Increased access to alternative services, for example through IAPT;
- Improved education and knowledge within Primary Care through enhanced support to GPs;
- Offering a broader range of recovery options including peer support, the Recovery College and third sector services;
- Creating an integrated network of care services encompassing the third and statutory sectors;
- Refocusing community mental health teams to support primary care;
- More timely discharge of people from secondary care back to community and primary care services with support from the third sector and self-help groups;
- Providing more step-down support post-discharge, for example step down beds and crisis house facilities.

Detailed projects developed by the mental health workstream

The mental health workstream has worked alongside LPT to develop a suite of projects that will deliver both the LPT mental health CIP target and the workstream savings target. These two savings components were brought together to reduce the risk of double count and ensure that opportunities to improve quality of care and deliver efficiency savings within mental health were maximised. The workstream projects described in this section therefore fully support and enable delivery of the LPT mental health CIP savings.

Figure 39: Mental health – costed projects

Intervention	Description	Net annual saving
Implement Crisis House, step down beds, discharge team and changes to inpatient acute pathway to reduce out of county overspill placements	Investing in step down care, including a crisis house and step down beds, to enable a reduction in DTOCs and changes to the acute inpatient pathway, leading to the repatriation of patients out of county placements. The crisis house will provide face to face and telephone support for service users in crisis, either by appointment or on a drop-in basis. Additional services will provide overnight accommodation for up to 7 nights as an alternative to hospital admission. This will be supported through enhanced provision of urgent response with primary care, investment in social prescribing and short term increases in capacity in psychological therapies.	£2,800,000
Reduction in spend on alternative health placements	The programme will work to reduce alternative health placements by 40%, returning to their 2012/13 level, through repatriation; accelerated pathways; improved procurement.	£2,160,000 (based on a reduction in spend on alternative health placements phased at 30% in 15/16 and further 10% in 17/18)
Reduce staffing costs within IAPT	Agency staffing used currently. Assumes increased capacity for transitional period will reduce waiting times and improve efficiency	£100,000
Urgent patient clinics	This development is required to support deflection of patients from CRHT to CMHTs and to ensure urgent response is available i.e. within 24 hours	(£150,000)
Additional workstream productivity savings through new models of care to be developed	Target savings assigned to year 4 and year 5	£778,000
	Total	£5,688,000

Outcomes

The benefits for the LLR population will be increased resilience amongst those at most risk from mental ill health; more choices about how and where they receive help; a more timely response when in crisis and less need to access services outside of LLR.

For the system, the benefits will be less reliance on bed-based treatments and greater resilience within the LLR population leading to a smaller secondary care estate. The timelines associated with the mental health plans are set out below.

The table below shows how these benefits support delivery of the overall programme objectives:

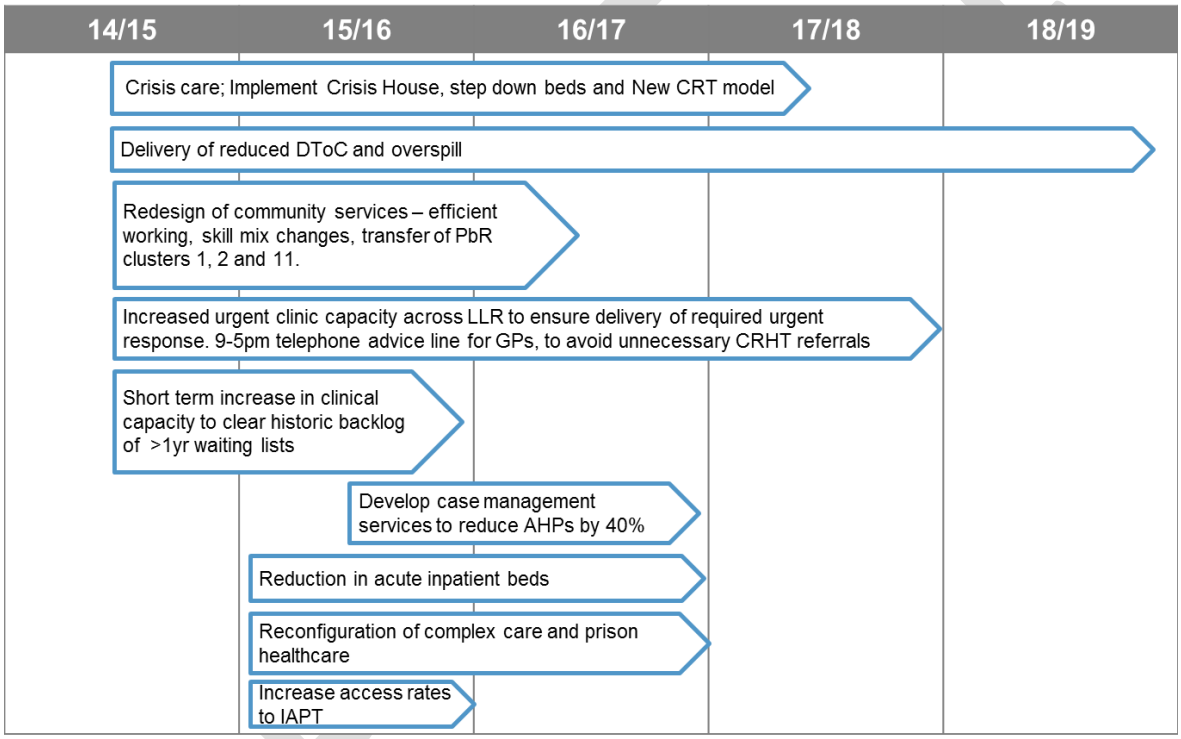
Figure 40: Mental health – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Mental health	• Joined-up delivery across health & social care	• More emphasis on tackling physical ill health	• Services more joined-up • Less reliance on admission	• MH clusters reduce variation in care	• Fewer admissions save LPT money	• New types of MH worker introduced

Timeline

The timeline for delivering these changes is shown below:

Figure 41: Mental health – timeline



Enablers

There are a number of links with enabling workstreams:

- Workforce – the mental health workforce skill mix will be reviewed to use consultants in consultancy and supervisory roles; reduce very senior staff numbers; up skill and extend the role of nurses including an assistant practitioner role; and develop the role of support workers. We will also build the role of peer support staff;
- IM&T – development of a universal connectivity to support remote working and access across clinical systems and create a culture and technology infrastructure to support performance management;
- Estate – exploit opportunities arising from the Centres of Excellence development and reduce the use of other inpatient sites and community bases. Community based staff will increasingly be co-located with colleagues.

2.7.8 Learning disabilities

The workstream seeks to address services for adults and children with learning disabilities (both community and residential based), supported housing (e.g. extra care housing), support for carers and Individual commissioning by social care and health.

Figure 42: Learning disabilities – summary

Objectives

The case for change for learning disabilities (LD) services is based on the need to provide care and support that is better co-ordinated and integrated between different health services and across the health and social care divide. The LLR-based provider market for learning disability is disjointed and underdeveloped leading to a high unit cost of care and a limited choice. In the future health and care services must fully embrace the principles of "Valuing People" and the personalisation agenda, to better support people to access universal services as standard practice rather than diverting to specialist LD services.

The aims for this workstream are to deliver responsive, high quality safe learning disability services and support that maximises independence. Services will support informed choice, be person centred, good value and meet the needs and aspirations of individuals and their family taking into account the diversity and changing demographics across LLR.

Services and support will be more joined up across social care, independent and voluntary sector providers, and between primary and secondary care helping to reduce duplication, maximise productivity and keep people local. Services will be based on best practice, easily accessible and quality assured by:

- Working with partners to ensuring practice is responsive to national policy and guidance including the Care Act, The Children and Families Act and the Winterbourne View joint improvement programme; Working with individuals, families and providers to develop local services and support that is outcome focussed;
- Providing enhanced support and information for carers, including access to short breaks;
- Reducing the number of joint funded out of county placements, which is likely to have a knock on impact on the need for transport to out of county settings;
- Maintaining the target for the number of health checks completed and improving the number of health action plans;
- Developing information systems for ensuring LD status are included in referrals to secondary and community care;
- Working with partners to consider options for improving effectiveness of autism pathways;
- Promoting the use of personal health and social care budgets.

What will happen across LLR to deliver these objectives

The follow projects will be implemented to deliver these objectives:

- 'Early identification and intervention for people with a learning disability (LD) to live more independently when they reach adulthood and prevent reliance on formal, specialist services 'Market Management' – LLR approach to stimulating and managing the market to meet changing aspirations and needs;
- Develop pathways which incorporate specialist provision such as assessment and treatment and outreach to support people to live in their local community for as long as possible, including the introduction of clear agreements and frameworks between health and social care for meeting people's needs;
- LLR approach to enable carers to be involved in service development and planning, including modernising the provision of short breaks, information, advice and guidance;
- Flexible LLR wide provision of short term intensive crisis support based on need;
- Develop locality based care, support and workforce, including primary care and secondary care, to broaden the offer and improve the experience for people with LD;
- Pooled personal budgets and personal health budgets for people with people with LD that meets needs in a cost effective and person centred way.

Detailed projects developed by the learning disability workstream

The workstream has developed the following projects:

Figure 43: Learning disabilities – system wide projects

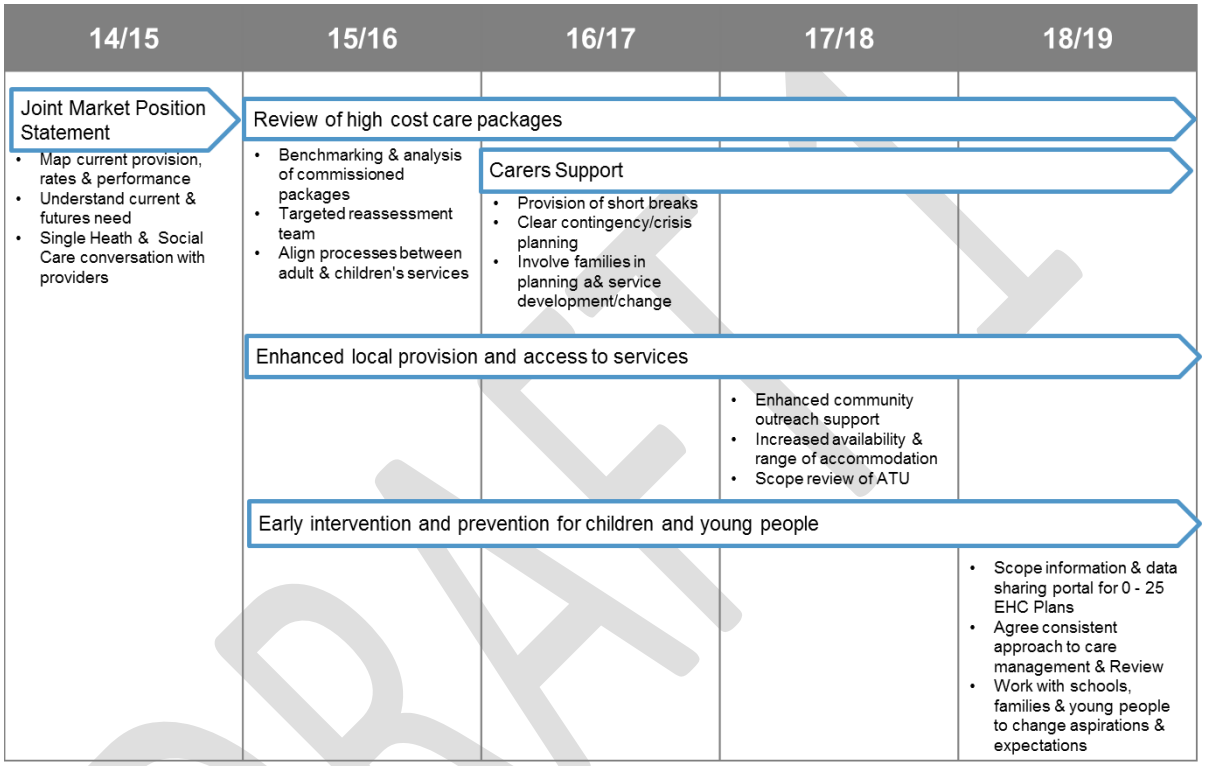
Intervention	Description	Net annual saving
High cost CHC packages	Putting in place a review team to benchmark and analyse the cost and content of high cost packages of care, focussing on consistency across health and social care. In conjunction with the development of a joint market position statement, this will ensure that health and social care leverage their combined resources to ensure best value for money is achieved for service users receiving packages of care.	£756,000 (based on a 5% reduction in expenditure)
Reconfiguration of short break services for LD patients / service users	A plan to reconfigure the provision of short break services for LD service users, ensuring a consistent approach across LLR. This will enable carers to be involved in service development and planning, including modernising the provision of short breaks, information, advice and guidance.	£969,000
LD Outreach Team	Implementation of an Outreach Team that will work between the community and the Agnes Unit for challenging individuals who require additional support. This team aims to reduce the number of admissions into the Agnes Unit by working with individuals in a community setting who are not suitable for admission, yet require additional support. The team will also help to reduce the length of stay in the unit by	£134,000 (based on a decommissioning of 4 beds and releasing 1 WTE Band 6 Nurse= £44,512 6 WTE Band 5 Nurse= £ 219,930 12 WTE Band 2 HCSW = £291,768) Offset against outreach team

	providing support to challenging individuals.	cost of £422,000 (6.6wte plus non-pay costs)
	Total	£1,859,000

Timeline for delivery

The timeline for delivery of these proposed changes is shown below:

Figure 44: Learning disabilities – timeline



Outcomes

These changes will enable individuals and their families/ carers to have more independence and control over their lives. Support will be tailored and joined-up across agencies and carers will benefit from better access to a range of respite services (short breaks) that are responsive and dependable. Services and planning arrangements will support people with LD and their families in times of crisis, reducing the need for admission to inpatient care. The majority of care and support will be provided locally and the need to travel outside LLR to access services will be reduced. People with LD will have their rights respected and upheld and will receive the same care and support as all other citizens.

These changes will also generate efficiencies through integrated service delivery and better collaborative working. Commissioners will gain better value for money from an improved marketplace offering greater choice and competition.

The table below shows how these benefits support delivery of the overall programme objectives:

Figure 45: Learning disabilities – meeting programme objectives

	Objective one Integrated care pathways	Objective two Reduced inequalities	Objective three Positive experience of care	Objective four Improved asset use, reduced duplications & waste	Objective five Financial sustainability	Objective six Workforce & IT capability and capacity
Learning disabilities	• Joined-up delivery across health & social care	• More support for carers	• Services more joined-up	• Less duplication between different teams	• Market development reduces placement costs saving commissioners money	• More partnership working across health & social care • More generic workers

Enablers

The key enablers underpinning these changes are:

- IM&T – technology supporting a single point of access; mobile devices to support mobile working; and shared information systems including access to records and support plans for individuals and families;
- Estate – the co-location of health and local authority staff;
- Workforce – new roles and approaches at all stages of the pathway; marketing the benefits of working in health and social care across all sectors; and support to GPs to enable them to support more people with LD in primary care.

2.8 Provider impact

2.8.1 University Hospitals of Leicester NHS Trust

A significant proportion of the health economy benefits will be delivered through organisational savings at UHL and LPT, however the delivery of these savings is reliant upon the broader delivery of the workstream projects, which will be required to enable the significant transformation programme set out here. More detail on trust savings programmes is set out in the Financial Case.

UHL has the following vision:

> *"In the next 5 years UHL will become a successful Foundation Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience…*

The trust's "strategic direction" was published in November 2012[14]. This set out at a high level the future shape of UHL's clinical services:

> *"Overall Leicester's hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community. As a result of centralising and specialising services we will improve quality and safety… this will be done in partnership with other local health organisations and social care though the Better Care Together programme. We will save money by no longer supporting an old expensive and under used estate and we will become more productive."*

The trust's plans to deliver against its vision and strategic objectives are set out in its five year Integrated Business Plan which seeks to ensure that the vision of "smaller more specialised hospitals" becomes a reality, and that ongoing issues with emergency and urgent care are solved and that the trust returns to financial balance. Whilst the trust has responded to growing demand, analysis has shown that a significant proportion of hospital beds are occupied by patients whose clinical needs could be met more appropriately in alternative care settings – the models of care described above are the route by which UHL will work with the rest of the health and social care community to provide treatment in more appropriate community settings for these patients.

The result of the shift to community settings will be less need for acute hospital beds and associated physical assets. The trust intends to use the resulting opportunity to consolidate acute services onto a smaller footprint and to grow its specialised, teaching and research portfolio; only providing *in hospital* the acute care that *cannot be provided in the community*. In doing this the trust expects to significantly increase the efficiency, quality and, ultimately, the sustainability of key services; shrink the size of the required estate; significantly rebalance bed capacity between acute and community settings, and thus reduce total costs. This refocus will also allow the trust to concentrate on the other element of its strategic direction, "to become more specialised".

The shift of activity to community settings involves UHL releasing 571 acute beds. In order to release those beds UHL needs to undertake a number of initiatives, primarily focussed on reducing the average 'Length of Stay' (LoS) of its' patients. The areas that UHL have focused on are reducing delayed transfers of care (DTOC) and increasing day surgery activity in line with BADS guidelines. The eight workstreams are also leading on ensuring that less activity arrives at UHL due to earlier intervention and providing more appropriate settings of care. Underpinning these initiatives and the eight workstreams is UHL's capital programme, which is a key enabler, to UHL being able to shift activity into the community. The programme entails 17 different business cases for a variety of estate changes. These include new builds and refurbishment of existing estate which enable UHL, to rationalise their sites from three to two.

In order to be able to receive the increased activity, LPT, Primary Care and Social Care will need to adapt their capacity to be able to receive more patients with more complex needs.

[14] UHL Strategic Direction, November 2012

2.8.2 Leicestershire Partnership NHS Trust

LPT's vision is to:

> "*To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways".*

The Trust's clinical strategy[15] has the following objectives:

- Care that is effective, safe and personalised;
- Integrated care in the community
- Helping people to stay healthy and well;
- A focus on recovery-based approaches;
- Working and learning together; and
- Research and innovation.

These objectives will, in part, be delivered through three transformation programmes aligned to BCT:

- Co-ordinated community health services – creating effective, more integrated pathways for frail older people and adults suffering from chronic conditions;
- Creating effective, more integrated pathways for children and young people; and
- Creating effective, more integrated pathways for adults with acute and enduring mental health conditions and those with complex learning disabilities.

As a consequence of delivering the eight BCT clinical workstreams, LPT expects its bed base to reduce by around 87 beds over the period, as more people who are currently treated in acute hospital settings will be treated at home by integrated mental health or physical health locality teams. The trust's community hospitals will also become hubs for co-located health and social care community teams, as venues for outpatient and diagnostic activity, and as settings for step down and step-up inpatient services. Whilst these sites experience more activity and become better utilised, this does not mean that the number of community hospital beds will increase.

LPT's efficiency programme includes a drive to reduce the length of stay, and need for admission for the existing cohort of community hospital inpatients, by providing more support through expanded community teams. Community hospital beds no longer required for these patients would then become available to be utilised by part of the cohort of patients who are currently admitted to UHL. The consequence will mean an overall reduction in the need for beds at UHL and an overall increase in the number of people cared for at home.

[15] LPT Clinical Strategy, March 2014

2.8.3 Bed reconfiguration summary

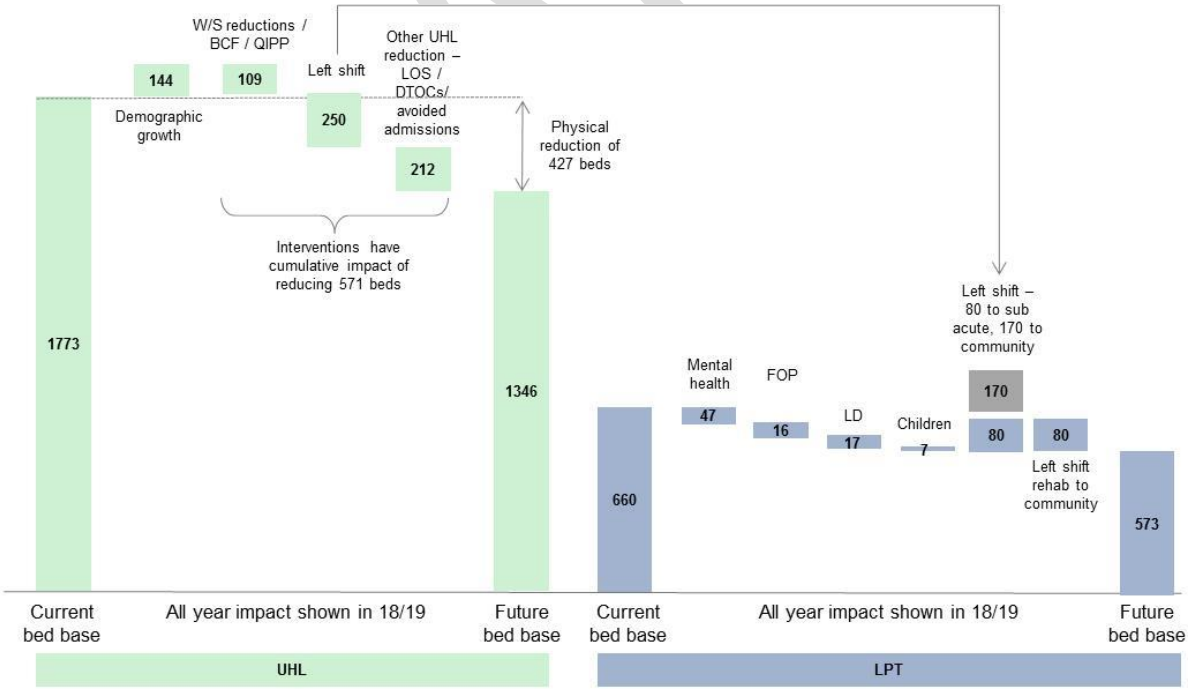
The LLR LHE strategy outlines a new model of care which results in a reduced number of acute beds and a shift of care into a community setting. The current bedded model of service provision across LLR includes 1773 acute beds across 3 acute hospital sites and 660 community and mental health beds in eight community hospitals and one mental health hospital.

The current plan is to re-provide the bedded activity through a smaller number of acute beds by increasing the level of acuity of patients treated within community hospitals and providing more support closer to home through community nursing teams and community based support.

In total, actions need to be taken across LLR to remove 571 beds from UHL. This is made up of:

- 462 beds related to UHL efficiency reductions and left shift of sub-acute patients to LPT;
- 109 beds related to workstream efficiency reductions. Overall, this will mean that UHL's bed base will reduce by 427 beds because some of this reduction is required to reduce anticipated activity growth over the five years of the plan. The graph and table below illustrates the left shift:

Figure 46: LLR bed bridge



The current phasing of beds to be taken out of UHL is as follows, however further details will be provided over coming months in order to develop a comprehensive beds strategy.

UHLs detailed bed reduction

Figure 47: Profiled bed reductions

Year	Physical beds reduced
15/16	203
16/17	122
17/18	61
18/19	41
Total	**427**

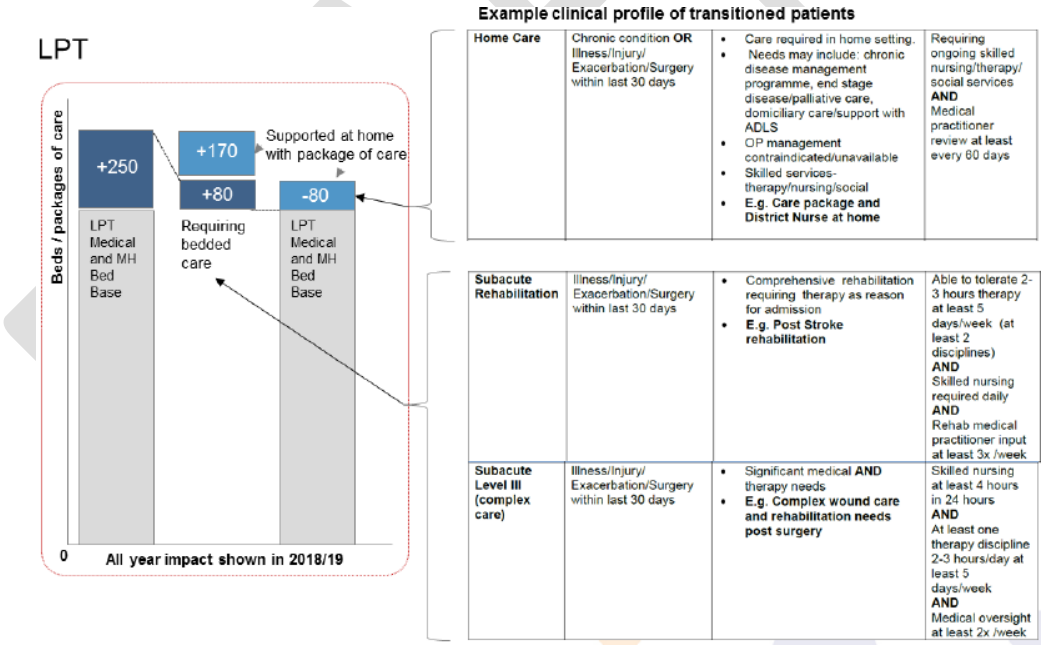
Left shift into the community

UHL and LPT have agreed that 250 beds worth of patients can be cared for outside of an acute setting. The 250 beds are broken down as follows:

- 170 where patients can be treated by expanded community teams;
- 80 "sub-acute" beds, where patients need to be treated in an existing community hospital bed, with enhanced home care support.

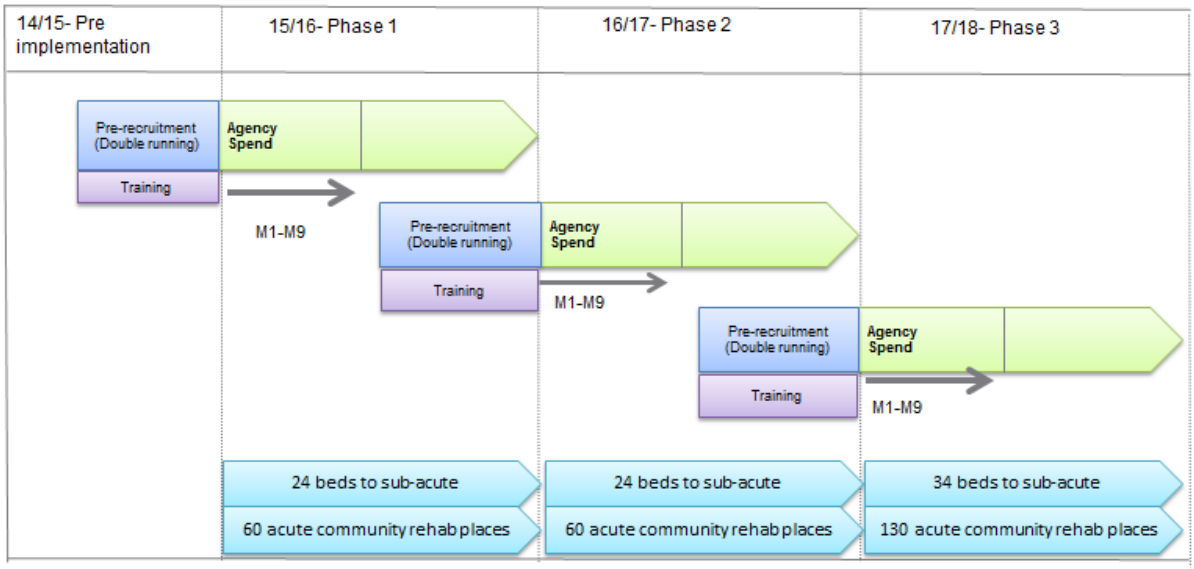
The shift is illustrated below:

Figure 48: LPT bed shift



Plans are being put in place to move patients from UHL to LPT in three phases. This is to allow time for sufficient staff recruitment to take place, and to give time for existing rehab patients currently being seen in community hospitals to be discharged from existing rehab beds to be treated in a community setting.

Figure 49: UHL reductions through efficiency gains and working more closely with different partners in the system



In June UHL identified 462 beds worth of activity which could be delivered outside of an acute setting. Of this 462, 250 have been agreed with LPT (as outlined above) to form the left shift to community settings, and a further 212 can be closed due to improvements in internal efficiencies. There are two main drivers for this reduction:

- BADS reductions – where activity that was previously provided in an inpatient "elective" setting in UHL can in the future be provided as a "day case", preventing the need for beds;
- Length of stay reductions, where the overall length of stay can be enabled through improved working with other partners in the system and greater efficiency at UHL. This will be achieved through reducing excess bed days, working with partners to reduce delayed transfers of care (DTOCs) and treating patients on ambulatory care pathways, where they are not admitted to a bed upon arrival at the hospital.

Workstream efficiencies

109 beds need to be removed through admissions avoidance, which will primarily cancel out the effects of forecast increases in activity growth at UHL over the next five years. This reduction will be achieved through planned work taking place driven by CCG QIPP and BCF initiatives, in addition to the system projects which have been identified by the clinical workstreams. The current reductions are outlined below:

Figure 50: Required efficiencies

Workstream	Initiative description	Bed impact assumptions
Urgent Care	Community based unscheduled care teams will be able to deliver care for patients with ambulatory care sensitive conditions, targeted at those patients with an existing length of stay of between 0-5 days.	24
QIPP – Better Care Fund plans	3 x BCF plans will reduce NEL admissions by 1013, 1911, 70 (total 2,994 admissions). Bed reduction based on ALOS of 3 days and reduced for 93% utilisation.	26

The numbers in the table above total 50 beds, which means that a gap currently exists against the 109 target. Currently other workstream initiatives have been discounted from this breakdown due the risk of double-counting patients, however further work is taking place to develop actions which will reduce the full number of beds as required.

Financial impact

An £11m benefit to the health economy has been identified against the elements of the beds reduction identified by UHL, encompassing BADS avoided admissions through treating patients in an ambulatory care setting, LOS reductions and patients shifted out to community settings. This is assumed to be broken down as follows:

Figure 51: UHL bed reductions – financial impact

Category	Bed reduction	Health economy impact	CCGs impact	LHE benefit
Left shift to LPT	250	• UHL loses margin on activity (-£2.3m), LPT gains additional contribution through providing at lower marginal cost (£4.3m) • No impact on commissioners	N/A	£2.01m
BADs	67	• UHL saving as daycase assumed to have a marginal cost of 50% of tariff compared to IP at 70% (£1.02m saving)	N/A	£1.02m
UHL efficiency gains	145	• Activity completely removed from UHL so lost contribution (£2.3m) (includes an additional financial impact equivalent to 32 beds after growth applied to 18/19) • Commissioner saving of tariff related to activity (£9.3m)	£9.3m	£7.98m
Total	**462**		**£9.3m**	**£11.01m**

Further work is required over the coming months to confirm the exact cohorts of patients affected by these bed reductions to ensure that LPT and UHL are completely aligned around the left shift and where changes to the model of care are required.

2.8.4 Primary care

Primary care is provided in community settings by a range of practitioners, including general medical services, dentists, pharmacists and optometrists. For the purposes of this section, the initial focus is the development of general medical services, with CCGs developing strategies in accordance with the NHS England Leicestershire and Lincolnshire Local Area Team framework for primary care (July 2014). CCGs have also applied the learning from best practice elsewhere[16].

While each CCG is different – i.e. different geography, different populations, and different history – there is a common theme of collaboration across primary care to overcome workload pressures, offer accessible local alternatives to acute care, and to prevent illness or exacerbation. All three CCGs have engaged GPs and others in setting out a vision for the future of local primary care.

The three CCG primary care strategies are summarised below:

Figure 52: Primary care – summaries

Leicester City	The vision is to develop a fit-for-purpose primary medical care service that will contribute to improving health outcomes and reducing health inequalities across the City. We are considering establishing four 'neighbourhoods' defined by health need. The proposed delivery model is for patients to be streamed to appropriate healthcare individuals; with the more complex seeing a GP. Resources across practices may be pooled and collaboration between practices would be encouraged though not enforced. Demand and capacity planning will be undertaken to establish the right standards of workforce, premises, skills and resources required for this new primary care delivery model. Discussions are ongoing about the development of a 'quality' contract based upon measurable improved health outcomes for those services over and above the core primary care contract. Through effective commissioning we will ensure that all patients have access to a uniform range of services, matched to their health need and delivered to a consistent level of quality. We shall do this by designing a framework with varying levels of delivery, as shown below. Elements of service delivery for Urgent Care, LTC, FOP and Planned Care will be delivered across primary care, with a mixed economy of individual practice delivery and local hubs for more complex services.

[16] NHS England, The Heart of Patient Care, Transforming Primary Care in Essex http://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2014/05/print-trans-prm-care-1.pdf, viewed 24 September 2014.

West Leicestershire	We have a clear vision for the future of primary care in our CCG in which general practice is the foundation of a strong, vibrant and joined up health and social care system. This new system is patient centered, and provides accessible high-quality, safe, needs-based care. This is achieved through expanded – but integrated – primary and community health care teams, offering a wider range of services in the community with increased access to rapid diagnostic assessment, co-located specialists and crucially patients taking increased responsibility for their own health and wellbeing We believe that the vast majority of health problems in the population – including mental health – could be dealt with by primary and community care. Currently we have not fully realised the potential of general practice and too often patients receive care in hospital that could be safely provided in the community, coordinated through their general practice, supported by the wider health and social care teams. Over the next five years our new model for general practice will be realised - the practice and the primary healthcare team will remain the basic unit of care, with the individual practice patient list retained as the foundation of that care. However, whilst a large proportion of care will remain within a patient's own practice thereby recognising the importance of the therapeutic doctor – patient relationship, an increasingly significant proportion will be provided by practices coming together to collaborate in federated localities, using their expertise, sharing premises, staff and resources to deliver care for and on behalf of each other. In this way, it will be possible to improve access and provide an extended range of services to our patients at scale.
East Leicestershire & Rutland	The vision for primary care is for general practices to work together to provide services at a greater scale across a local area, bringing more specialists and wider primary care professionals together, in order to provide better integrated care particularly for those patients with complex needs. General practice will be fully integrated, proactive, coordinated and sustainable; with a model of service provision delivering seven day services 'wrapped around' each patient. Continuity of care will be offered by a named GP. ELR's plan involves the development of up to 11 hubs, with extensive support to agree a contract to provide Community Based Services to a population of 25,000 – 45,000. Working at scale enables key specialist nursing and medical staff to be brought to this level to work with the GPs. It enables a more integrated way of working with the community services hubs already structured in this way, and offers broad career opportunities which will make ELR much more attractive to GPs and others, increasing our ability to recruit and retain a high quality primary care workforce.

How will improved primary care support the delivery of the clinical workstreams?

Three specific workstreams have been identified as having a particular overlap with the continuing development of primary care services.

Figure 53: Workstream contribution to primary care

Workstream	Primary care contribution
Urgent care	In ELR a streamed service will likely mean greater access for patients who need immediate care. Four urgent care hubs will be commissioned from April 2015 which will greatly increase both in hours evening and weekend access for patients. This will reduce the burden on ED departments for non- emergency patients. Leicester City is putting plans in place to pilot 7 day working across the 4 health need neighbourhoods, subject to securing additional winter funding from NHS England. In addition, the seven day working pilots already underway in West Leicestershire will be used to help inform the wider rollout of seven day working in primary care and community settings which is a key component of the Urgent Care Work stream.
LTC / FOP	In East Leicestershire and Rutland the patients who are streamed into the "complex" group will have greater GP and nurse/ MDT access with detailed plans in place for all aspects of their care. This service is planned to be offered 7 days per week for these complex patients to reduce the need for emergency services. Pilots have already commenced in 2014. Leicester City has begun to look at a model where all 62 practices undertake core sets of services and are able to apply to undertake additional community based services on behalf of their own patients and others. It is anticipated there will also be hubs which provide more complex services, delivered by a small number of accredited providers. In West Leicestershire the Primary Medical Care Plan identifies the need for greater integration and collaboration and the provision of integrated care at a locality level. Using the four localities as the geographical unit at which care is commissioned coordinated and provided we will build on existing structures such as virtual wards and Federations to support patients with frailty and the move to deliver more sub-acute care outside of an acute setting. Our overarching philosophy is that admission to secondary care should be the last resort for any patient where it is clinically appropriate and that discharge home from acute care should be achieved as quickly and efficiently as possible. In our model we will increase the proportion of care patients receive close to home through effective, timely interventions. This will require increasing access 7 day care management and where appropriate over a 24 hour period, developing flexible models that enable care to be provided in both a scheduled and unscheduled manner to meet the needs of patients and at the time they require it.
Planned care	Appropriate peer review, improved diagnostics and specialists working in an out of hospital setting will help to reduce the need for patients to be referred in for Outpatients. This will need to be managed in line with local alliance / federation contracts. Working in this way has the potential to support the planned care workstream through improving the quality of referrals, up skilling GPs and supporting the development and implementation of new pathways.

Improving efficiency in primary care

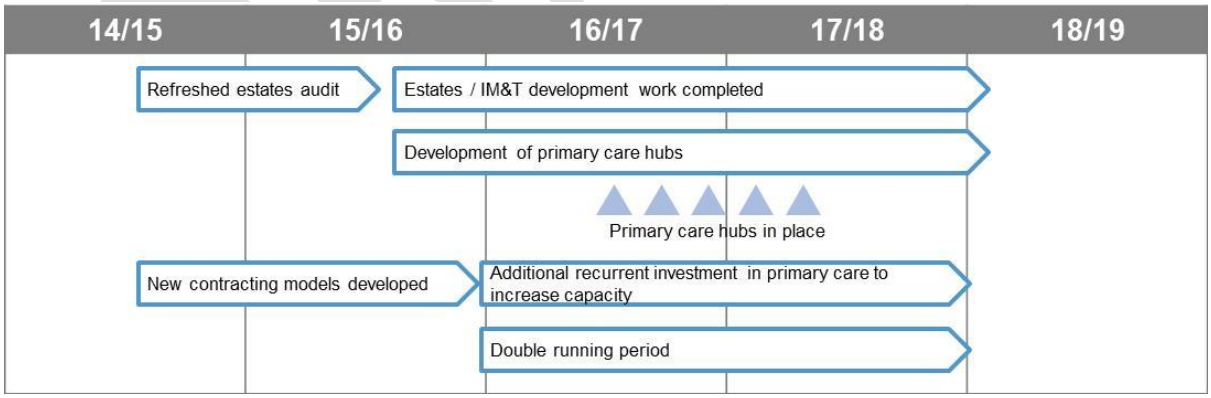
Discussions from across LLR suggest that:

- Significant clinical time could be saved through better organisation and a redesign of the general practice model;
- It may be possible to stop up to 10% of GP contacts by organising better and improving access to other health professionals, allowing GPs to focus their time on those patients who need them the most;
- A significantly greater number of patients could be empowered to self-care through developing a new model in general practice;
- The model of funding and delivering primary care is complex with Core, DES, Local investment and Community-Based services all paying for elements of the service provided. Any changes will enable simplification and scale, reducing duplication and the need for as many non-clinical staff. This will create an opportunity for re-investment into new or differently skilled clinical staff to support the practices /hubs;
- The new model will require a broader range of clinical skills both within general practice and in the ancillary services. Within general practice there will need to be more highly trained nurses and GPs with broader skills for both planned and complex care. This will require new investment alongside the reinvestment of any efficiencies;
- Delivering the same GP system across all practices, community services and urgent care centres in East Leicestershire and Rutland will enable clear information sharing and ability to manage patients appropriately first time without any delay.

Driving forward transformational change in primary care

The transformation plans set out for all three CCGs will require significant planning in order to significantly increase capacity. The below timeline sets out the expectations for how this development will be phased over the next 4 years:

Figure 54: Primary case phasing of transformation



Additional funding to support the changes in primary care

It is anticipated that significant additional funding will be required, both recurrently and non-recurrently, to enable the transformation in primary care which is planned across LLR. The non-recurrent elements of this are being worked through in further detail but are likely to be broken down into:

Double running costs to deliver the change in capacity required by primary care to enable the left shift
Estates costs of improving existing premises and developing primary care hubs
Any associated **IM&T costs** associated with new equipment / services

Double running costs

During the period where capacity is increasing in primary additional non-recurrent funding will be required as new services develop and new staff are trained. This funding will cover the following categories:

- Education and training;
- IM&T improvements and alignment to support development of hubs;
- Management costs, including legal;
- New equipment;
- Time and motion studies to enhance the model.

Broad estimates have been made on the overall level of non-recurrent funding required to support this shift, on the assumption that the left shift will require a similar level of support for primary care as in other care settings.

Estates

Across Leicestershire there is a need for new estates development as hubs develop. In East Leicestershire there are currently 33 practices, of which half have previously been identified as in need of significant estates development. The CCG estimates that the required capital will be around £29m.

The West Leicestershire Primary Medical Care Plan clearly identifies that investment in primary care premises is crucial to the successful implementation of the plan. Investment is needed both in terms of bringing existing primary medical facilities up to date, addressing the growth in the number of new homes and associated population, and in ensuring there are appropriate facilities to support the wider health economy transformation. In order to make this a reality where possible we will explore with our partners options for utilising existing facilities more effectively however there is still a clear need for capital investment in primary medical estate to support primary medical care to work at a greater scale as outline in the Better Care Together 5 Year Strategy.

In West Leicestershire it is estimated that £9.25m is required to expand 3 high risk premises in North Charnwood, the expansion of two high risk premises in South Charnwood, and additional investments in HWL and Hinckley and Bosworth.

Leicester City CCG anticipates that around £8m will be required for new buildings, expansion and refurbishment, enabling the facilities to undertake planned care activities. This is based on an assumption of £2m for each of the four health need neighbourhoods.

IM&T

Data and information are at the heart of any drive to improve quality and patient service. Across West Leicestershire and East Leicestershire and Rutland there is a need to align GP systems. Having all practices, community services and urgent care centres on the same system would enable clear information sharing and ability to manage patients appropriately first time without any delay. West Leicestershire estimates that it will cost £500k to move all practices to one IT system and in ELR this figure would be around £300k. In Leicester City and West Leicestershire the CCGs estimate that £0.15m will be required to increase access to virtual consultations, and in the City an additional £0.15m will be used to prepare for hub working, improving system configuration.

2.8.5 Social care

Social care is a critical element to the successful delivery of the Better Care Together programme. Working together, health and social care partners across LLR aim to provide integrated, high quality services, delivered in local community settings where appropriate, whilst improving emergency and acute care.

What is adult social care?

Some people need extra care or support - practical or emotional - to lead an active life, do everyday things and to fully participate in local communities. Adult social care aims to provide care for those who need extra care and support, and enable people to retain/ regain their independence and dignity.

Adult social care provides support for adults, including unpaid carers, who are in need of support because of serious illness, physical disability, learning disability, mental health problems or frailty because of old age. Access to adult social care is subject to rules about needs and ability which determine eligibility for support and whether a person needs a short period of support to prevent, maintain or improve their independence, or whether longer term support is required. If the person has ongoing needs, a Needs Assessment will be carried out to determine how needs can be met.

What does social care provide now?

Adult social care services provide advice and information, assessment and support for all adults over 18 years of age. Provision focuses on offering accurate advice and information for individuals to make informed choices.

Re-ablement services are time limited projects aimed at minimising the impact of disability or illness. This approach aims to support individuals to regain new skills and adapt to their conditions through a period of intensive support and/ or provision of equipment.

Crisis response services work with partners to support people experiencing a health or social care crisis within their own home. This flexible and responsive approach aims to deal with urgent needs that without support could result in a residential or hospital admission.

People with eligible needs can receive financial support to meet their assessed social care needs through a Personal Budget. Adult social care has a responsibility to ensure there are

services and goods available in the market for people to buy using their personal budget, which can support them to meet their outcomes.

In Leicestershire, Leicester and Rutland, policies and procedures are in place to ensure the relevant agencies and services work together to prevent abuse and to help and support adults with community care needs who may have been the victim of abuse.

Figure 55: Social care – services and outcomes

Support	Services	Outcomes (ASCOF)
Primary Prevention (universal services)	Information and Advice	Ensuring that people have a positive experience of care and support
Secondary Prevention (targeted towards those at risk of needing support)	Low level mental health support, support groups, lunch clubs, carer services – promoting carer health and wellbeing.	Delaying and reducing the need for care and support
Tertiary Prevention (minimising impact of disability)	Re-ablement Assistive technology, equipment and adaptations. Intermediate Care – Crisis Response Services, Carer Support	Delaying and Reducing the need for care and support
On-going support (access via assessment of eligibility, need and allocation of resources – Personal Budgets)	Personal Budgets (Cash or Managed) Home Care Community Life Choices Shared Lives Service Home Care/ Domiciliary Care Residential Care Supported Living Support for carers - Respite	Ensuring that people have a positive experience of care and support Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm. Enhancing quality of life for people with care and support needs

Service Utilisation

The adult population in Leicester, Leicestershire and Rutland is forecast to grow by around 28,300 (3%) by 2020, the majority of which will be people aged over 65yrs. There is a rising demand for health and social care, with the local population growth being much more significant (12%) in the over-65 population as illustrated below:

Figure 56: Social care – utilisation

	13/14 Receiving Care	Leicestershire	Leicester	Rutland
Aged 18 – 64yrs	Community Based Services	2,705	2,175	165
	Nursing/Residential Care	515	430	25
	Total Care	3,220	2,605	190
	% of 2014 population	**1%**	**1%**	**1%**
Aged	Community Based Services	4,825	2,620	480

65yrs or over	Nursing/Residential Care	1,695	930	135
	65+ Total Care	**6,520**	**3,550**	**615**
	% of 2014 population	**5%**	**9%**	**7%**

What is the vision for social care?

The aim of adult social care is to promote the wellbeing and maximise the independence of older and disabled people. This means improving outcomes for vulnerable people and ensuring that publically funded care and support is provided where it is cost effective and only when it is really needed. These objectives are most likely to be met through integration of commissioning and services with the NHS. Integration is required across the whole health and care system and will require an agreed approach to sharing risks, costs and benefits, for example through pooling of resources. Commissioning strategy will be directed towards improving outcomes through appropriate incentives for providers, and moving away from using the historic time and task approach which will become unsustainable.

Social care will support the “left shift” by managing demand and helping to ensure that there is an effective unified prevention offer that enables communities, families, carers and service users to be self-supporting. It will also work with the NHS, housing bodies and other partners to provide more targeted secondary preventative approaches for people at risk of losing their independence. These approaches will ensure scarce care and support resources are directed effectively. The model for delivering longer term support will continue to promote independence, choice and control; and will seek to improve outcomes for service users and their families whilst remaining cost effective. Enabling people to access support in the appropriate housing will be key to success.

A strong communication and engagement strategy with the workforce, communities, service users and carers will be needed to achieve the delivery of this vision for social care.

Performance

All adult social care departments use the Adult Social Care Outcomes Framework (ASCOF) to measure progress in the delivery of care and support. The ASCOF is a national framework written by the Department of Health and it helps support our understanding of the outcomes and experiences of people who use care and support, based on information collected from all councils providing social care across the country which is then published.

The Care Act 2014

The Care Act 2014 seeks to consolidate existing social care and health laws and introduce new duties to local authorities to ensure that wellbeing and equitable provision is delivered across England to all those with eligible needs. From April 2015 this will include unpaid carers and people in custodial establishments. The Care Act 2014 will also reform the funding of social care provision, in particular, how care is charged for and how much people will have to pay towards their care costs.

The Care Act 2014 also assists people and their families with low level needs by ensuring adequate information, advice and guidance is developed and delivered. A focus on

preventing need and reducing decline will ensure that people can live independently for longer and have choice over the support they receive.

Key risks to delivery

The demographic changes driving demand for the NHS also drive demand in social care. The increasing numbers of frail older people and younger people with complex needs will continue to increase demand for service into the long term. These demand pressures are not reflected in the resources allocated to councils to meet local need.

The current economic situation continues to be extremely challenging, resulting in significant and on-going reductions in Government funding. With an increasing demand for services, further duties under the Care Act 2014, reduced funding and a need to achieve efficiency targets, social care faces difficult decisions in order to deliver its savings commitments.

In Leicestershire County (the third lowest funded County Council) the savings target over the next four years for the adults and communities department alone is £21million (16% of its total budget) even though £40million of savings have already been achieved.

Since the onset of funding cuts in 2011/12, Leicester City Council has approved plans to reduce its expenditure by £85m per year. Whilst there is no certainty beyond 2015/16, if the current trajectory of funding cuts continues, the Council will need to make reductions amounting to a further £60m per year by 2017/18. It is unclear at this stage what the impact on social care will be.

Rutland County Council has a five year medium term financial plan and by 2018/19 will be required to save up to a minimum of £3m (c10%) of its current budget to maintain spend within a reduced level of resource. As a low cost Council whose spend per head on all services and on adult social care is lower than the national average, this target will be challenging. The Council has undertaking a review of its People Directorate and will be making savings in this area but further savings may be required.

The situation is similar in Rutland where 33% of current council expenditure is on adult social care. Significant savings across all three councils will impact on corresponding health services, although this process will be assisted by the expansion of the BCF fund in 2015/16.

The implementation of BCF plans will act as a catalyst to integrating health and social care provision, in addition to offering protection for critical adult social care services. The fund will further progress integrated locality working resulting in a more efficient and coordinated service for the people of Leicester, Leicestershire and Rutland. Social care has a key role in managing pressures in acute care and failure to manage the demand and budget pressures on councils will have a significant impact of hospital discharges and DTOC.

The Care Act 2014 consolidates over sixty years of social care legislation and reforms the way care is funded. The Act brings many challenges and opportunities, although work to determine the costs of implementing new/ revised duties so far indicate a significant shortfall in funding compared to cost.

Funding concerns can be summarised as follows:

- Increased demand for information and advice, assessments and carers' support services will have a significant financial impact, particularly in light of reductions in councils' overall baseline spending power;

- Understanding the volume and behaviour of carers and self-funders locally needs to underpin local planning and preparation;
- Financial assessments;
- Capping costs;
- Deferred payment agreements.

Significant change is required to meet these challenges and needs to be delivered with customers at the heart of service redesign.

Market issues

Although traditional service models are still in the majority, the social care market place is changing. Providers will need to be less reliant on block contracting arrangements as these opportunities will reduce; replaced with direct arrangements between providers and people using services. Within these conditions there remains a commitment to ensure the independent sector provides high quality services, which is reinforced through clear contractual agreements and monitoring requirements. For home care service provision has been mapped and commissioning aims to meet appropriate quality and ethical standards.

Changing demand and commissioning arrangements will see a shift towards a more diverse market place with opportunities for providers to offer more creative, non traditional service models. Business models will need to reflect the move away from block contracting; marketing services directly to those that will be using them, including those that fund their own care and support.

The integration agenda will challenge providers to look at ways in which they can meet both health and social care needs. Newly commissioned services will be outcome focused, supporting individuals to maximise their independence and minimise reliance on statutory services.

The Care Act formalises Local Authority responsibilities to work with the market to support and shape its development to meet the needs and choices of local people.

Contribution to the Better Care Together Programme

Adult social care has a critical role to play in delivering an enhanced community offer that will lead to a reduction in demand for higher cost and more acute services. The left shift needed within the health and care economy will only work if social care plays its full part. The significant financial challenges and increased levels of demand faced by social care are significantly compromising the community offer, even though there is a necessity to increase resources to successfully support independent living. The opportunities to secure investment through the Better Care Together programme must be maximised to ensure a robust and high-impact community offer which effectively and measurably reduces and delays the need for health and social care support. This will be particularly key as activity shifting towards the community and requiring increased social care provision will not be met by BCF (in itself not guaranteed beyond 2016/17). Social care will continue to compete for funding within Local Authorities which are facing multiple budget pressures.

Key priorities for delivery through BCF are the integration of unscheduled and planned care across social care and community health services. This includes the creation of coterminous locality teams and crisis and out of hour's responses. Significant activity is already underway

to develop more integrated customer/ patient pathways across many areas, including frail older people, long term conditions, learning disabilities and mental health, where the role of adult social care is critical if positive outcomes are to be achieved. An example of successful integration in the city is the Integrated Crisis Response Service, delivering a rapid, joined up project to avoid hospital admissions. In the county, an overnight nursing assessment service has been launched to complement the local social care crisis response service, aiming to further reduce hospital admissions.

Adult social care is contributing to the reduction in need for care through clear integration agendas. Better Care Fund services supporting this work are varied across the authorities and include:

- Enhanced crisis services to avoid hospital admissions;
- Support for assistive technology and equipment to reduce and delay need;
- Proactive care management in aligned planned care teams;
- Carer support;
- Care navigators to focus on over 75s;
- Early support for those diagnosed with dementia.

The overall aim of Better Care Together is to ensure organisations work together to provide more support at home, reducing the risk of serious illness requiring admission to hospital, but this needs investment. Enhancing the social care offer will not only keep people well, but also improve their quality of life. Social care must have a central role in the Better Care Together approach if a truly customer centred approach is to be achieved.

What does Adult Social Care need from the NHS?

The scale of funding reductions in Government funding facing local authorities is unprecedented. The 3 LLR councils have all prioritised services for vulnerable people and afforded Adult Social Care with a significant level of protection from budget reductions. It will not however, be possible for Councils to maintain service levels or to meet increasing levels of demographic need without financial support from the NHS. The BCF plans already contain a significant element of protection of services, but more will be required if there is to be an effective Adult Social Care offer in the left shift to community and preventative services.

Adult Social Care cannot deliver effective outcomes for service users/patients without appropriate therapeutic and clinical input from health services. For example there is an emerging evidence base that outcomes and long term care costs can be significantly improved by targeted and timely physiotherapy input as part of social care reablement. This will require increased access to these therapeutic service and appropriate levels of investment in staffing and joint training and development.

Effective two way sharing of information and intelligence held by the NHS and councils will be required so that ASC and NHS can provide the right care to the right people, and also gain a better understanding of end to end care costs. There needs to be a much more structured programme for the management of data and business intelligence across integrated health and care interventions which supports impact assessment/ROI/evaluation, costing integrated pathways, risk stratification, case management/care planning. Information

sharing agreements in LLR are outdated and inhibiting progress and need to be replaced by a new integrated approach that includes the adoption of NHS number as a key enabler.

Workforce

Through greater integration and the left shift towards prevention a different skill set will be required from staff, and there will be key challenges relating to merging of health and social care cultures; ensuring clear communication, ensuring a clear customer focus and employing the key principles of promoting wellbeing/ reducing need will help to ensure success.

Most staff in adult social care in LLR work in the independent sector. As demand for social care has increased this workforce has expanded proportionately. The status of direct care staff is however not sufficiently high, and this is reflected in relatively poor pay and conditions. Many care staff are paid close to the minimum wage and zero hours contracts are often the norm. Increasingly some sectors face real challenges in recruiting and retaining staff with the required competencies. The availability of staff will be a key constraint on the capacity of the market to deliver the service volumes and quality standards required to provide the required level of effective community services.

Actions to address these issues are outlined in the workforce enabler of the BCT programme.

Implementation of the Care Act 2014 will have significant implications for the adult social care workforce including:

- An increased demand for carers assessments and services
- Increasing challenges relating to retention of staff
- Staff will need to be multi-skilled in order to support greater levels of integration

Measuring success

By 2019 we will have fully co-ordinated and effective services, a skilled workforce, seamless provision from a customer perspective; we will be effectively delaying/ reducing the need for formal health and social care projects. We will be able to demonstrate efficient delivery of services – ensuring that investment across health and social care is successfully reducing need and managing demand. There will be a demonstrable change in our spending patterns with a shift from areas we traditionally fund into preventative services that keep people well and living in their local communities.

2.8.6 Better Care Fund

LLR CCGs and local authorities have made a five rather than two year commitment to using BCF to drive change. The size of BCF funds for the next two years is summarised below:

Figure 57: BCF components

	Fund (£m)	
Local authority	2014/15	2015/16
Leicester City	14.8	23.2
Leicestershire	18.2	38.4
Rutland	0.8	2.2
Total	33.8	63.8

Source: Planning information provided by LLR CCGs

The three BCF plans reflect broadly similar ambitions, mirroring those of the five year strategy, but allowing for flexibility of local implementation. The plans outline how opportunities presented by the fund will be maximised to lever real transformational change, thereby delivering the five year vision.

The aim of the BCF is to enable people to access a range of support early enough, including through social and community networks, thereby empowering them to take control of their health and wellbeing, live healthier lives and maintain their independence for longer.

By investing in prevention a reduction in the number of people accessing services in a crisis or inappropriately is expected alongside an increase in the provision of care interventions that offer optimum independence within a supportive community.

Priorities and activities covered by the BCF have been grouped into themes, under which sit a range of projects that will support implementation, including: single point of access, 24/7 services integrated across health and social care, urgent community response services within two hours, and case management for over 75s. The themes generally across the three BCFs are:

- Citizen participation and empowerment;
- Prevention and early intervention/detection;
- Integrated crisis response;
- Improving hospital discharge and reablement;
- Integrated, proactive care for people with long term conditions.

These themes will directly contribute to both a high quality sustainable model of care. The performance and effectiveness of the changes will be measured through:

- Reduction in avoidable emergency admissions;
- Reduction in delayed transfers of care;
- Reduction in residential admissions;
- Improved effectiveness of rehabilitation after discharge from hospital;
- Improved patient/service user experience.

Whilst each of the three Health and Wellbeing Boards has set area-specific targets for each measure, a total cumulative impact across LLR is also being measured. These performance measures will also contribute to the delivery of specific outcomes from the NHS, Adult Social Care and Public Health Outcomes Frameworks.

In Leicester the Better Care Fund is a key strategic driver to the delivery of the Better Care Together Strategy particularly in the frail older people, long term conditions and urgent care workstreams. The following outcomes will be achieved from the Better Care Fund projects:

- Prevention, early detection and improvement of health-related quality of life;
- Reducing the time spent in hospital avoidably;
- Enabling independence following hospital care.

The Leicestershire Better Care Fund plan is a countywide plan. The aim of which is to deliver support to the citizens of Leicestershire in a co-ordinated way when they find themselves in need of services. The plan recognises that people rarely need support from a single service as they age or if they are vulnerable through mental ill health or disability. In the past our populations have told us that they find it difficult to navigate between services and feel that there are barriers in the way as they move between health, social care and other statutory services. The barriers that citizens find as they try to access different statutory services are not understandable or acceptable to the population we serve. As a result, this plan aims to reduce and eventually remove those barriers by working towards a fully integrated service provision with people at the centre of the services that we deliver.

The following section describes the plans that have been developed by the BCT programme's four enabling workstreams; estates, workforce, IM&T and contracting. This section has described the changes that will take place in the settings of care over the next five years. These changes, and the proposed changes to the service pathways, are dependent on changes that will be delivered by these enabling workstreams. Without these system wide enabling developments it will not be possible to change the way health and social care is delivered in LLR.

2.9 Estates Strategy

Estates – case for change

The health care estate case for change has two key drivers; the first is to enable the estate to respond to the service pathways being developed as part of the Better Care Together programme. The second is related to the estate itself.

Responding to the service pathways

The BCT service pathways set out how the system will change over the next five years. A key enabler to that change is ensuring the estate is fit for purpose, located in the right place for the patient, whilst maximising efficiencies. The table below describes the key impacts the service pathway changes will have on the estate:

Figure 58: Estates impact summary

Service Pathways	Impact on estates
Urgent care	To deliver improved efficiencies and patient flow, and address capacity issues and clinical adjacencies, a redevelopment of the emergency floor is required. In sizing this development the impact of the changing service models needs to be considered, in particular for frail older people and LTCs. A consistent approach to urgent care and minor injuries may impact on the accommodation requirements. In addition, improving the urgent care pathway will result in the need for fewer non-elective beds. There will be a need to provide more services outside of hospital which will impact on the estate requirement in the community.
Planned care	The shift of outpatient and day case activity into the most appropriate setting is likely to lead to a reduction of activity in the acute hospital setting but will require more to be done in community settings. In addition, increased occupancy and utilisation rates will impact on the estate requirement. The solutions for the city and the counties will be different.
Frail older people and long term conditions	More people being cared for in the community and in their own homes will lead to changes in the numbers and types of beds required; reduce readmissions and reduce length of stays. This is likely to impact on both hospital and community beds. This is supported by recent bed utilisation reviews which have shown that many patients in acute hospital beds could be cared for in alternative settings. Co-location of teams across health and social care will support the delivery of improved pathways for frail older people; this will require an estate solution to support integrated working such as community hubs.
Children's services	Better integration and a community based focus on outpatients is likely to reduce acute hospital based planned care and may require additional accommodation in the community. Teams may be co-located in community settings to encourage integrated working.
Maternity and neonates	Currently there are two obstetric-led units supported by different clinical services delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team was suggested that this was only clinical sustainability on a temporary basis. The system needs to review what a sustainable service looks like and how many sites it should be delivered from.
Mental health	The focus on anticipatory care models and improved crisis support is likely to lead to less reliance on bed-based treatments and greater resilience within the LLR population, leading to a smaller secondary care estate and community sites. Community based staff will increasingly be located within integrated teams.
Learning disabilities	Improving joined up services across health and social care will mean more staff are co-located.

Overall, the service pathway changes require more work to be done in the community and less in acute hospital settings. The Strategic Direction of University Hospitals Leicester NHS

Trust (UHL) supports this: “overall Leicester’s hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community”. Leicestershire Partnership Trust, the providers of community services, are developing an estate strategy to respond to more services being delivered in the community through the hub and spoke model and better utilisation of assets.

The case for change describes how a very large number of properties are being used to deliver care across LLR; in total 148 estates, with a variety of tenure, totalling 283,000 square metres. Many of these properties are under-utilised and in some cases as much as 50% of the space is not being used efficiently. Over the last few years investment in the estate has been variable and most of the estate is in a poor condition. The current total backlog maintenance is £128m across the health sector. The health estate costs circa £82.2m per annum and the two biggest costs are facilities management and rental charges.

Given the estate implications of both the service pathway changes, and the fact that the current estate remaining as-is is not a feasible option, the estate has to change.

The future estate

In response to the service pathway changes and the estate challenges outlined in the previous section, the estate needs to change over the next five years. The key features will be:

- **A smaller but more specialised acute estate**, with consolidation of services onto two sites, enabling clinicians and patients to benefit from co-located services and eliminate the inefficiencies of running multiple sites. This will result in fewer beds in acute hospitals. Internal UHL efficiencies will reduce the bed base from 1,773 beds to 1,346 beds.
- **An adapted community bed base that will** transfer 250 beds worth of activity from UHL to LPT. Services will be expanded to enable patients to be cared for in their own homes (equivalent to 250 beds worth of current activity, 170 direct from the current UHL activity and 80 from the existing community hospital activity). Figure 46 summaries the changes in bed numbers.
- **Hub and spoke model for the community** based on three levels of estate. The county wide hub will be for a population of one million plus, these will house highly specialised services and will have offices and clinic space. Community Hubs will serve an average population of 115,000 in the counties and 70,000 in the city. They will provide specialised services with clinics, diagnostics, and in some cases inpatient wards. Team bases will cover a population of 35,000 and be a base for more generic community services with clinic rooms and offices (in the city these may be provided alongside the community hubs).
- **Adapting the primary care estate** to support the service pathways will be required to support the left shift of services, this may include the development of hubs, refurbishments, premises improvement grants and in some areas new builds.
- **A more efficient estate** by 2018/19 with improved efficiency and utilisation rates. To support this LLR will develop an estate base and process for booking of shared clinical space.

- **A smaller health care estate footprint** will result from all the impacts described above. There is also likely to be a reduction in the square metre and number of properties across the health sector.

Phasing

The acute sector changes will be managed in two phases. In the first phase, lasting two years, UHL will focus on in-hospital efficiency and productivity with the aim of repositioning key clinical services from outliers in terms of benchmarked data to top quartile. Phase one will include two urgent estate-based developments – the emergency floor at the Royal Infirmary and the transfer of vascular services from the Royal with the potential for the inclusion of renal services at a later date.

Phase two, which will be delivered from 2016 onwards, will enact a major reconfiguration of the hospital estate. This will coincide with other services coming on line in the community and allow the trust to safely rebalance bed numbers (i.e. reducing acute bed numbers and making better use of community capacity). They will repurpose or move out of buildings which are no longer required and this will reduce double and triple running costs. The options to consolidate main services onto two sites will be worked through with partners and the wider community in 2015. Although the trust will appraise all options, the direction of travel to date indicates that it is likely that the Royal Infirmary and the Glenfield will emerge as the two main acute sites. If this is the case, it would enable the Leicester General Hospital site to be developed to further support integrated community services and the Diabetes Centre of Excellence. The General would also continue to provide a home for East Midlands Ambulance Service, the UHL Young Disabled Unit and Leicester Partnership Trust services.

As a consequence of the shift to community settings with fewer patients, UHL intends to consolidate acute services onto a smaller footprint and grow its specialised, teaching and research portfolio, only providing acute care in hospital when it cannot be provided in the community. In doing this the trust expect to significantly increase the efficiency, quality and ultimately the financial sustainability of key services, shrink the size of the required estate and significantly rebalance bed capacity between acute and community settings, reducing total costs.

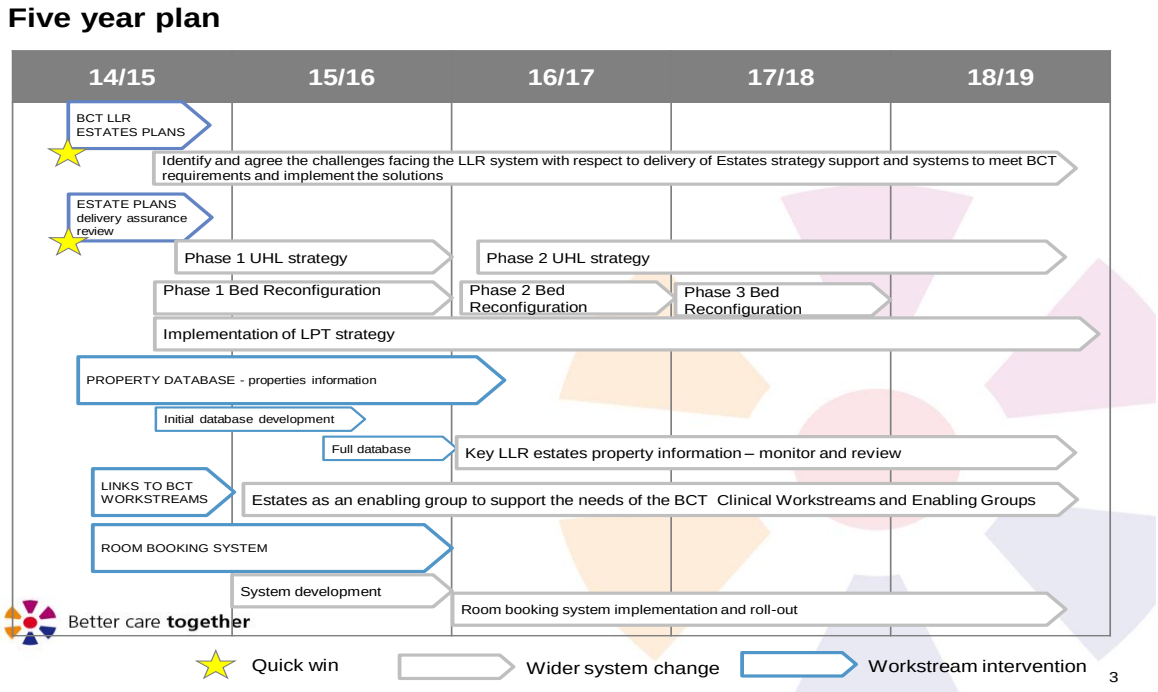
Leicestershire Partnership Trust is currently undertaking a clinically driven review of their estate. This will take forward the development of the hub and spoke model described above and ensure efficient and effective use of the estate. The first draft of this is due at the end of November 2014 and will be used to phase the estate impacts into the Better Care Together Programme. Indicative capital costs have however been included in the Strategic Outline Case.

An integral part of the Strategic Outline Case is the delivery of the bed reconfiguration between UHL and LPT, as shown in figure 46. This shift will be achieved by providing more services into patients' homes and the provision of sub-acute beds in the community; this will not increase the overall community bed base but use it in a different way. The change will be phased over three years, with the first 60 beds being released from UHL by 31 March 2016; the second 60 beds by 31 March 2017; and the final 130 beds by 31 March 2018. During these phases the appropriate level of community based support and sub-acute provision will be made available prior to releasing the beds.

To support the efficient use of space a data base of information will be compiled and maintained; this work will be commenced in 2014/15 and be fully implemented by April 2016. This will include a system for booking of clinical space.

The following diagram demonstrates the high level phasing for the estate enabling work:

Figure 59: Estates – timeline



2.10 Workforce strategy

The Better Care Together programme has identified workforce as a key enabler in delivering the size and scale of change required across LLR to ensure our workforce meets the health and social care needs of our population. To deliver a workforce in LLR that supports care delivered out of hospital, a greater focus on prevention and supporting healthier communities the programme has recognised the significant challenge in supporting the capacity and capability to support the development of new pathways across secondary and primary care.

By delivering the BCT programme it is acknowledged that, as a health care community, we will also need to inspire a new generation within our workforce to work across organisational boundaries and with a greater focus on community provision and working with the 3rd sector to support a patient profile that has increasing co-morbidities.

To articulate the future state a range of work is already underway and is detailed in the workbook focussed around new role development and a series of initiatives already supported by Health Education East Midlands. These include

- Support to double the number of apprenticeships in LLR by April 2016 (236);
- Support to deliver 200 Assistant Practitioners in LLR by April 2016 in UHL & LPT;

- New Role Development – up to 50 Physician Associates (with the majority in Leicester), 24 Urgent Primary Care Practitioners (12 in Leicester), GP Nursing programme run at DMU, plus ring fenced monies for Advanced Practice and a supporting Clinical Framework;
- Primary Care Taskforce to support practice learning opportunities in General Practice and in Nursing and Residential Homes and the development of Community Provider Education Network (working collaboratively with HEIs, CCGs and the LETC);
- Innovative solutions to Medical Workforce Challenges – making LLR a more attractive place to work, learn and train, developing fellowships and other appropriate out of training experiences for medical trainees and developing multi professional solutions in conjunction with the University of Leicester and De Montfort University;
- Development of a Strategic Training, Education And Learning Transformation Hub (STEALTH) project in conjunction with our local HEIs to analyse, model and develop appropriate educational experiences to support the “left shift”, sub-acute clinical pathways and more integration with social, primary and the third sector.

The health care workforce case for change has two key drivers; the first relates to underlying workforce challenges across LLR. The second is to enable the workforce enabling group to respond to the service pathways being developed as part of the Better Care Together programme:

- The health care workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. However, those placing the greatest demand on services are older people with multiple conditions who require support from a range of services;
- An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad;
- By 2021 there will be a national shortfall of between 40,000 and 100,000 nurses and there could be 16,000 fewer GPs than are needed (nationally produced figures, local impact on staff groups continues to be assessed);
- The ageing population means that by 2025 the national social care workforce will need to increase from 1.6 million to 2.6 million;
- The nature of work undertaken by staff is changing. As the population ages, our staff will need to care for more people with complex needs and multiple co-morbidities;
- We recognise that in future we could face shortages of staff in some key disciplines and that those staff we do employ will need to work differently. They will need to work much more in multi-disciplinary teams that treat the “whole person” and not just the presenting condition; they will need to have more generic skills; and they will need to be more productive, partly through use of new technologies;
- BCT recognises the importance of clinical, non-clinical and managerial leadership development across LLR, continuing to support local leadership initiatives and the support to the East Midlands leadership academy.

Responding to the BCT service pathway requirements:

Figure 60: Workforce impact summary

Service Pathways	Impact of workforce
Urgent care	With the planned redesign of the emergency floor the resulting service models and workforce requirements need to be considered. There will be a need to provide more services outside of hospital which will impact on the workforce requirement in primary, community and social care.
Planned care	The shift of outpatient and day case activity into the most appropriate setting is likely to lead to a reduction of activity in the acute hospital setting but will require more to be done in community settings and will impact on workforce requirements.
Frail older people and long term conditions	More people being cared for in the community and in their own homes will lead to changes in the numbers and types of beds required; reduce readmissions and reduce length of stays. This is likely to impact on both hospital and community beds. This is supported by recent bed utilisation reviews which have shown that many patients in acute hospital beds could be cared for in alternative settings. Co-location of teams across health and social care will support the delivery of improved pathways for frail older people; this will require a workforce solution to support integrated working such as community hubs.
Children's services	Better integration and a community based focus on outpatients are likely to reduce acute hospital based planned care and development of new pathways will lead to workforce requirements for recruitment, development and training.
Maternity and neonates	Currently there are two obstetric-led units supported by different clinical services delivering over 10,500 births a year. When reviewed in 2010 by the National Clinical Advisory Team was suggested that this was only clinical sustainability on a temporary basis – we need to review what a sustainable service will be and what the resultant workforce requirements will be taking into consideration the planned increase in home births.
Mental health	The focus on anticipatory care models and improved crisis support is likely to lead to less reliance on bed-based treatments and greater resilience within the LLR population. Community based staff will increasingly be located within integrated teams with an associated impact on workforce development requirements.
Learning disabilities	Improving joined up services across health and social care will result in impacts on the workforce requirements for recruitment, development and training.

In addition the BCT workforce group aims are to ensure that the LLR health and social care community:

- Employs the right workforce with the right skills, in the right place, at the right time and with the right numbers;
- A workforce with the appropriate values and behaviours;
- Collaborates to reduce vacancies and agency usage to deliver high quality, safe and patient focussed outcomes with appropriately skilled workforce;
- Develops an appropriate primary and community workforce to support the "left shift";

- Maintains and develops the acute and sub-acute workforce;
- Supports and develops appropriate education, training and workforce development to support social care (e.g. support local authority policies around carers, offering appropriate support, development and valuing the contribution).
- Is supported around improving Organisational Development – an additional £200k has been set aside in the funding requirements for the LHSCE.

The emerging models of care discussed above bring a number of workforce considerations. For example, shifting care from secondary to community settings will require a review of both generalist and specialist skill balance; the need to ensure a supply of nurses becoming community focused over time; and the need to ensure more social care staff are available to support people at home. It is therefore essential that there is a clear understanding of the impact on workforce of changes across the LLR health and social care system.

The Better Care Together Workforce Enabling Group will provide this understanding by providing leadership and delivery of a workforce planning and education commissioning strategy. Its core membership is based on the Leicester, Leicestershire and Rutland Local Education Training Committee (LETC), supported by Health Education East Midlands (HEEM), with support from health provider organisation directors of human resources, social care (local authorities and Skills for Care), CCGs and local universities. The group has undertaken the following key pieces of work:

- Development of a LLR workforce capacity plan, highlighting and prioritising the immediate workforce issues in LLR;
- A workforce plan/framework across years 1 and 2 that identifies the immediate workforce requirements and gaps across the LLR health and social care system;
- A longer term piece of work to identify the strategic workforce development initiatives arising from the emerging service models.

Immediate priority areas for workforce development are:

- Innovation and development within the primary care workforce (e.g. GP and practice nurses) – the local GP fill rate is 66% and the LLR practice nurse to 1,000 population ratio is lower than neighbouring areas and England as a whole;
    - Refocused use of primary care workforce through up-skilling and releasing GPs to focus on the more complex cases;
    - Development of primary care federations and hubs, allowing an increased level of services within primary care;
- Wider workforce development e.g. the Cavendish Carer Certificate (Bands 1 to 4 and equivalent). This will help address the problem associated with the recruitment of the harder to source higher band level resource;
- New role development for a generic post (band 3-4) across health and social care, providing apprenticeships, career pathway development and looking to improve staff retention;
- Development of multi- specialist skills e.g. nurse to enable a broad range of conditions to be managed by a single community based healthcare professional ideally in one appointment;
- Integration (secondary, tertiary, primary and social care, medical and non-medical);

- Reduction of costs associated to agency and other elements of the non-substantive workforce (current agency spend is c. 8% of turnover);

Key workforce initiatives being developed to respond to the transition of our workforce include:

- Different staffing and organisational models to support service change:
  - Translating and articulating the future workforce in the right numbers, in the right place and with the right behaviours to best support patient care;
  - Review of both the specialist and generalist skill balance;
  - Ensuring that the supply of nurses and other health care professionals are more community focussed over time;
  - Changing professional skills in primary care settings;
  - Developing skills and competencies that support more integrated working;
  - High acuity, specialist led services in an acute setting;
  - Supporting the workforce to deliver technology enabled solutions and, where appropriate, to support more patient led self-care.
- Utilising educational and training opportunities to support emerging workforce development:
  - Ensure investment in areas like Learning Beyond Registration, Wider Workforce Funds, Education Commissioning and other funding streams are aligned to the transformation agenda;
  - Ensure practice placements and support for mentors, supervisors and educators support multi professional and multi-agency solutions.

Ensuring the LLR workforce meets the health and social care needs of our population as set out in the BCT programme.

2.11 IM&T plan

IM&T – case for change

The Information Management and Technology (IM&T) case for change takes into account a number of national priorities that have an effect on the informatics agenda as well as factors influencing strategic thinking at a local and regional level as part of the Better Care Together programme. It forms part of a key enabling vision for the transformation of health and social care services in Leicester, Leicestershire and Rutland by providing professionals with the information they need to enable them to work more productively and share collective information around the needs of the individual.

In the case for change section we described a number of reasons that changes were required in relation to IM&T. These focused on problems caused by information systems that do not “talk to each other”; systems that do not mirror workflows; and a general lack of innovation concerning the use of new and emerging technologies such as smart tech, “big data” and social media.

It is recognised that across the local health and social care economy there will always be different IT systems and processes in place as a result of a complex environment, which

spans multiple organisations and settings. Whilst these may be rationalised over time, with joint working across organisations, the IM&T enabling strategy aims to deliver a set of solutions to join systems and information up, where it makes sense to do so collectively, to deliver high quality care.

We recognise that IM&T is an important enabler to changing models of care, particularly in its ability; to support the provision of safe, integrated care for people with LTCs and for older people (shared records etc); to drive innovation in service delivery (telehealth, telecare, telemedicine, mobile working etc); to enable better use of "big data" in support of risk stratification and other targeted projects. We believe that IM&T can be used to transform virtually every aspect of healthcare delivery: how and where it is delivered, by whom and, when.

- How – IM&T is a powerful tool for automation and standardisation of processes;
- Where – IM&T can be used to reduce reliance on physical healthcare locations and minimise unproductive travel time for patients and practitioners;
- Who – IM&T allows specialists to be present in multiple locations either directly through remote consultation facilities, or indirectly through protocol driven logic designed by experts or analytics-driven clinical decision support systems using the latest best practice guidance and research to give real-time advice;
- When – e-mail and social network-type sites (e.g. MyHealthSpace) allow asynchronous communication removing the need for both parties to be available at the same time.

Responding to the BCT service pathway requirements:

Figure 61: IM&T impact summary

Service Pathways	Impact of IM&T
Urgent care	• Mobile working programme for LPT – increasing the access to mobile systems by clinical community staff to provide maximum efficiency; • Scheduling/handling system - increased utilisation of the SPA – winter plan funded and started the process to fund people resources. The new service will require an IT system to help manage capacity and demand. The system should be able to do real-time scheduling.
Planned care	• Referral Hub – Enable sharing of data from the GP to the referral hub, set up IT infrastructure for referral hub; • Pathways - Computer upgrade across hospitals to support new pathways, implantation of PRISM.
Frail older people	• Upgrades to RIO within LPT, ensuring spine compliance and utilisation of Choose and Book; • Health and social care systems sharing information about the person; • Improved data capture; • Improved data reporting and greater use of risk stratification.
Long term conditions	• Health improvement – Easy access to data, links with public health, University of Leicester APPs to check treatment, write down questions, shared with consultants prior to meeting, shows pathway; • Self care – telecare / telehealth – COPD pilot in the City, Digital First, Virtual health coaching; • Patient at high risk – sharing of the care plans and sharing of MDT meetings; • Acute Care – virtual ward approach, seeing the community and discharge information.
Children's services	• Virtual clinics; • Teleconsultation; • CQUINS; • APPs to support school nurses.
Maternity and neonates	• Mobile Working – improvements in infrasture to support this; • Data sharing - access to data across clinical systems; • Performance Management – systems and tools to support this.
Mental health	• Mobile Working - Developed universal connectivity to support remote working; • Data sharing - access to data across clinical systems.
Learning disabilities	• Improvement in referals - developing information systems for ensuring LD status are included in referrals to secondary care.

The LLR IM&T enabling group will ensure that the full benefits of IM&T are realised by:

- Producing plans for a "quick win" around implementing a patient clinical records sharing service for primary and secondary care across LLR. The service will allow clinicians from different providers to view each other's clinical records;
- Producing reports and plans which:
    - Identify major gaps in current services or plans;

- Set out best practice from elsewhere that could be bought in or replicated;
- Outline short-term and longer-term options for closing identified gaps.

The groups' short-term work plan (to be delivered within six months) is to focus on primary care records sharing implementation using the medical interoperability gateway (MIG), including work with MIG to expand the solution, for example to include social care. The group will also focus on PRISM; ensuring full use of NHS number in EMAS and social care; providing a secure e-mail account for Leicestershire police; care planning standards and templates; agreeing a LLR-wide information sharing specification; "Digital First" phase one; real-time data interchange initiative for primary care data; and e-conferencing.

In the medium term the group will:

- Review and analyse needs of the BCT Clinical Workstream and prioritise initiatives;
- Issue a care planning specification and amend associated templates;
- Continue to progress initiatives to pilot and widen patient access to general practice systems;
- Focus on improving clinical analytics;
- Develop system integration of primary care out of hours' services;
- Develop a strategic plan for patient access and involvement;
- Introduce analytical tools;
- Further develop the "Digital First" initiative.

In the longer term the group will:

- Develop an LLR-wide patient-centred (not organisation-based) integrated digital care record with shared and inter-operating systems as appropriate;
- Consider further development of clinical portal functionality for the sharing of UHL, LPT, social care, ambulance service, and primary care out-of-hours data;
- Review clinical codes used within NHS provider organisations;
- Introduce a "clinical contact service centre";
- Develop "clinical analytics" to allow, patients, the public, commissioners and care providers, access to comparative performance information spanning all health and social care activity.

As well as looking for new solutions and systems we will also look to explore and encourage best use of existing systems. Improving their utilisation and effectiveness will ensure best value is delivered from existing resources which may also support the drive for quick wins in the first two years of the programme.

2.12 Summary of financial benefits which will be delivered by this programme

Our new models of care will deliver significant benefits to local people and to health and social care commissioners and providers. As explained further in the economic and financial cases the health economy needs to close a projected financial gap of £398m across the five years of the plan. The way in which this will be achieved is broken down below. The table shows that if all of the elements of the strategy are delivered the health economy will achieve a surplus of £1.88m by 2018/19. Further efficiencies delivered by the UHL estates programme will bring a further £30.7m of recurrent savings for the trust which will be realised in 2019/20.

Figure 62: Benefits summary by source

Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	19/20 (£'000)	20/21 (£'000)
Expected funding gap (without interventions)	(113,246)	(187,345)	(260,572)	(327,486)	(398,114)	(475,308)	(559,759)
Adjustment to investment plan	10,118	11,826	12,457	12,865	13,637	13,637	13,637
Net Funding Gap (without Interventions)	(103,128)	(175,518)	(248,115)	(314,621)	(384,477)	(461,670)	(546,121)
LTC Workstream	0	255	1,102	1,694	1,684	1,684	1,684
FOP Workstream	0	0	0	0	0	0	0
Children's Workstream	0	55	300	300	300	300	300
LD Workstream	0	932	1,273	1,657	1,857	1,857	1,857
Maternity & Neonatal Workstream	0	0	378	378	378	378	378
MH Workstream	680	3,615	4,910	5,299	5,688	5,688	5,688
Planned Care Workstream	0	957	2,585	4,614	5,495	5,495	5,495
Urgent Care Workstream	0	(295)	352	1,000	1,000	1,000	1,000
CIPs	58,068	105,106	149,943	193,516	238,372	263,951	326,162
QIPP	28,323	44,475	61,244	80,633	96,687	115,957	138,622
Bed reconfiguration	1,102	4,249	7,503	9,450	11,020	11,020	11,020
UHL site running costs reduction	0	0	0	0	0	30,700	30,700
Additional Efficiencies	(246)	5,642	4,078	984	23,874	23,874	23,874
Revised position	**(15,202)**	**(10,526)**	**(14,448)**	**(15,097)**	**1,878**	**235**	**658**

2.13 Risks, constraints and dependencies

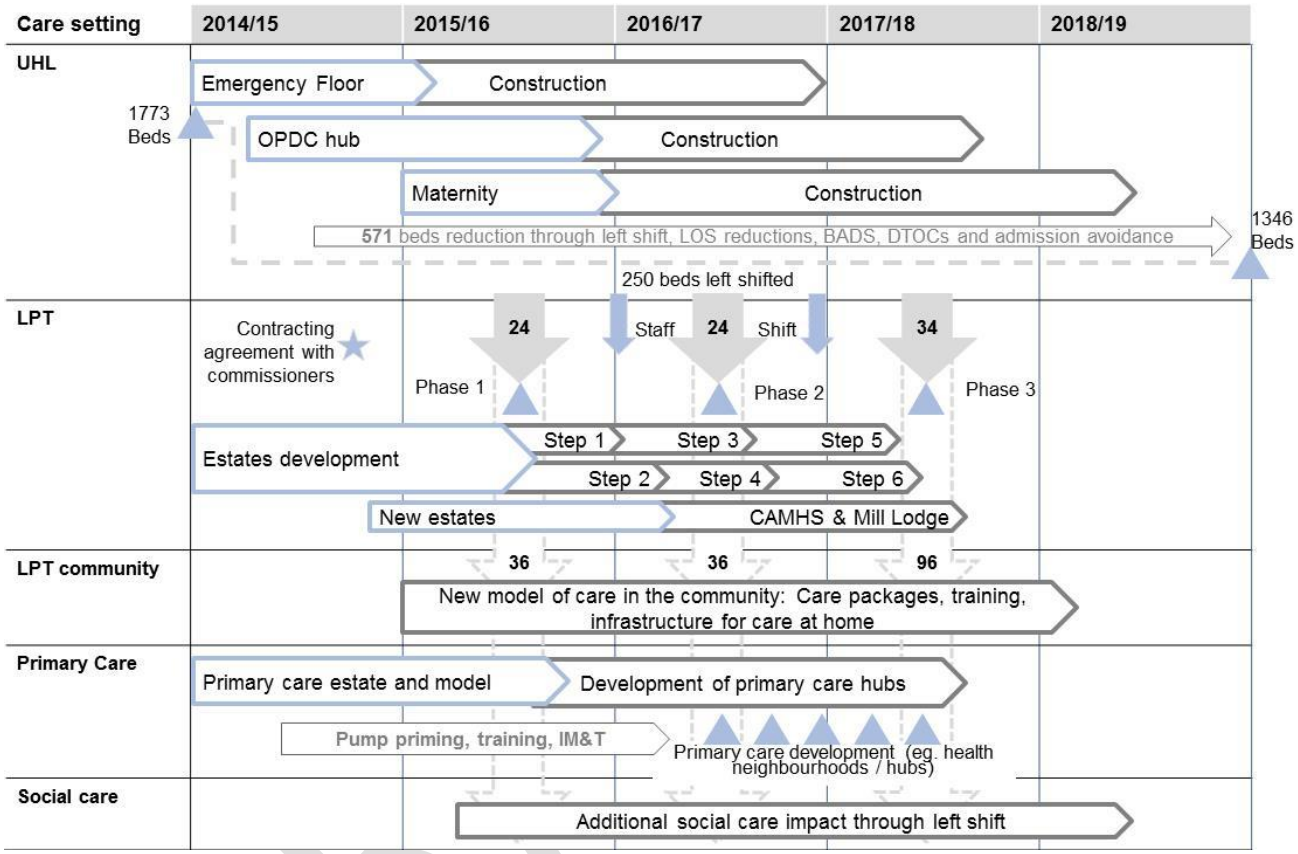
In order to deliver benefits to close the £398m gap across LLR it is imperative that all of the different organisations work together to deliver the projects set out in the strategy. Many of the changes will be enabled through the beds reconfiguration programme, which looks to ensure that patients who do not need to be in an acute setting can be discharged safely and treated in either community beds or by community nursing teams.

The significant change to the model of care which is proposed will enable delivery of the savings programmes required by LPT and UHL. The key to this programme is ensuring that care is developed and improved in a way which enables efficiencies to be delivered within providers. The transition support required by the programme is predominantly aimed at helping to ensure that organisations remain viable during the period of change and double running, and to deliver the services and initiatives required in the community which will help to transform the model of care without impacting on the sustainability of individual organisations.

Figure 63 shows the critical path for the programme which needs to be achieved in order for the health economy to reach financial surplus by 2018/19. Estates changes at UHL are

predicated on more care (and healthcare providers) being in the community, and by improving services such as the new emergency floor and obstetric unit UHL will be in a position to provide the highest quality complex care in a sustainable way which will be able to meet future healthcare demands.

Figure 63: BCT critical path



3 Economic Case

3.1 Introduction

The purpose of the Economic Case at SOC stage is to set out why the BCT programme should progress to the next stage of planning, assessing its ability to deliver value for money (VFM). Going forward this will mean the progression of individual Outline Business Cases (OBCs) and Full Business Cases (FBCs) which support the delivery of the chosen model of care. The shortlisted options will be assessed at this stage to determine the best value for money (the balance of cost, benefit and risk) and affordability (revenue and capital). This section describes:

- CSF used alongside Investment Objectives (IOs) to assess the long list of options;
- The rationale behind moving from a long list of options to the short listed options;
- Economic Appraisal of short listed options (including detailed assumptions);
- Sensitivity analysis for short listed options;
- Qualitative risk assessment for short listed options and comparison to CSF and IOs.

3.2 Critical success factors

In addition to the Investment Objective set out in Section 3.4, the Partnership Board identified a number of factors which, while not direct objectives of the programme, would be critical to its success, and would be relevant in judging the relative desirability of options.

In doing so, the Partnership Board considered the possible CSF suggested in the five-case model best practice guidance and, as recommended in the guidance, selected the CSF that were most applicable and relevant to this particular programme.

The original project CSF contained within the PID have been compared to OGC best practice guidance to demonstrate that all relevant criteria are covered:

Figure 64: Critical success factors

Original PID Criteria	PID Definition
Business Needs	Critical to us realising the new operating model
Strategic Fit	With local and national priorities
Affordability	Deliverable within allocated resources, delivering necessary savings or benefits whilst delivering value for money
Achievability	Achievable within the allocated time, resources and circumstances
Impact on clinical quality	Enables the six dimensions of high quality care
Impact on access	The ease with which the individual uses the health or social care service

3.3 Option appraisal

Three alternatives were initially considered as the method to deliver financial and clinical sustainability for the programme and achieve the CSF outlined above;

- Delivery through the BCT strategy;
- Delivery of financial balance through organisational efficiency alone (do minimum option);
- Ceasing delivery of non-agreed services to regain financial balance.

The following considerations were made in order to arrive at the final shortlisted options

Option 1 – Delivery through the BCT strategy

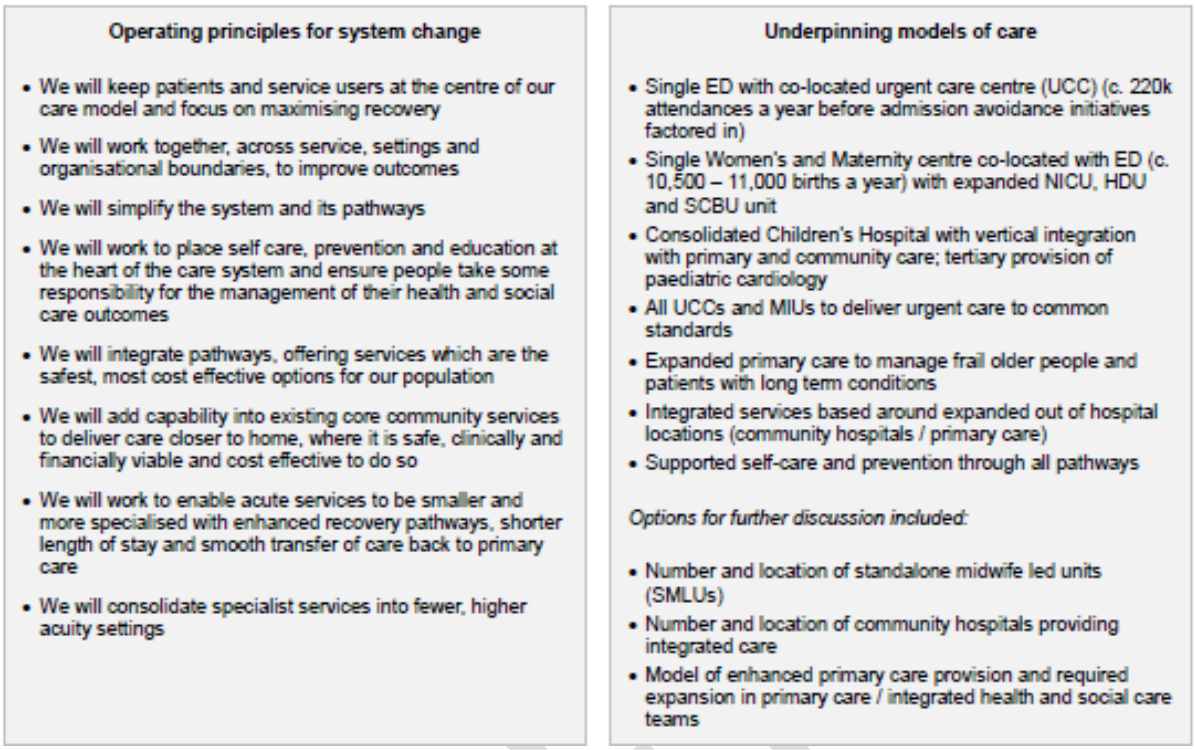
There are a number of clear reasons why the BCT programme agreed on the models of care set out in the five year strategy as the preferred solution.

If change is to be delivered successfully it will require all parts of the health economy to commit to changing the way services are delivered and the location they are delivered from. In order to improve the quality of care in a sustainable way, clinicians have been involved from an early stage to develop the required clinical models that would drive the required change.

The key drivers for change are;

- The NCAT Review of Maternity Services concluded the only long-term sustainable maternity services solution is a single-site, centralised maternity service;
- Centralisation of Maternity and Paediatrics, allowing specialisation and flexibility;
- The requirement to ensure adequate ED capacity supporting the new models of care;
- A “left shift” of patients into more appropriate settings, seeing more flexible care offered closer to home. A review of acuity suggests that the equivalent of 250 beds worth of patients can be moved from University Hospitals Leicester to Leicester Partnership Trust;
- Centralisation of Surgery – greater efficiency will be enabled by separating planned and unplanned surgery, including a dedicated day case facility.

Figure 65: BCT option characteristics



Option 2 – Achieving financial balance solely through organisational efficiency (do minimum option)

The second option considered was whether the constituent organisations could deliver the LHSCE challenge through individual efficiencies without any major changes to how and where services were delivered, and with no significant estates reconfiguration.

The scale of the quality challenge alongside the need to identify efficiencies of £398m within five years is deemed much greater than can be delivered solely by individual organisations alone. This would have equated to an efficiency requirement for both main providers of 7-8% each year. More than 5% savings is not sustainable based on international evidence, and this approach would bring further delivery risks to the health economy and have an adverse impact on patient experience.

Secondly the need to find additional savings would incentivise providers to take a more independent and competitive approach, seeking additional income streams rather than working collaboratively. This would put at risk the drive to change models of care and the ability to deliver the required activity shifts.

Finally this option would not address any of the underlying issues of service quality as outlined in the case for change. There is much that can be done through organisations working together to reduce inappropriate admissions and attendances, however the financial constraints would prevent organisations from having the ability to plan far in advance to tackle these issues and change the model of care.

Option 3 – Ceasing delivery of non-essential services

The third option considered to make the health economy financially sustainable entails undertaking a detailed review for each service across the Health Economy, before making a series of decisions to reduce or remove services considered to be “non-essential”. At the same time a decision to allow non-compliance against performance targets could ease the financial pressure on the system. This option was appraised and discounted for the following reasons;

- There is no agreement on a list of protected services across the Health Economy;
- The inability to ensure continuity of service quality whilst reducing or removing services in a structured and co-ordinated way;
- The non-existence of a single source of information that would enable robust decisions to be made under this option;
- This approach had been attempted to various degrees before and has not delivered the required outcomes;
- Failure to meet performance and access targets would have a significant, adverse impact on the quality of patient care and would be politically unacceptable.

In addition any approach to radically alter the services that are offered would require public consultation which would delay the implementation of the proposed changes, particularly as this option would be opposed. This option will have a substantial negative impact on the general population as access to services will be reduced.

The local decision around any services which would be protected would be open to legal challenge given the lack of precedent around this process in the NHS. Any process which defines “designated services” has only been enacted during a period of special administration, which operates within a different statutory framework. This makes the approach inherently more risky due to the uncertain outcome.

3.4 Meeting the CSF and investment objectives

The table below compares each of the three described options against both the investment (system) objectives and the CSF. The assessment seen below was undertaken by EY in response to the discussion of issues within several CFO forums. It is qualitative in basis and as such offers an opinion of how each option meets IOs and CSFs:

Figure 66: Option comparison

Ref	Criteria	Option 1 – Better Care Together	Option 2: Organisational efficiency alone	Option 3 Ceasing delivery of non-essential services
IO1	Quality of Care out of Acute Hospitals			
IO2	Reduction in Inequalities			
IO3	Improved Patient Experience			
IO4	Efficient delivery of Care			
IO5	Financial Sustainability			
IO6	Developed workforce			
CSF1	Business Needs			
CSF2	Strategic Fit			
CSF3	Affordability			
CSF4	Achievability			
CSF5	Impact on clinical quality			
CSF6	Impact on access			
Assessment				

The analysis above leads to the conclusion that the only viable option for delivering the investment objectives is through the BCT programme.

Implementation options

Having identified the preferred option though a qualitative assessment, consideration was also given to a "counter factual". Given the experience from elsewhere a "do minimum" option, including an attempt to achieve financial balance through other means would place providers in LLR at risk of being placed into special administration. In this instance an

administrator would be appointed for each provider organisation. Therefore two options have been assessed in the economic appraisal:

- the proposed Better Care Together programme; and;
- A "do minimum" option, which is likely to result in a Trust Special Administration (TSA) process being initiated for the two NHS trusts – given the appraisal to date it is considered a TSA would conclude that the BCT programme is the best route to clinical and financial sustainability.

3.5 Transitional costs

Transitional costs for each organisation and work stream have been summarised below in three main categories.

3.5.1 Capital

The external capital requirement for each organisation can be seen in the below table. These are broken down in more detail within appendix 12, the assumptions behind relevant capital programmes can be viewed within Appendix 14 (UHL), Appendix 16 (LPT), Appendix 23 (Primary care) and Appendices 1-13 (for workstreams).

Figure 67: Capital requirement

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Total Requirement	**46,530**	**120,221**	**125,672**	**117,834**	**72,121**	**482,378**
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	**167,707**
	External Capital Requirement (Gross)	**12,023**	**86,921**	**92,372**	**84,534**	**38,821**	**314,671**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
LPT	Total Requirement	**14,636**	**14,652**	**23,000**	**48,944**	**52,332**	**153,564**
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	**58,368**
	External Capital Requirement (Gross)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
	Receipts	-	-	-	-	-	**-**
	External Capital Requirement (Net)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
Primary Care	Total Requirement	**-**	**4,625**	**13,875**	**13,875**	**13,875**	**46,250**
Planned Care	Total Requirement	-	-	250	-	-	**250**
Urgent Care	Total Requirement	**-**	2,070	-	**-**	**-**	**2,070**
Long Term Conditions	Total Requirement	-	200	-	-	-	**200**
	External Capital Requirement (Net)	**-**	**6,895**	**14,125**	**13,875**	**13,875**	**48,770**
OVERALL	Total Requirement	**61,166**	**139,698**	**164,867**	**180,653**	**138,328**	**684,712**
	Use of capital resource limit	49,143	44,208	45,908	43,408	43,408	**226,075**
	External Capital Requirement (Gross)	**12,023**	**95,490**	**118,959**	**137,245**	**94,920**	**458,637**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**95,490**	**118,959**	**137,245**	**66,570**	**430,287**

UHL's anticipated receipt attributable to the disposal of land has been included in18/19 as a capital advance. (The capital receipt value has been based on current estimates to provide a basis for planning. It is anticipated that best value will be sought at time of disposal and, as such, the final value is likely to be subject to variation.)

The investments for each work stream include;

- Planned care: Establishment of a Referral Hub – Alliance will own the asset;
- Urgent care: Mobile working technology and scheduling system – LPT ownership;
- Long term conditions: Tele-health equipment – LPT ownership.

3.5.2 Transitional revenue support

The table below sets out the level of transitional revenue support that will be required to deliver the programme. A breakdown of the assumptions behind the bed reconfiguration plans for both trusts can be seen within Appendices 15 (UHL) and 17 (LPT). A detailed breakdown of work stream funding requirements is within Appendices 1-13.

Figure 68: Revenue requirement

		14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
LPT		131	3,614	4,558	5,218	2,920	**16,441**
UHL		1,200	19,707	21,880	22,836	22,920	**88,543**
Work streams	Planned Care	118	2,276	470	88	0	**2,952**
	Urgent Care						**0**
	Mental Health	94	1,262	713	182	177	**2,428**
	LTC	137	550	550			**1,237**
	FOP						**0**
	Maternity & Neonates						**0**
	Childrens		172	100	50		**322**
	Learning Disabilities	13	731	289	118	95	**1,246**
Central PMO		1,539	997	997	997	997	**5,527**
Primary Care		0	3,000	6,000	3,000	3,000	**15,000**
Consultation Costs		0	200	200	100	100	**600**
Enablers		366	616	446	224	224	**1,292**
TOTAL REVENUE		**3,598**	**33,125**	**36,203**	**32,813**	**30,433**	**135,588**

The current working bed reconfiguration plan assumes 250 beds worth of patients can be cared for outside of an acute setting. The transitional revenue support calculations contained in this document are based on the shift completing by 2018/19. At the time of writing consideration is being given to the feasibility of this shift occurring by 2017/18. This is at a very early stage of discussion and as such it would be inappropriate to account for this in the financial calculations. However if after due consideration an acceleration of the 250 bed shift is considered feasible, it would have an impact on the financial calculations contained in this document. The transitional revenue support calculations would require review and potential revision. The most likely figure(s) to be impacted would be the UHL and LPT revenue requirement calculations.

3.5.3 Cash deficit funding

The table below sets out UHL's current requirement for cash deficit support:

Figure 69: Deficit funding requirement

		14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
Cash	UHL Deficit support	40,700	36,100	34,300	33,300	30,800	**175,200**
	DEFICIT SUPPORT TOTAL	**40,700**	**36,100**	**34,300**	**33,300**	**30,800**	**175,200**

Note: UHL have submitted an application to the Trust Development Authority for 2014/15 deficit support. This application also included capital resource and £5.5m cash to ease liquidity pressure.

3.6 NPC analysis of two potential options

Treasury Green Book guidance requires a baseline option against which VfM can be benchmarked.

A detailed review of the benefits and costs associated with programme delivery has been undertaken. The detailed view of this can be seen within Appendices 19-20. Presented below is the high level comparison of the two main options that formed the short list.

The overall "total" figures demonstrate the Net Present Cost (NPC) of total programme benefits set against the transitional costs required to deliver them. This clearly demonstrates the BCT delivery option has the lowest NPC and therefore represents the best value for money over the appraisal period.

Figure 70: NPC comparison

Costs/(Benefits)	RANK	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total (£m)
BCT Option	1	(31,580)	74,785	93,990	103,778	19,166	(78,422)	(66,711)	115,007
Do Minimum Option	2	(29,878)	84,079	101,808	106,918	16,677	(62,014)	(84,946)	132,644

3.7 Assumptions

Assumption 1 – Inflation

In accordance with best practice for quantitative assessments for the economic case, the forecasts for each option exclude the effects of inflation - all values included in the forecasts are in real terms.

Assumption 2 – Discount rate

The discount rate used in NPC calculations is 3.5% in real terms, in accordance with Treasury Green Book guidance for the purposes of discounting forecast values for quantitative assessments.

Assumption 3 – CIP/QIPP inclusion

For the undertaking of the quantitative analysis it has been assumed that all CIP/QIPP and work stream savings are a direct result of investment in the programme. In reality there are elements of savings contained within the CIP/QIPP classification that would be for each organisation to deliver as part of the general NHS efficiency regime.

Assumption 4 – Timing of savings realisation

For the "do minimum" option the work stream savings have been delayed by 12 months to represent the delay arising from winding down the current BCT programme and the need to re-engage in a different programme.

It has been assumed for the purposes of the NPC calculation that CIP/QIPP savings set out within the original modelling will be delivered.

It has been assumed that the benefits relating to work streams will not continue to increase after achieving their planned year five value.

Assumption 5 – Pay and non-pay

Pay and non-pay costs have been included from each organisation as per the modelling work undertaken at the time of the 5 year strategy. These were based upon organisational LTFMs and were subject to agreed inflationary/efficiency factors where necessary.

For the purposes of extending the modelling work to include year's 2019/20 and 2020/21, the level of inflation/efficiency has been rolled forwards from 2018/19 to future years. The exception to this rule was work stream savings which were deemed to have reached full delivery by 2018/19 (as mentioned in assumption 4).

Assumption 6 – Depreciation

Depreciation is not normally included in the NPC calculation since it is an accounting adjustment rather than a cash flow. A comparison of originally modelled capital plans and those that have been used for the SOC has been undertaken. UHL have stated that any differences are not deemed sufficiently material to alter revenue consequences, whilst LPT have built the increase in revenue costs associated with increased capital investment into their transitional cost submission.

Assumption 7 – PDC dividend

The quantitative assessment excludes material cash flows that are circular in nature, such as PDC dividends. Such cash flows are considered to have a neutral effect and have been excluded from economic forecasts for each of the options from which the NPC has been derived.

Assumption 8 – Redundancy costs

Redundancy costs of £9.27m (UHL) and £7.7m (LPT) have been excluded from the economic forecasts for the purpose of this assessment, in accordance with Treasury guidance provided by the Department of Health.

Assumption 9 – Administration cost

A figure of £6m per annum for administration has been added from years 2 to 4.

Assumption 10 – Capital expenditure

The capital cost estimates have been taken from UHL/LPT submissions. The capital figures used in the economic appraisal of each option exclude VAT, as it is a circular cost and does not include inflation.

Capital works are expected to require immediate funding under the BCT option. It is inevitable that there would be a delay in carrying out any but the most urgent capital investment under the administration option**.** It has therefore been assumed that with the exception of backlog maintenance, all capital expenditure will be incurred 12 months later under the "do minimum" option.

Assumption 11 – Land, residual values and opportunity cost of land

The benefits associated with the disposal of the UHL land are assumed as a Capital receipt of £28.35m. This has been provided through work undertaken by GDA Grimleys, Holbrow Brookes and Mark Ryder Bucknell.

The revenue benefits of this disposal are forecast to deliver cash reductions of site running costs (£8.2m), capital charges & depreciation (£7.5m) and reduction in pay costs (£15m).

As per assumption 6 the benefits of a reduction in capital charges and depreciation has been excluded from both options.

3.8 Sensitivity analysis

It is necessary to understand the risks associated with each of the two options. Seven specific sensitivities were agreed and applied to the Economic case for LLR;

Sensitivity 1: Assuming the "do minimum" option, workstream capital expenditure is delayed by a further 12 months due to increased lead time in authorisation and agreement with general direction of consultation;

	7 years **BCT Option** **NPC** £'000	7 years **Do Minimum Option** **NPC** £'000
Baseline NPC	115,007	132,644.4
Sensitivity 1 Workstream Capex and benefits delayed further 12 months	114,894.7	131,698.7
Sensitivity 1 - Rank	**1**	**2**

Under this option the BCT programme remains the favourable choice.

Sensitivity 2: Assuming the "do minimum" option, cost of workforce increases due to increased staff turnover. Covered by temporary staffing at a premium. The overall staff spend has been split for both UHL and LPT based upon UHL's 2013/14 Annual report;

Nursing Staff = 37%

Medical Staff = 32%

Non-Clinical Staff = 31%

A 4% increase in clinical staff spend has been applied to both organisations as this reflects previous trends witnessed in organisations that have entered administration. The increase has been assumed to exist between 2015/16 and 2017/18 until stability has been regained.

	7 years **BCT Option NPC** £'000	7 years **Do Minimum Option NPC** £'000
Baseline NPC	115,007	132,644.4
Sensitivity 2 Agency Premium cost	114,139.2	190,467.6
Sensitivity 2 - Rank	**1**	**2**

The increased cost equates to around £19m per annum across both Trusts.

Sensitivity 3: Including increased synergies from site rationalisation

This sensitivity asserts that the current benefits for site rationalisation (which are as follows);

- Site running cost reduction (£8.2m per annum);
- Reduction in pay costs (£15m per annum);
- Reduction in depreciation and cost of capital (excluded as non-cash).

The sensitivity explores what would happen under each option if 10% additional benefits were realised:

	7 years **BCT Option NPC** £'000	7 years **Do Minimum Option NPC** £'000
Baseline NPC	115,007	132,644.4
Sensitivity 3 Additional site rationalisation synergy	112,251.8	130,786.6
Sensitivity 3 - Rank	**1**	**2**

Sensitivity 4: Non-achievement of 10 % CIP has been modelled in order to demonstrate level of overall risk;

	7 years **BCT Option NPC** £'000	7 years **Do Minimum Option NPC** £'000
Baseline NPC	115,007	132,644
Sensitivity 4 10% CIP/QIPP shortfall	147,053.2	165,524.2
Sensitivity 4 - Rank	**1**	**2**

The reduction equates to £8m in 14/15, £5.7m 15/16, £5.4m in 17/18 and reduces as the discount factor takes effect.

Under this option the BCT option remains favourable.

This sensitivity analysis clearly shows that BCT remains the preferred option under any sensitivity scenario.

3.9 Qualitative assessment of benefits

We have undertaken a qualitative assessment of benefits and risks associated with each of the two short-listed options. In doing so we have identified the following three critical areas to be evaluated:

- Impact on travel times;
- Impact on health inequalities;
- Impact on health outcomes.

Qualitative assessment of benefits: Better Care Together programme

The option to progress with the Better Care Together programme is expected to offer potential benefits to health outcomes. There will be significant benefits through the development of new services at UHL, particularly through the development of a single larger maternity hub and the new Emergency Floor. Care will be provided in a more appropriate setting for many patients with new services in place to treat people more effectively at home. This will be coupled with a significant improvement in primary care, making more services available more often for those who need them.

In summary, LLR will benefit from a unique opportunity to focus finances, resources, expertise and equipment to better serve patients. It will provide the capacity and impetus to review and improve delivery models. Specific benefits include the following:

- Greater integration through having a joined up programme to deliver more care closer to home, with a signed up plan to treat people in the community rather than in a hospital setting where dependency will increase and their condition could deteriorate;
- More appropriate referrals ensuring that patients are treated by the right team in an integrated way. 18 elective pathways will be redesigned around patients to ensure a better experience of care and fewer unnecessary hospital appointments;

- Greater collaboration between professionals within the larger organisation which will drive superior provision of care for patients, reduce costs to the organisation and create a more satisfied workforce;
- Better care for those with the highest needs through a range of services to identify those requiring more care through risk stratification through to enabling them to live more independently till later in life;
- Better treatment for mental health patients with physical health needs.

Qualitative assessment of benefits: "do minimum" option

The "do minimum" option assumes that providers will not be able to continue to operate in their current form and continue to be financially sustainable. This is the basis for the assumption that an administration process would be required, however at this stage it is not possible to pre-empt the TSA recommendations. Whilst this option may ultimately deliver similar benefits this remains dependent on the TSA recommendations over which there is significant uncertainty.

Evidence from previous TSA at South London Healthcare NHS Trust and Mid Staffordshire NHS Foundation Trust is that the legal requirements and requirement to scope further options will lead to duplication of work but also increase pre-implementation timescales (and as a result cost) considerably. This cost would be seen in the form of additional resource, required by the TSA, to appraise all options but also in maintaining fragile services over an extended period.

Although assuming similar benefits would be achievable, a TSA led process may lead to short term loss of benefits and further risk as recruitment and retention of staff may become more difficult leading to considerable clinical risk. The uncertainty during a TSA process (during which multiple options will need to be appraised) may lead to a number of staff members leaving already fragile services. This could lead to an increasing reliance on more costly temporary staffing and a deterioration of service delivery. The existing fragility of services and this deterioration may lead to increased demands on capacity at surrounding providers which could detrimentally impact the whole health economy.

The scope of the TSA will be to maintain services through Business As Usual. Maintaining this will not deliver the step change improvements (financially and clinically) until the proposed solution is developed and agreed.

A TSA process may lead to an improvement in the governance at the organisation as a TSA is appointed as sole accountable officer which will be a step change to the existing accountability framework.

There is currently a lack of alternative options that could lead to a positive turn around for the LLR health economy in the near future. Therefore there is a high likelihood that the proposed solution by the TSA will be the same as that proposed by the Better Care Together programme.

Qualitative assessment of benefits: conclusion

In conclusion, the BCT option is expected to deliver a higher level of benefits more quickly and with a lower level of uncertainty. The cost and risk of the TSA process will be greater due to uncertainty around staffing and the need to scope further options and comply with the additional legal requirements. It is therefore ranked above the "Do Minimum" option in the qualitative assessment of benefits.

3.10 Qualitative risk assessment

Both of the proposed solutions will involve a number of risks that will need to be mitigated.

The first key risk is the lack of a health economy wide approach to workforce planning given the scale of services that will be provided outside of hospital. This will require joined up programme management around recruitment and training, as well as the shifting of staff from an acute setting to a lower-acuity setting.

Secondly, there is a need to ensure that the beds programme is actively managed by all of the partners in the health economy. The current plans require a reduction of 427 beds at UHL, 80 of which will be into new sub-acute wards in the community and 170 of which will be cared for through the new primary care hubs and community teams. This is a significant undertaking and requires coordination between the CCGs and providers.

The scope of the TSA will be to appraise all potential options and recommend a preferred solution whilst maintaining business as usual. The key risks during the administration will relate to maintaining safe services where it has already been shown that "do nothing" is not a viable option.

Uncertainty could lead to a loss of key staff and a deterioration of services. The TSA process is a high cost process and there is a high likelihood of a similar solution being developed particularly given the detailed scoping of options already undertaken in LLR.

It should also be noted that implementing a recommended solution from the "do minimum" option is likely to incorporate the same risks as the Better Care Together programme (albeit at a later stage). The delay may increase the risks given the potential deterioration of services in the interim.

The additional risks of the "do minimum" option can also be mitigated although there is an unavoidable additional risk from implementing this option.

In conclusion, the additional risks associated with the "do minimum" option result in it ranking below the Better Care Together option in the qualitative risk assessment.

Qualitative assessment of capital risk

The capital programme is assumed to be the same under both options with the exception that there is an assumed 12 month delay under the "do minimum" option reflecting the time

required for the administrator to be appointed and make recommendations and for the implementation of those recommendations. The 12 month delay has not been applied to Backlog Maintenance due to the urgent nature of the works.

3.11 Conclusions

The BCT programme approach has a lower net present cost of delivery than the “do minimum” option and is able to avoid a number of the delivery risks around workforce, service disruption and timing uncertainty that are inherent to the “do minimum” option.

It is the conclusion of the Economic Case that the BCT option is the preferred method of delivery for the programme based on the above assessment.

4 Commercial Case

4.1 Introduction

The Commercial Case sets out the approach that the health economy will be taking to ensure there is a market for the supply of services. The aim of this section is to prove that a commercially viable position can be reached that will allow the programme to deliver good value for money.

4.2 Procurement strategy

Until a preferred option is agreed the procurement strategy for the programme will be an examination of possible options. This will develop alongside increased certainty around specific developments.

4.3 Private sector partnership

Partnership with a private provider under a Private Finance Initiative (PFI) has been a favoured route of procuring large scale development solutions in many areas of healthcare and local government. Under such an arrangement the LLR health economy would contract with a named developer to work with stakeholders to undertake a development scheme and the developer funds the associated capital costs themselves. In return, the developer would seek an annual rent payable over a long lease term.

The current public private partnership vehicle takes the form of PS2 which aims to provide a faster and more transparent model of infrastructure procurement. Some of the characteristics of PS2 are as follows:

- An 18-month time limit on PFI bidding processes. If the process is not complete during this time, the funding may be lost;
- PF2 project companies publishing their revenues and profits.

Existing contractual arrangements should also be considered as they can add complexity to joint delivery of a PS2 solution. It should be noted that long term contracts exist between UHL and IBM, with additional long term contractual service provision between Interserve and UHL/LPT.

The framework that UHL have with Interserve for estates and FM services is inclusive of capital consultancy and construction. This runs for a period of 7 years from March 2013 to 28 February 2020. There is market test provision on the framework component in 2017 but FM services are for the full 7 years.

The provision of estates and FM services is encapsulated in a contract for the 7 years. UHL have rights to terminate services for poor performance or breach should they so require, but in this latter scenario UHL would be liable to contractual terms.

The Lot 2 component which relates to external consultancy (design and construction) is at both UHL and LPT's full discretion with no exclusivity given.

Similarly whilst UHL do not envision that their contract with IBM would immediately halt a PFI solution it would likely be a key consideration as to whether IM&T would be involved in any such agreement.

4.4 LIFT

The LIFT model is an alternative to PS2 and takes a long term strategic approach to local health provision which combines the benefits of national support and local control. A LIFTCo is a local joint venture made up of local stakeholders (typically CCGs, Local Authorities and GPs) and a private sector partner. The LIFTCo takes ownership of the premises it builds or refurbishes and then leases the space to health and social care providers.

LIFT is not seen as the preferred way of progression for required capital schemes for either UHL or LPT.

4.5 PDC/loan finance

The most likely procurement route to be followed for this scheme is through a combination of existing CRL funds and additional PDC loans. This offers flexibility to organisations within LLR around fully shaping the design of services and assuring a focus on quality. Utilisation of internal NHS funds has the benefit of being the cheapest form of long term capital likely to be available for such projects.

A full break down of costs for individual organisations can be seen in the following appendices: UHL (Appendices 14-15), LPT (Appendices 16-17), workstreams (Appendix 1-13) and Primary Care (Appendix 23).

If internal NHS funding is deemed to be the preferred procurement route, then further detailed planning of requirements will be needed as soon as the SOC is approved.

Private financing arrangements could be considered however this is unlikely to be attractive because:

- The existing Interserve agreement precludes third party provision of FM services;
- Given the nature of proposed developments – all being within the existing estate footprint/ extensions to existing buildings it would be difficult to deliver the required risk transfer that would enable a solution to offer value for money.

5 Financial Case

5.1 Introduction

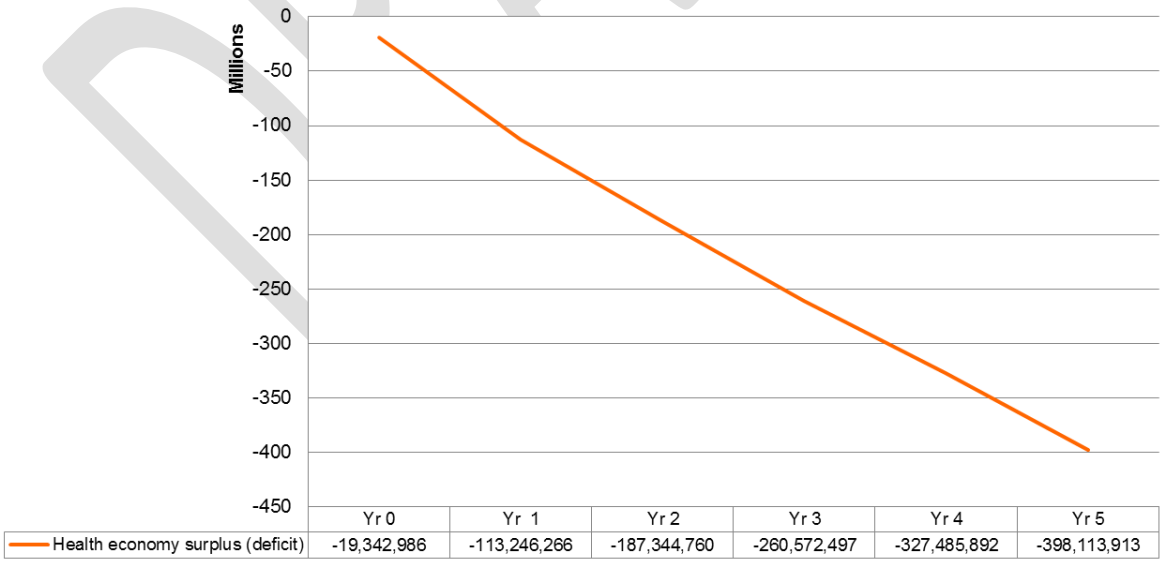
The purpose of the Financial Case is to set out clearly the financial impact of the investment proposal. It details the capital costs and the revenue implications of not only the preferred way forward but also the other short-listed options arising from the appraisal. There are also details of the "do minimum" option to allow a true comparison of the proposed investment. Finally the section also includes the assumptions that have been made at this stage of planning from which the capital and revenue costs have been derived.

5.2 Financial challenge facing the health economy

Economic modelling was undertaken alongside the production of the five year strategy to ensure that a common understanding of the upcoming financial challenge was shared across all parts of the LLR LHSCE. The approach to modelling has been to formulate a single Health Economy wide understanding based upon agreed assumptions concerning demographic growth, funding levels etc. The key focus has been to express the interrelationship between savings and efficiency schemes on all organisations across the LHSCE rather than each in isolation.

The resultant financial position for LLR shows that the total gap between income and expenditure in 2018/19 is £398m before any CIP/QIPP or other projects are modelled. This has been calculated and agreed by the Finance Directors of all commissioner and provider organisations in LLR.

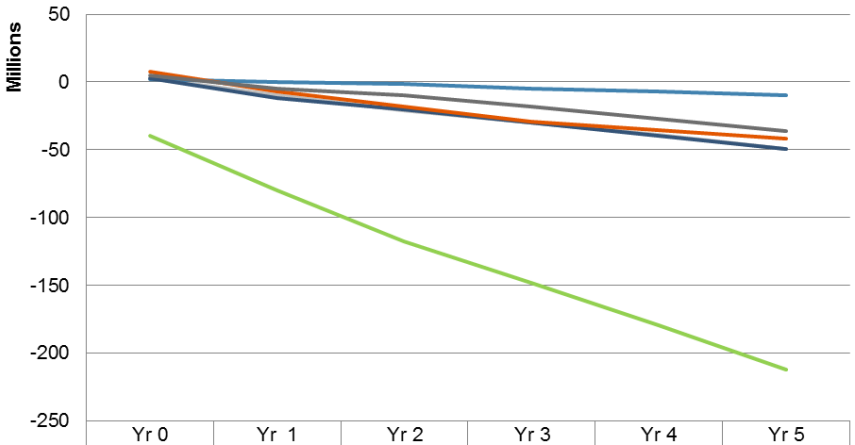
Figure 71: Position at 2018/19 with no savings or productivity improvements in LLR



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Health economy surplus (deficit)	-19,342,986	-113,246,266	-187,344,760	-260,572,497	-327,485,892	-398,113,913

Figure 45 shows how the £398m financial challenge is split across organisations. The graph shows that in year 5, UHL would have a deficit of £212m if no plans were successfully implemented.

Figure 72: Individual LLR organisation position (excluding savings / productivity)



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Leicestershire Partnership NHS Trust - RT5	2,911,000	-9,636,734	-20,530,145	-30,043,441	-39,242,889	-49,231,090
University Hospitals Of Leicester NHS Trust - RWE	-39,794,000	-79,961,955	-117,137,721	-148,294,360	-179,203,169	-212,295,747
Leicestershire & Lincolnshire AT	1,937,000	164,556	-1,497,553	-5,147,624	-7,296,649	-9,482,978
NHS East Leicestershire and Rutland	3,045,862	-11,743,514	-20,273,471	-29,698,708	-39,297,623	-49,529,196
NHS Leicester City CCG	7,627,648	-7,198,785	-18,218,003	-29,323,088	-35,577,569	-41,615,324
NHS West Leicestershire CCG	4,929,504	-4,869,834	-9,687,867	-18,065,276	-26,867,994	-35,959,579

Eliminating the gap of £398m would require reducing spend by approximately £1 for every £5 currently spent. This cannot be achieved by 'general' organisational CIPs of 3-4% alone.

The whole health economy model has shown that if the BCT cross system initiatives deliver according to the initial plans, and all organisations deliver a 3-4% CIP (some of which is dependent upon the BCT projects), then the economy as a whole would deliver a £1.9m surplus in year five before the UHL reconfiguration benefits of £30.8m in year 6.

Commissioner and provider positions are improved through reconfiguration of beds, with delivery of CIPs further improving provider positions. In some cases the BCT workstreams and commissioner QIPP are beneficial to commissioners but represent a loss of margin to providers. However, the workstreams have a positive net impact on the whole health economy position.

Managing this is subject to ongoing discussions regarding transition and transformation funding requirements.

5.3 Capital costs and requirements

The overall net capital requirement that cannot be funded through combined Trust Capital Resource Limits (CRL) equates to £428m. UHL will require an advance of £28.3m in 2018/19 against their disposal receipt in 2019/20.

This encompasses LPT's Community Hospital Estates Transformation as well as the 17 individual business cases that will enable UHL to deliver the new Emergency floor, planned care and maternity and children's developments.

Figure 73: Capital requirements by organisation

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Total Requirement	**46,530**	**120,221**	**125,672**	**117,834**	**72,121**	**482,378**
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	**167,707**
	External Capital Requirement (Gross)	**12,023**	**86,921**	**92,372**	**84,534**	**38,821**	**314,671**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
LPT	Total Requirement	**14,636**	**14,652**	**23,000**	**48,944**	**52,332**	**153,564**
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	**58,368**
	External Capital Requirement (Gross)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
	Receipts	-	-	-	-	-	**-**
	External Capital Requirement (Net)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
Primary Care	Total Requirement	**-**	**4,625**	**13,875**	**13,875**	**13,875**	**46,250**
Planned Care	Total Requirement	-	-	250	-	-	**250**
Urgent Care	Total Requirement	**-**	2,070	-	**-**	**-**	**2,070**
Long Term Conditions	Total Requirement	-	200	-	-	-	**200**
	External Capital Requirement (Net)	**-**	**6,895**	**14,125**	**13,875**	**13,875**	**48,770**
OVERALL	Total Requirement	**61,166**	**139,698**	**164,867**	**180,653**	**138,328**	**684,712**
	Use of capital resource limit	49,143	44,208	45,908	43,408	43,408	**226,075**
	External Capital Requirement (Gross)	**12,023**	**95,490**	**118,959**	**137,245**	**94,920**	**458,637**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**95,490**	**118,959**	**137,245**	**66,570**	**430,287**

UHL's projected transformational capital spend across the five years is £482.4m (including all transformational business cases and the installation of the enabling EPR system. UHL's gross requirement above CRL has been reduced by the forecast receipt of £28.4m due to sale of one acute site (as a result of reduction from 3 sites to 2). Within the above table this is shown as a capital advance in year 5. As mentioned above the initial requirement is offset by usage of UHL's CRL to leave a final requirement of £286.3m. (The capital receipt value has been based on current estimates to provide a basis for planning. It is anticipated that best value will be sought at time of disposal and, as such, the final value is likely to be subject to variation.)

Three work streams have forecast a need for capital funding. Planned care has identified a need to develop a referral hub with a forecast cost of £0.25m in 2016/17. In 2015/16 urgent care require a £2.1m investment in technology to enable mobile working as well as a scheduling system. Long term conditions plan to spend £0.2m on Telehealth equipment in 2015/16.

The element requested for primary care transformation equates to £46.3m. The assumptions behind these figures can be seen within Appendix 23.

As a result of the above the overall external capital requirement for the programme is £430.3m.

5.4 Assumptions made for revenue impacts

Initial planning was undertaken (within the 5 year strategy) to model the over-arching financial position of the health economy. Since this point workstreams and organisations have continued to produce increasingly granular plans that better reflect the likely profiling of benefits. These can be seen below (with CIP/QIPP included as it was set out during economic modelling) mapped savings can be seen within Figure 75:

Figure 74: Benefits by workstream to 2020/21

Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	19/20 (£'000)	20/21 (£'000)
Expected funding gap (without interventions)	(113,246)	(187,345)	(260,572)	(327,486)	(398,114)	(475,308)	(559,759)
Adjustment to investment plan	10,118	11,826	12,457	12,865	13,637	13,637	13,637
Net Funding Gap (without Interventions)	(103,128)	(175,518)	(248,115)	(314,621)	(384,477)	(461,670)	(546,121)
LTC Workstream	0	255	1,102	1,694	1,684	1,684	1,684
FOP Workstream	0	0	0	0	0	0	0
Children's Workstream	0	55	300	300	300	300	300
LD Workstream	0	932	1,273	1,657	1,857	1,857	1,857
Maternity & Neonatal Workstream	0	0	378	378	378	378	378
MH Workstream	680	3,615	4,910	5,299	5,688	5,688	5,688
Planned Care Workstream	0	957	2,585	4,614	5,495	5,495	5,495
Urgent Care Workstream	0	(295)	352	1,000	1,000	1,000	1,000
CIPs	58,068	105,106	149,943	193,516	238,372	263,951	326,162
QIPP	28,323	44,475	61,244	80,633	96,687	115,957	138,622
Bed reconfiguration	1,102	4,249	7,503	9,450	11,020	11,020	11,020
UHL site running costs reduction	0	0	0	0	0	30,700	30,700
Expected CCG allocation growth	0	0	4,333	8,667	13,000	13,000	13,000
Additional Workstream efficiencies	0	2,500	5,000	7,500	10,874	10,874	10,874
Revised position	**(14,956)**	**(13,669)**	**(9,193)**	**85**	**1,878**	**235**	**658**
Position originally forecast by Economic Modelling	(15,202)	(10,526)	(14,448)	(15,097)	1,878	235	658

Two additional benefit lines have been added to the breakdown shown in the table above to represent an updated health and social care economy view of how the £398m gap will be closed. These benefits are based on a prudent assessment that the previous savings allocated to a) the development of new contracting models and b) additional funding available from NHSE around primary care, were not sufficiently robust. The additional ways to close the gap shown above reflect the following:

1. **The opportunity for significant additional savings to be delivered through clinical workstreams**. The number of £10.5m includes the financial impact once initially calculated benefits are grown in line with anticipated inflation to 18/19 (£2.5m), in addition to a prudent estimate that there is potential to deliver new projects totalling savings of at least £8m. This was assessed based on additional opportunities identified but not yet developed into detailed initiatives.
2. **Likely changes to CCG allocations CCGs following recent announcements from NHSE**. The allocations for CCGs were prudently set to grow by 1% each year in the original health economy model. Based on the alternative scenarios set out in the 5 Year Forward View it is now estimated that CCGs can expect to receive at least a 1% increase in allocations above that originally set out. In addition, any increase in the pace of movement towards target CCG allocations would constitute an source of funding given that CCGs in LLR are currently on average of 5% under allocation. These two funding effects have been estimated as having a minimum 1% impact each, which would be equivalent to at least £22m for CCGs. The impact prudently forecast to be £12.5m in the benefits breakdown above.

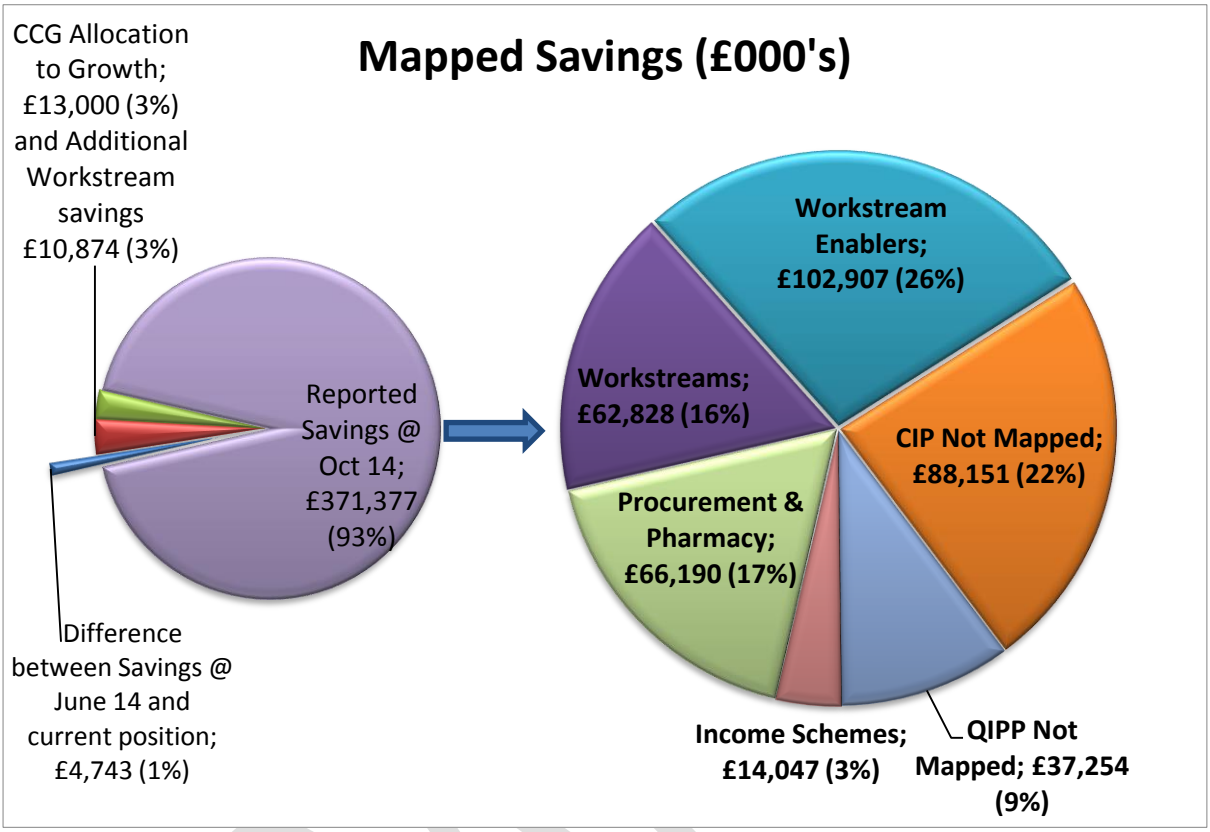
The overall risk of under-achievement of benefits across the programme is a risk that will be proactively managed by BCT. The sensitivities section of the Economic Case (section 4.8) models downside risks of under-achievement and this is also captured within the programme risk register (Appendix 21).

Organisational CIP/QIPP Schemes

Alongside the work stream savings numbers above the BCT programme will enable the delivery of organisation's own CIP/QIPP efficiency targets.

The below table sets out the values that are currently planned for CIP/QIPP delivery across LLR and how these plans can be mapped to specific work streams. Please note that the figures below do not exactly match the planned 5 year CIP/QIPP figures due to slight changes to plans since the original health economy modelling.

Figure 75: Organisation CIP/QIPP planning



The PMO has worked alongside each individual organisation to show the linkages between CIP/QIPP values, originally agreed through Economic modelling, to defined workstreams.

Figure 75 shows (at most recent assessment) the mapping of £371.4m of originally designated workstream and organisational CIP/QIPP savings to the key work stream areas which they enable;

- 45% (£166m) of organisation specific plans can be directly map to supporting the delivery of workstream objectives
- The remaining 55% (£206m) relate to areas of focus around pharmacy, income generation or general efficiency that cannot be mapped directly to work streams.

Further information on Trust specific costs can be seen in Appendix 14 and 15 (UHL) and 16 and 17 (LPT), whilst workstream requirements can be reviewed in Appendix 1-13

Figure 76: Transitional cost requirement summary

Support Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
UHL Deficit funding	40,700	36,100	34,300	33,300	30,800	**175,200**
LPT revenue support	131	3,614	4,558	5,218	2,920	**16,441**
UHL revenue support	1,200	19,707	21,880	22,836	22,920	**88,543**
Work streams	362	4,991	2,122	438	272	**8,185**
Central PMO	1,539	997	997	997	997	**5,527**
Consultation Costs	0	200	200	100	100	**600**
Primary Care	0	4,500	6,000	3,000	1,500	**15,000**
Enablers	366	254	224	224	224	**1,292**
TOTAL REVENUE/(CASH) REQUIREMENT	**44,298**	**70,363**	**70,281**	**66,113**	**59,733**	**310,788**
Funded by						
Uncommitted CCG Transformation funds	0	3,280	3,484	3,684	3,885	**14,333**
Independent Trust Financing Facility (deficit support already applied for by UHL in 14/15)	40,700					**40,700**
Remaining External Funding Requirment	**3,598**	**67,083**	**66,797**	**62,429**	**55,848**	**255,755**
	44,298	70,363	70,281	66,113	59,733	**310,788**

The value of external funding required for 2014/15 does not include the £40.7m of deficit support that UHL have applied to the Independent Trust Financing Facility to cover.

Transformation fund values represent transformation fund values within CCG 5 year strategic returns, less CHC Risk Pool contributions and an assumption that 20% of the balance will be committed to other areas of transformation. 14/15 confirmed as entirely committed.

The additional external requirement to support the programme over future years is therefore **£225.8m**, representing a remaining **£134.5m** of UHL deficit funding and **£121.3m** of programme revenue costs (net of uncommitted CCG transformation funds).

The current working bed reconfiguration plan assumes 250 beds worth of patients can be cared for outside of an acute setting. The transitional revenue support calculations contained in this document are based on the shift completing by 2018/19. At the time of writing consideration is being given to the feasibility of this shift occurring by 2017/18. This is at a very early stage of discussion and as such it would be inappropriate to account for this in the financial calculations. However if after due consideration an acceleration of the 250 bed shift is considered feasible, it would have an impact on the financial calculations contained in this document. The transitional cost requirement calculations would require review and potential revision. The most likely figure(s) to be impacted would be the UHL and LPT revenue support calculations.

Social care impact

There is significant uncertainty related to the delivery of the BCT plan in respect of its impact on adult social care, particularly given the current funding environment and the dependence on political decisions, both locally and nationally. Over the next 5 years both health and social care organisations are facing significant financial pressures which will mean services need to be provided in different ways. Any changes and cuts made across health and social care will inevitably have an impact on each other's' ability to provide corresponding services safely and in a sustainable way.

Work has begun to make estimates to quantify this impact, and this has begun by reviewing the current beds programme. One of BCT's objectives is to provide care for patients in the community who were previously being treated in an acute inpatient setting in UHL. Provisional work has suggested that the financial cost to social care of treating these patients in the community could be around £5m, based on a weighted average of the current cost of care packages. This will only be one element of the joint impact of the changes taking place however this highlights the need for careful planning and coordination between the different services. Further work will be required as the programme moves forward.

In order to mitigate an element of this risk, the health economy model has assumed that funding for the BCF will continue into the final years of the plan (current BCF values indicated below). However, given the large amount of uncertainty surrounding the impact of the cuts to both services a joint programme of work is required to collectively ensure that potential disruption and risk is minimised.

6 Management Case

6.1 Introduction

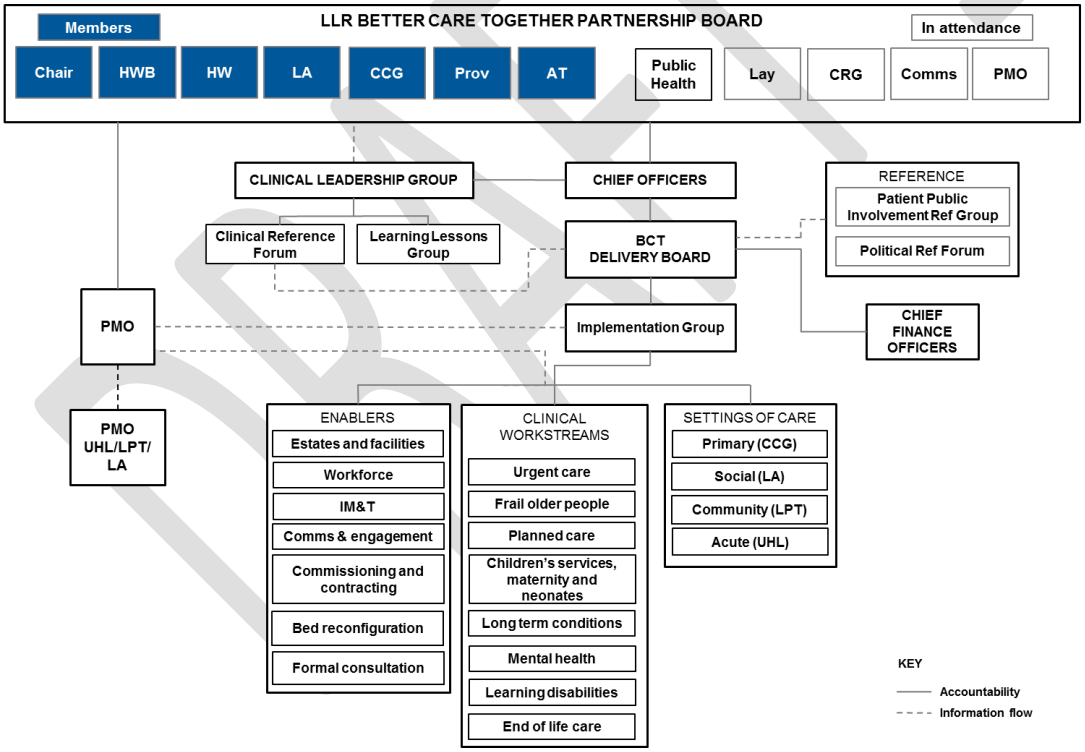
This section of the SOC addresses the deliverability of the programme. Its purpose is to set out the proposed actions that would be required to ensure the successful delivery of the programme.

The programme comprises a number of individual business cases and developments. The structures and processes set out in this section describe the overall proposed programme approach to ensure the programme runs successfully, despite key responsibilities sitting with a range of organisations. Further detail can be found in the separate Programme Initiation Document (PID).

6.2 Outline programme governance structure

The programme requires a clear governance structure and lines of responsibility to ensure that it is able to deliver the required outcomes. This is set out in the diagram below;

Figure 77: BCT programme structure



6.3 Group membership and outline programme roles and responsibilities

There is a clear understanding, within the above structure, as to the responsibility that each element possesses. These were first set out in the PID and will continue to be a key part of the governance process for the programme. The responsible body / person(s) and their responsibilities are summarised below.

Figure 78: Programme roles and responsibilities

Role	Responsibility
LLR Partnership Board	Ultimately accountable for the success of the Programme. Recommending the investment in the BCT Programme to partner organisation boards, cabinets and Executives. Ensuring the Programme remains aligned to LLR strategy. Directing the BCT Delivery Board through the joint SROs. Ensuring the Programme remains worthwhile and viable. Representing and promoting the Programme. Authorising the closure of the Programme.
Chief Officers	Leading their staff through the turbulence and emotion of transformative change. Delivering the BCT Programme outcomes within their organisations. Supporting the Chair of the Partnership Board in providing a supportive LLR environment for the BCT Programme.
Joint SROs	Ensuring the Programme realises the vision and achieves its objectives. Directing the Programme, through the Programme Director.
BCT Delivery Board	Supporting the joint SROs. Driving the Programme forward to deliver the changes and benefits required to achieve the Programme's objectives. Ensuring that Programme planning and control is satisfactory. Authorising the Programme Director to progress to the next stage. Obtaining adequate external assurance. Monitoring and, if necessary, correcting the progress of the Programme.
Programme Director	Managing the Programme, day-to-day, on behalf of the Delivery Board Leading Programme staff.
Chief Financial Officers	Planning and managing financial aspects of the system-wide change to a new operating model of health and social care.
Partner Organisations	Committing resource. Maintaining delivery of routine services while delivering change. Through the workstreams and projects: • delivering the changes required by the Programme; • realising the benefits from the changes; • incorporating the benefits into their new routine services.
Clinical Workstreams and Enabling Groups	Planning and delivering the changes in their area of responsibility that will yield the benefits required for the Programme to achieve the six system objectives (Section 2.5.2).
Political, Clinical and PPI Reference Groups, other stakeholder fora and User Groups	Engaging with and supporting the LLR Case for Change, providing assurance and user input to help the Programme deliver successfully and meet user needs and expectations.
The PMO	Providing control of the Programme to the Programme Director. Facilitating successful delivery of the Programme by coordinating and synchronising Programme resources, work and achievement of objectives. Establishing processes, setting standards and promoting best practice.

6.4 Risk management approach

The programme will apply the following principles in its management of risk;

- The risk management process will feed back to LLR partner organisations.

- The BCT Partnership and Delivery Boards will use a Board Assurance Framework (BAF). The BAF will allow those Boards to assess for themselves the adequacy with which Programme risks are being managed. This assurance of risk management will inform the view of those Boards on the overall deliverability of the Programme.

- Risks in well defined areas will be owned by the relevant or appropriate body in the Programme governance structure, such as clinical risks being owned by the Clinical Reference Group.

- Risk will be managed at the lowest possible level of the organisational structure. An escalation and de-escalation mechanism will link the levels of projects, workstreams and the BCT Programme. The Programme's reporting of risk will be compatible with the reporting mechanism used by LLR partner organisations.

Risk management – process

The risk management process enables the partners to understand and minimise the impact of risks, and provides assurance that risks are proactively and effectively managed.

The risk management approach that the programme will follow is set out below;

- **Identify the context of the risk and the risk** – the risk may be a threat or an opportunity. The objectives or benefits determine the relevance of a threat or opportunity.

- **Assess the risk** – this step may be divided into estimating the likelihood and impact (together the severity) of the threat or opportunity and evaluating the net effect of the aggregated threats and opportunities on an activity. The proximity of the risk may be added to the estimating step.

- **Plan the response to the risk** – responses to a threat can be categorised as: Remove; Reduce; Transfer; Retain or Share. A combination of responses may be possible to reduce the risk to a level at which it can be tolerated. Responses to an opportunity can be categorised as: Realise; Enhance; and Exploit. 'Realise' seizes an identified opportunity. 'Enhance' improves on realising the opportunity by achieving additional gains. 'Exploit' seizes multiple benefits.

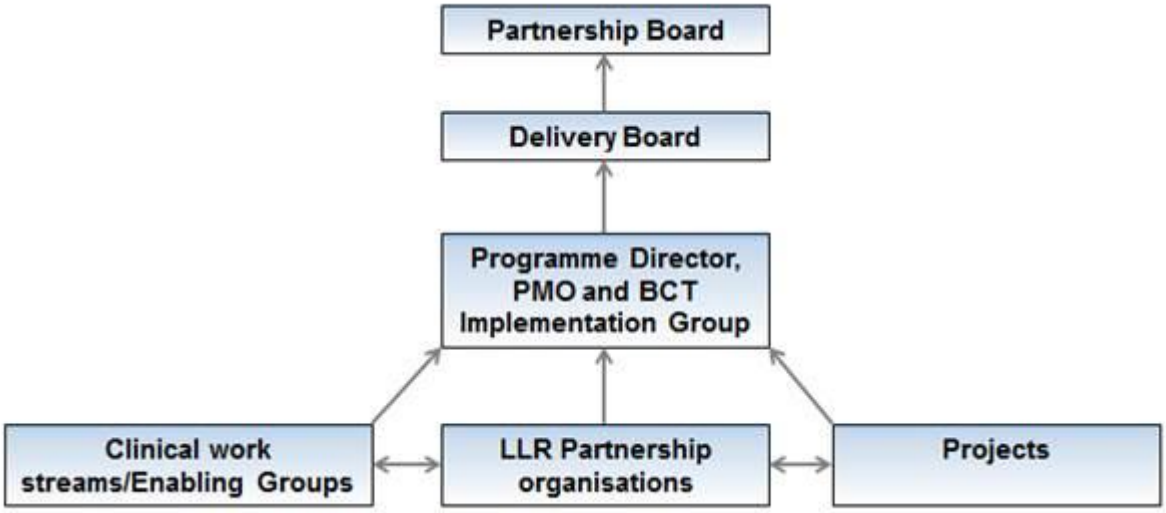
- **Implement the response to the risk** – this step ensures that the planned response(s) is implemented and monitors its effectiveness. If a response to a risk does not achieve the expected result, corrective action will be taken as part of this step.

Risk escalation

In delivering the Programme, the Delivery Board will oversee a core escalation mechanism for: information and performance management; benefits realisation; risk management and issue resolution; quality (programme management and clinical quality); and change control.

The escalation mechanism will be as follows:

Figure 79: Escalation structure



Current risk register

The programme risk register will inform a Board Assurance Framework (BAF) for the Delivery Board. Whereas the programme risk register will be used to control risk, the BAF will be used for the Board to satisfy itself that assurance about risk is adequate.

The programme risk register can be seen within Appendix 21.

6.5 Benefits realisation

The BCT programme will apply the following principles:

- LLR system-wide change and BCT programme-wide change will be benefits-driven;
- benefits will be clearly linked to the six strategic objectives;
- benefits will be measured, tracked and recorded through appropriate performance management arrangements; and
- oversight of benefits delivery is discharged through the BCT Delivery Board.

The BCT programme will realise benefits through a sequence of:

- planning benefits and resourcing their realisation;
- delivering change (elements of transitioning to the new model of integrated health and social care);
- realising the benefits from those changes and embedding the new configuration of infrastructure, organisation, workforce, working practices and relationships; and
- further developing or exploiting those benefits to the advantage of the partnership and its capability to serve its stakeholders.

The Delivery Board will oversee benefits realisation through:

- a benefits plan that maps out the system-wide impact and identifies key dependencies;
- a benefits profile that describes how benefits will be attributed to partner organisations;
- a description of how benefits will be measured, tracked and realised including the name of the responsible owner for delivery; and
- the PMO monitoring the actual realisation of benefits against those planned.

The workstreams projects introduced in the Strategic Case of this document have identified specific key performance indicators, against which performance will be monitored.
These are outlined in the following tables;

Figure 80: Workstream benefits mapping against investment objectives

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
Urgent care	• Increase number of calls to Out Of Hours for over 65's • Increase number of calls to Acute Visiting Service for over 65's		• Increase the number of people feel confident to manage their own condition	• Increase number of contacts dealt by SPA Navigation • Increase GP satisfaction and number of calls into SPA Navigation	• Reduce number of Admitted bed days for Urgent Episodes • Increase number of patients EMAS see and treat at the scene	
Frail older people	• Increase the proportion of older people (65 and Over) still at home 91 days after discharge from hospital into reablement/rehabilitation services. By 15/16 the target is to increase trajectory to 90.0	• More people dying in their place of choice • Reduce injuries due to falls. Target is to reduce emergency admissions in 15/16 by 1700 • More people with dementia living well • Measure new attendance of people to reduce people feeling socially isolated	• Frail Older People identified as being at high risk of admission will benefit from having a Quality Care Plan. Target is to reach 100% care plans for the +75 years old cohort • Improved Patient/Service User Experience. Target is to reach 93.1% satisfaction through surveys	• Decrease Delayed Transfer of Care and Length of Stay. Target is to decrease admissions by 3.0% by 15/16	• Fewer care home admissions. 671 by 15/16 • Reduction in non-elective activity by a total of 1,911 admissions. Target is to reduce Rutland falls admission by 2.4% • Reduce admissions into the Older Peoples Unit-Geriatric Assessment.	

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
Long term conditions	• Reduce dependency on access to care in acute settings for people with LTCs • Improve integrated model of care for COPD Development. Target is to achieve a 1979 spell reduction for HRG DZ21A-K over 5 years	• More people living in their own homes and not in care. The target is to increase this number in Rutland by 93.1% by 15/16	• An increased number of care plans in place and people on disease registers. The target is to reach 100% care plans by all CCGs • More people reporting higher personal resilience and support for self-management. Target is a 30% reduction in re-admissions • Increase in patients reporting activity levels when diagnosed with LTCs. • Positive experience of care. Target is to achieve 66.8% agreement in	• Earlier identification, intervention and escalation preventing delay in treatment. In 5 years the target is to achieve a 30% reduction in the bed days in excess of 15 days	• Shorter inpatient stays for LTCs ; Increase out of hospital care for patients with defined	• More people with LTCs supported by telehealth, telecare and healthcoaching services where it is proven to be of benefit thereby supporting them to self-manage their condition

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
			the CQC Inpatient Survey by 15/16			
Planned care	• Wider health economy transformation including provider CIPs and BADS. Target is 25 bed reductions as per UHL CIP • 40% left shift of acute activity into community			• Reduce face to face follow ups where appropriate	• 10% of outpatient activity attendances will be decommissioned. Target reductions by 2018/19 is £5.17m • 50% of out of county activity (Out patient attendances and Day cases) will be repatriated to LLR (excluding City CCG). Target to reach £6.78m by 2018/19 • Reduced cost of activity due to reductions in acute tariffs • Reduction in elective care cancellations. • Reduction in DNA for follow up appointments.	• Apply consistent application of elective care protocols (Enhanced policy, management and education programme).

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
					Reduce average to 6%.	
Maternity and neonates		• Improve uptake of antenatal and parenting support, particularly in hard to reach groups. Set to reach 21% uptake • Better perinatal outcomes in Leicester City. Target is to achieve 7.6 per 1000 births		• Increase the number of neonates in the right cot and the right time, by a 12-15% reduction each year in neonatal refusals	• Sustainable long term model for maternity and neonatology services that complies with national service specifications.	
Children's services	• Joined-up delivery across health & social care • Reduce number of consultant lead appointment for constipation management • Transfer of Hepatitis B ward attender activity out of UHL. Target is to achieve 0 children attending UHL.	• Children and young people, with the greatest need, will be seen by a specialist emotional health and wellbeing service within the agreed waiting times. Target is 13 week RTT. • All children and	• Reduce referrals to community paediatrics for behaviour management	• Reduce duplication, through workforce integration and better utilisation of facilities to maintain sustainability of children's services. Target is for no children to be on Children's	• Fewer children with eating disorders will be admitted to inpatient beds and will have a reduced stay. Aim to achieve 50% reduction • Reduce attendance/ admissions for childhood asthma and admission for	• A multi skill universal level workforce able to deliver emotional health and wellbeing support to children and young people

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
	• Tier 2 emotional and wellbeing services will be developed to prevent escalation to tier 3.	young people will have an integrated plan of care supporting them from 0-25 yrs. Target is that 100% of children have a plan.		Community Nursing Respite service • Rationalisation of management posts across LPT and UHL • Fewer children and young people will need to access tier three/four specialist provision	respiratory conditions.	
Mental health	• Develop community provision. Target is to negotiate 70,000 contracts.	• Reduce waiting times for community assessment.	• Increase rehabilitation service being provided closer to home. Target is to achieve this for 43 patients.	• Timely crisis and urgent response. Target is to respond within 4 hours and/ or on the same day	• Reduce the demand for bed days. Target is to reach 0 overspill patients	
Learning disabilities		• Increase the number of people with learning disabilities and family carers have expectations and experiences	• Equitable access to the right services and support at the right time, including universal provision. Aim to reach 70%		• Spend her head is proportionate to need and support setting. Target is to be developed and relies on benchmarking on high cost	

	Objective one – integrated care pathways	Objective two – reduced inequalities	Objective three – positive experience of care	Objective four – improved asset use, reduced duplications & waste	Objective five – Financial sustainability	Objective six – workforce & IT capability and capacity
		which are comparable to the general population. Aim to reach 60% agreement through performance review feedback. • Improved physical/mental health and wellbeing for all people with learning disabilities and family members. Aim to reach 70% agreement through surveys. • Increase the number of individuals to lead independent and fulfilling lives. Target to achieve 60% agreement through surveys.	agreement through surveys • Support to be tailored to individual needs. Aim to reach 80% agreement through surveys.		placements	

6.6 Post implementation review

The programme will continually seek to learn lessons in how it can improve its own performance and how it can find opportunities to realise benefits.

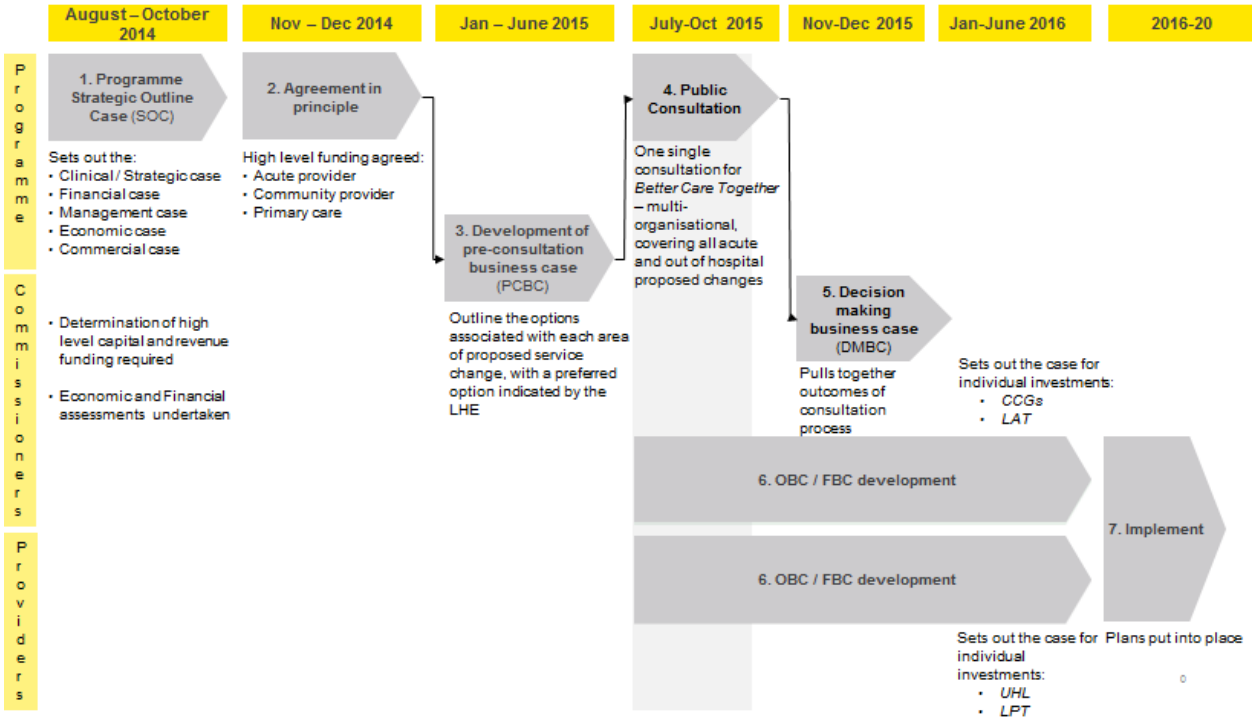
The PMO is to be the custodian, focus and disseminator of lessons learned throughout the BCT programme. This dovetails with the PMO's roles in being the information hub of the programme and in setting standards for the programme.

The Partnership Board will cascade good leadership throughout the programme to create a climate conducive to the good two-way communication that facilitates learning from experience. As part of the Programme Closure Stage, the Partnership Board will arrange for a Post Implementation Review (PIR) of the programme. The PIR will assess the benefits delivered by the Programme and how well the partnership has learned from experience during and after the programme. The PIR may be conducted as part of a larger OGC Gateway Review.

6.7 Business cases

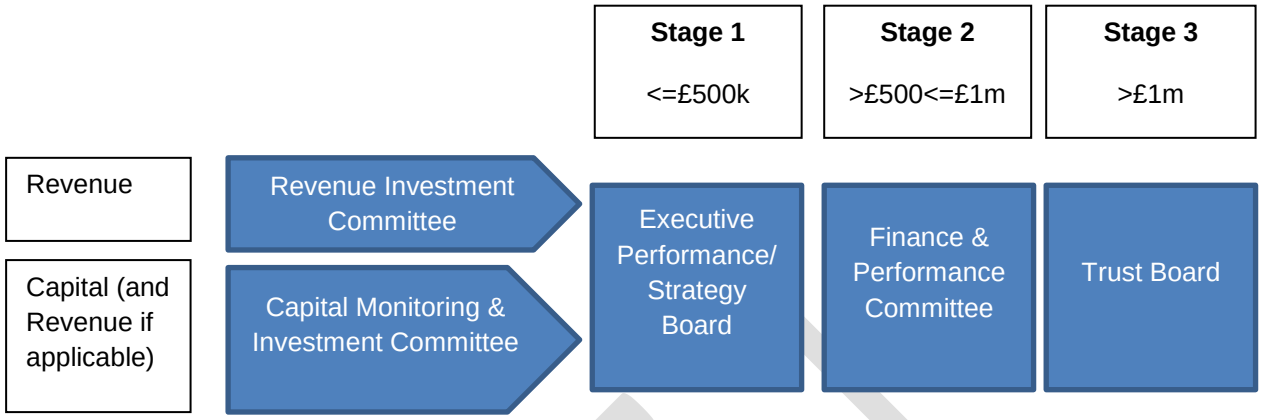
Whilst the SOC forms the overall case for change at a systems level, further detailed work will be required to develop each project referred to in the SOC into either a Request for Funding (RFF), an Outline Business Case (OBC) and/ or a Full Business Case (FBC). This will ensure that ownership of each project passes through the relevant governance, control and monitoring mechanisms of the relevant organisation(s) ultimately charged with delivering the project. The proposed process for major projects that are subject to formal consultation is summarised below:

Figure 81: Overall OBC/FBC approval timeline (re major schemes subject to public consultation)



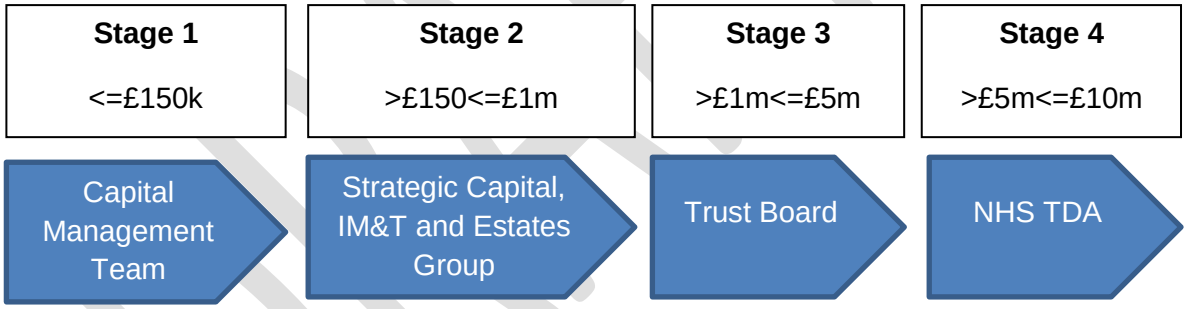
In addition, UHL and LPT's internal authorisation processes are outlined as follows;

Figure 82: UHL business case authorisation structure



UHL uses an initial gateway process based upon whether a project has a capital or revenue consequence. This is followed by a further three levels dependent upon the size of investment that is being bid for. Any request over £5m requires OBC and FBC submission to the National Trust Development Authority (NTDA).

Figure 83: LPT business case authorisation structure



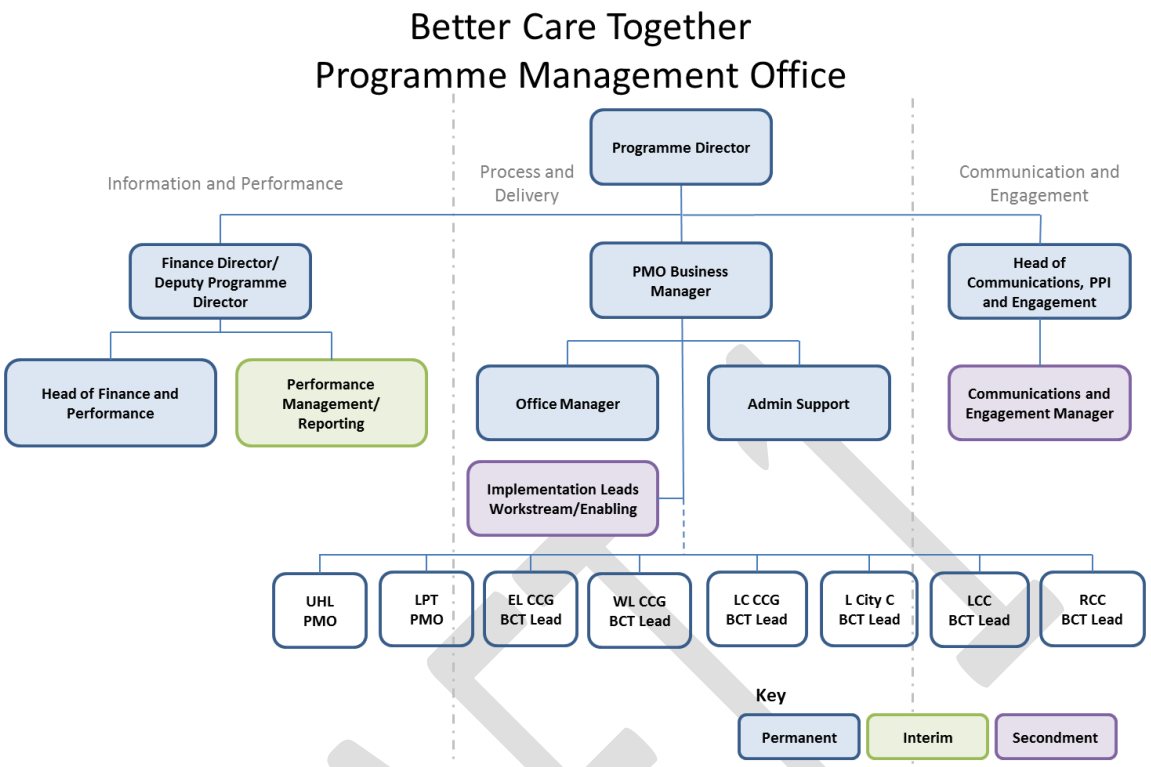
LPT utilises a similar approvals process based dependent upon the size of investment requested.

It will be crucial that the robust authorisation processes within each Trust (and through to the TDA) are satisfied as to the validity of each case as they develop towards OBC and FBC.

6.8 Delivery resource

The diagram below sets out the proposed programme management structure required to deliver the BCT five year strategy.

Figure 84: PMO structure



The programme will be jointly managed through a shared PMO which will be responsible for managing the workstreams across different care settings. This matrix approach will be critical moving forwards to ensure that complex programmes such as beds reconfiguration can be managed in a transparent and effective way across different organisations.

7 Appendices

Appendix 1: Urgent care – benefits

Appendix 2: Urgent care – transition costs

Appendix 3: Long term conditions – benefits

Appendix 4: Long term conditions – transition costs

Appendix 5: Planned care – benefits

Appendix 6: Planned care – transitional costs

Appendix 7: Maternity and neonates – benefits

Appendix 8: Children's services – benefits

Appendix 9: Children's services – transitional costs

Appendix 10: Mental health – benefits

Appendix 11: Mental health – transitional costs

Appendix 12: Learning disability – benefits

Appendix 13: Learning disability – transitional costs

Appendix 14: UHL funding requirements

Appendix 15: UHL transitional cost assumptions

Appendix 16: LPT funding requirements

Appendix 17: LPT transitional cost assumptions

Appendix 18: Detailed capital breakdown

Appendix 19: NPC BCT option

Appendix 20: NPC comparator option

Appendix 21: BCT programme risk register

Appendix 22: Financial positions by organisation

Appendix 23: Primary care funding requirements

7.1 Appendix 1: Urgent care – benefits

Workstream Title:	Urgent Care
Implementation Lead:	Caron Williams
Senior Responsible Officer:	Dave Briggs
Workbook Finance Lead:	Ryggs Gill

Net benefits (Benefits-Recurrent costs)

Benefit /Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit	Non pay	CCGs	Cost savings through reduced admissions for ACS conditions through improved system navigation (investment in scheduling system) and increased productivity of unscheduled care teams in the community (investment in mobile working). Saving based on tariff costs associcated with 12 months activity against ICD10 codes: I48.X, I50.0, I63.9, J18.1, J18.9, J22.X, K59.0, L03.1, N39.0, R07.3, R07.4, R41.0, R54.X, R55.X with length of stay 0-5 days. Activity will be delivered in the community within existing capacity of unscheduled care teams (productivity of teams increased through investment in mobile working)	-	3,899	7,798	7,798	7,798	7,798
Cost	Non pay	UHL	Reduced income from reduced admissions for ACS conditions through improved system navigation (investment in scheduling system) and increased productivity of unscheduled care teams in the community (investment in mobile working). Lost income based on tariff costs associcated with 12 months activity against ICD10 codes: I48.X, I50.0, I63.9, J18.1, J18.9, J22.X, K59.0, L03.1, N39.0, R07.3, R07.4, R41.0, R54.X, R55.X with length of stay 0-5 days.	-	(3,899)	(7,798)	(7,798)	(7,798)	(7,798)
Benefit	Non pay	UHL	Reduced cost base as a result of reduced admissions for ACS conditions through improved system navigation and increased productivity of unscheduled care teams in the community. Reduction of 26 beds based on current length of stay, adjusted for 93% utitilisation, at £50,000 per bed	-	-	647	1,295	1,295	1,295
Cost	Pay	CCG	Increased resource for the SPA team - 9.64 FTE band 3 service coordinators	-	(257)	(257)	(257)	(257)	(257)
Cost	Pay	CCG	System engineer	-	(38)	(38)	(38)	(38)	(38)
NET BENEFIT				-	(295)	352	1,000	1,000	1,000

7.2 Appendix 2: Urgent care – transitional costs

Transitional Costs

Capital/ Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital		Non pay	Mobile working technology to increase productivity of unscheduled care teams in the community	-	770	-	-	-	770
Capital		Non pay	Scheduling system to allow SPA to live allocated resources in the unscheduled care teams	-	1,300	-	-	-	1,300
CAPITAL				-	2,070	-	-	-	2,070
REVENUE				-	-	-	-	-	-
TOTAL COSTS				-	2,070	-	-	-	2,070

7.3 Appendix 3: Long term conditions – benefits

Workstream Title:	Long Term Conditions
Implementation Lead:	Helen Seth
Senior Responsible Officer:	Dawn Leese
Workbook Finance Lead:	Donna Enoux / Gareth Jones

Net benefits (Benefits-Recurrent costs)

Benefit /Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000 Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Costs	Mixed	UHL	Integrated COPD Service Model	-	(200)	(388)	(374)	(361)	(361)
Costs	Mixed	UHL	Workplace Wellness	-	(17)	(34)	(34)	(34)	(34)
Costs	Mixed	UHL	Exercise Medicine	-	(112)	(225)	(225)	(225)	(225)
Costs	Mixed	UHL	Specialist Oxygen review and prescription services	-	(61)	(122)	(122)	(122)	(122)
Costs	Mixed	UHL	Stratified cancer pathways	-	(112)	(223)	(223)	(223)	(223)
Costs	Mixed	UHL	Remote monitoring of cardiac devices	-	(14)	(28)	(28)	(28)	(28)
Costs	Mixed	LPT	Home administration of intravenous diuretics to heart failure patients	-	(20)	(40)	(40)	(40)	(40)
Costs	Mixed	CCG	Evidence based cardiovascular disease screening and treatment	-	(475)	(950)	(950)	(950)	(950)
Costs	Non-Pay	CCG	NICE Hypertension guidelines	-	(1,126)	(2,252)	(2,252)	(2,252)	(2,252)
Benefit	Non-Pay	CCG	Integrated COPD Service Model	-	333	646	624	601	601
Benefit	Mixed	UHL	Workplace Wellness	-	86	172	172	172	172
Benefit	Mixed	CCG	Exercise Medicine	-	0	600	1,200	1,200	1,200
Benefit	Mixed	CCG	Specialist Oxygen review and prescription services	-	116	233	233	233	233
Benefit	Mixed	CCG	Stratified cancer pathways	-	117	235	235	235	235
Benefit	Mixed	CCG	Remote monitoring of cardiac devices	-	15	30	30	30	30
Benefit	Mixed	CCG	Home administration of intravenous diuretics to heart failure patients	-	39	78	78	78	78
Benefit	Mixed	CCG	Evidence based cardiovascular disease screening and treatment	-	500	1,000	1,000	1,000	1,000
Benefit	Mixed	CCG	NICE Hypertension guidelines	-	1,185	2,370	2,370	2,370	2,370
NET BENEFIT				-	255	1,102	1,694	1,684	1,684

7.4 Appendix 4: Long term conditions – transitional costs

Transitional Costs

Capital/ Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000 Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	IT hardware and software/connectivity	Non-Pay	Equipment - Telehealth (especialy COPD)	-	200	-	-	-	200
Revenue		Pay	Project Team - 1 x 8d Implementation Manager; 4 x 8a Project Management; 1 x Band 4 A&C; 2 PA's per clinical lead 2 x 6; 0.5 Band 7 Finance; 0.5 Band 7 Business Intelligence	137	550	550	-	-	1,237
CAPITAL				-	200	-	-	-	200
REVENUE				137	550	550	-	-	1,237
TOTAL COSTS				137	750	550	-	-	1,437

7.5 Appendix 5: Planned care – benefits

Workstream Title:	Planned Care
Implementation Lead:	Helen Mather
Senior Responsible Officer:	Kate Shields
Workbook Finance Lead:	Sabbir Esat

Net benefits (Benefits-Recurrent costs)

Benefit/Cost	Cost Type (Pay/Non-Pay where	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit		CCGs	10% of outpatient services decommissioned. Expenditure reduction in LLR commissioners. This is based on the following phasing of reduction in activity: - 5% reduction in 6 specialties in Q1 2015/16, 10% reduction Q2 2015/16. - 5% reduction in further 6 specialties by Q3 2015/16 and 10% by Q4 2015/16. - 5% reduction in remaining 6 specialties in 2016/17, 10% reduction in 2017/18.	-	2,937	4,707	5,120	5,170	5,170
Income reduction		UHL	10% of outpatient services decommissioned. Income reduction in UHL. This is based on the following phasing of reduction in activity: - 5% reduction in 6 specialties in Q1 2015/16, 10% reduction Q2 2015/16. - 5% reduction in further 6 specialties by Q3 2015/16 and 10% by Q4 2015/16. - 5% reduction in remaining 6 specialties in 2016/17, 10% reduction in 2017/18.	-	(2,937)	(4,707)	(5,120)	(5,170)	(5,170)
Benefit		UHL	10% of outpatient services decommissioned. Cost reduction in UHL, assuming average marginal cost rate of 69% across three sites and UHL cost reduction phasing of 30%, 50%, 70%, 100%. This is based on the following phasing of reduction in activity: - 5% reduction in 6 specialties in Q1 2015/16, 10% reduction Q2 2015/16. - 5% reduction in further 6 specialties by Q3 2015/16 and 10% by Q4 2015/16. - 5% reduction in remaining 6 specialties in 2016/17, 10% reduction in 2017/18.	-	444	1,275	2,013	2,882	2,882
Benefit		Provider	50% repatriation of outpatient activity into UHL from outside of the health economy. Additional income to provider. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	1,299	3,315	6,707	6,778	6,778
Cost		Provider	50% repatriation of outpatient activity into UHL from outside of the health economy. Cost of delivering the repatriated activity. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	(896)	(2,288)	(4,628)	(4,677)	(4,677)
Benefit		Provider	50% repatriation of daycase activity into UHL from outside of the health economy. Additional income to provider. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	324	813	1,616	1,616	1,616
Cost		Provider	50% repatriation of daycase activity into UHL from outside of the health economy. Cost of delivering the repatriated activity. The financial benefits are currently under review. The basis for calculation of activity reduction is as follows: 10% in 2015/16 25% by 2016/17 50% by 2018 and beyond	-	(223)	(561)	(1,115)	(1,115)	(1,115)
Benefit		UHL	Reduction in procedures of limited clinical value. Reduction of £5k per quarter for 18 months - procedures currently under review	-	10	30	30	30	30
Cost			PRISM licence fee. As per quote.	-	0	0	(10)	(19)	(19)
NET BENEFIT				-	957	2,585	4,614	5,495	5,495

7.6 Appendix 6: Planned care – transitional costs

Transitional Costs

Capital/ Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	Facilities costs e.g. cleaning	Non-Pay	Referral hub set up, mission critical to facilitate repatriation and decommissioning benefits. Includes: - Computer software package to support triage of patients to the right place first time, it will hold all relevant services available to support all 18 pathways. - Computer hardware to support software - Local licences linked to all 18 referral specialties and the alliance - Relocation of chose and book into the hub	-	-	250	-	-	**250**
Capital	IT hardware and software/connectivity	Non-Pay	Computer upgrades to enable new system and cross organisational connectivity	-	-	-	-	-	**-**
Revenue		-	Referral hub development team consisting of clinical lead time, project management, IT support, admin. There is an assumption that this is required for 12 months to enable set up of the referral hub. Efficiencies will be generated across LLR to allow recurrent ongoing support from current workforce.	-	-	156	-	-	**156**
Revenue		-	Non pay costs incurred by referral hub development team, including travel, communications and engagement	-	-	48	-	-	**48**
Revenue		-	Workforce costs as follows to support development of PRISM pathway referral management across 18 specialties: 0.5 x B4 Service Desk Analyst 2 x B7 Product Facilitators 0.5 x B7 PRISMsystm One Integration 1 x B5 PRISMsystm One Trainer	104	156	156	78	-	**494**
Revenue	IT hardware and software/connectivity	Non-Pay	PRISM licence fee during development	14	19	19	10	-	**62**
Revenue	Multi-site staffing during phased bed closure	Pay		-	2,101	91	-	-	**2,192**
CAPITAL				-	0	250	-	-	250
REVENUE				118	2,276	470	88	-	2,952
TOTAL COSTS				**118**	**2,276**	**720**	**88**	**-**	**3,202**

7.7 Appendix 7: Maternity and neonates – benefits

Workstream Title:	Maternity & Neonates
Implementation Lead:	David Yeomason
Senior Responsible Officer:	Karen English
Workbook Finance Lead:	Stuart Shearing

Net benefits (Benefits-Recurrent costs)

Benefit/ Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit	Pay	UHL	Saving of 6 x Band 6 midwives and 5.4 x Band 2 nursing auxiliary from redesigning how mid-wife led services are provided in the community	-	-	**378**	**378**	**378**	**378**
Benefit	Non pay	UHL	Saving of rent from redesigning how mid-wife led services are provided in the community	-	-	**140**	**140**	**140**	**140**
Cost	Non-pay	CCG	CCGs liable for rent payment until alternative use is found for the building	-	-	**(140)**	**(140)**	**(140)**	**(140)**
NET BENEFIT				-	**0**	**378**	**378**	**378**	**378**

7.8 Appendix 8: Children's services – benefits

Workstream Title:	Children's Services
Implementation Lead:	Mel Thwaites
Senior Responsible Officer:	Lesley Hagger
Workbook Finance Lead:	Stuart Shearing

Net benefits (Benefits-Recurrent costs)

Benefit/ Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Overall Total
				Total	Total	Total	Total	Total	(£'000)
Benefit	Mixed	NHSE	Reduced costs from reduced admissions and length of stay for patients with eating disorders, enabled by implementing a community based eating disorders team. Reduce admissions by 50% and length of stay by 30%.	-	375	500	500	500	500
Cost	Pay	CCGs	Cost of implementing a community based eating disorders team. Team consists of Consultant Psychiatrist 0.4WTE, Family Therapist 0.6WTe, Clinical Physiologist 0.8WTE, Nurses 3.0 WTE , Dietician 1WTE, Psychotherapy 0.2WTE, Admin 1.0WTE.	-	(330)	(440)	(440)	(440)	(440)
Benefit	Mixed	CCGs	Saving from reducing number of people referred to CAMHS services through development of improved counselling services. Saving based on reducing referrals by 40 people, at a cost per person of £2,333.	-	-	93	93	93	93
Cost	Mixed	LPT	Cost of implementing improved counselling services to reduce people referred to CAMHS. Cost based on 5-6 sessions for 40 people at a cost of £500 per person. Pump prime funded through transition funding for first year; critical to being able to implement the new service	-	-	(20)	(20)	(20)	(20)
Benefit	Mixed	CCGs	Cost savings from moving consultant led workload within Acute settings to nurse led where possible e.g for bowel management services. Reduce consultant led provision by 50% and increase nurse led provision by 50%	-	7	13	13	13	13
Cost	Mixed	UHL	Reduced income from moving consultant led workload within Acute settings to nurse led where possible e.g for bowel management services. Reduce consultant led provision by 50% and increase nurse led provision by 50%	-	(7)	(13)	(13)	(13)	(13)
Benefit	Mixed	UHL	Reduced cost base from moving consultant led workload within Acute settings to nurse led where possible e.g for bowel management services. UHL have confirmed they can reduce their costs associated with this activity.	-	7	13	13	13	13
Benefit	Mixed	CCGs	Cost saving from moving ward attender Hep B activity out of UHL into primary care, in line with NHSPHE directive re babies with Hep B. 100% of activity moved out of UHL	-	15	15	15	15	15
Cost	Mixed	UHL	Reduced income from moving ward attender Hep B activity out of UHL into primary care. 100% of activity moved out of UHL	-	(15)	(15)	(15)	(15)	(15)
Benefit	Mixed	UHL	Reduced cost base from from moving ward attender activity out of UHL such as Hep B patients. UHL have confirmed they can reduce their costs associated with this activity.	-	15	15	15	15	15
Cost	Mixed	CCGs/primary care	Cost of providing Hep B activity in primary care. Increase capacity in primary and public health support team 0.5 WTE band 2 and agree local payment for GP for vaccination. All costs are included in this estimation.	-	(12)	(12)	(12)	(12)	(12)
Benefit	Pay	LPT	Saving from increased integrated working between health and social care which will deliver efficiencies in terms of number of duplicate visits from health and social care workers. A health and social care worker will attend visits together to support with lifting and deliver all care in one visit, rather than two health workers attending and two social care workers in separate visits. Saving of two band 3 HCAs costed at £ 21,977 plus £3,500 non pay costs (based on assumptions from LPT).	-	-	51	51	51	50
Benefit	Pay	UHL/LPT	Saving from provider integration. Rationalisation of management posts across LPT and UHL to reduce two band 7 posts costed at£46,346 plus £3,500 non pay costs (based on assumptions from LPT).	-	-	100	100	100	100
NET BENEFIT					55	300	300	300	299

7.9 Appendix 9: Children's services – transitional costs

Transitional Costs

Capital/Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Overall Total
				Total	Total	Total	Total	Total	(£'000)
Revenue		Pay	Data Systems Analyst Post	-	50	-	-	-	50
Revenue		Pay	Project Management Support	-	50	50	50	-	150
Revenue		Pay	Release of clinical time	-	50	50	-	-	100
Revenue		Mixed	Pump prime funding to pilot implementation of integrated counselling services, critical to being able to pilot the new counselling service and realise the benefits of reduced referrals to CAMHS	-	20	-	-	-	20
CAPITAL				-	-	-	-	-	-
REVENUE				-	170	100	50	-	320
TOTAL COSTS				-	170	100	50	-	320

7.10 Appendix 10: Mental health – benefits

Workstream Title:	Mental Health
Implementation Lead:	Jim Bosworth
Senior Responsible Officer:	Sue Lock
Workbook Finance Lead:	Chris Poyser

Net benefits (Benefits-Recurrent costs)

Benefit/Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
LPT CIP	Pay and Non Pay	LPT	Reduction in community services cost through reduction in staffing, efficient working, skill mix changes, estate - bringing down from 8/9 sites, more clinic working,mobile working, reduced travel, PbR clusters 1, 2 and 11 transferring to primary care	-	375	750	750	750	**750**
LPT CIP	Pay and Non Pay	LPT	Reduction in acute inpatient beds	-	490	1,410	1,410	1,410	**1,410**
Benefit	Pay and Non Pay	LPT	Crisis House, step down beds, discharge team, changes to inpatient acute pathway to reduce out of county overspill placements	1,150	4,600	4,600	4,600	4,600	**4,600**
Cost	Pay and Non Pay	LPT	Crisis House, step down beds, discharge team, changes to inpatient acute pathway to reduce out of county overspill placements	(450)	(1,800)	(1,800)	(1,800)	(1,800)	**(1,800)**
LPT CIP	Pay and Non Pay	LPT	Reconfiguration of rehabilitation service - beds shift from Mill Lodge to Stewart House	17	100	100	100	100	**100**
Benefit	Non Pay	CCG	Reduction in spend on alternative health placements. This is a phased reduction of 30% from 15/16 and a further 10% in 17/18	-	810	1,620	2,160	2,160	**2,160**
LPT CIP	Pay and Non Pay	LPT	Complex care reconfiguration	-	400	550	550	550	**550**
LPT CIP	Pay and Non Pay	LPT	Reconfiguration of Prison Healthcare	-	170	250	250	250	**250**
LPT CIP	Pay and Non Pay	LPT	Future SDI themes (primarily focussing on efficiencies that can be achieved through skill mix review)	-	-	-	1,000	2,000	**2,000**
LPT CIP	Pay and Non Pay	LPT	Management/administrative efficiencies	150	200	250	250	250	**250**
LPT CIP	Pay and Non Pay	LPT	Reduction in agency spend	870	1,020	1,170	1,170	1,170	**1,170**
LPT CIP	Pay and Non Pay	LPT	Notice served on loss making services	-	100	350	350	350	**350**
LPT CIP	Pay and Non Pay	LPT	Other smaller schemes	-	340	1,333	1,333	1,333	**1,333**
LPT CIP	Pay and Non Pay	LPT	TBC	-	-	-	1,250	2,500	**2,500**
Benefit	Pay	CCG	Reduce staffing costs within IAPT	-	100	100	100	100	**100**
Cost	Pay	CCG	Clinic at end of each day to see urgent patients - 8 clinics each consultant has 1 urgent session a week. A clinic every day across patch (one patch city, one patch county) 5 clinics across city and county per day for 1 hour per clinic b6 / b7 4 WTE from Jan 2015 . This development is required to support deflection of patients from CRHT to CMHTs and to ensure urgent respone is available i.e. within 24 hours	(38)	(150)	(150)	(150)	(150)	**(150)**
Benefit	TBC	TBC	Additional workstream productivity savings through new models of care to be developed	-	-	-	389	778	**778**
NET BENEFIT				**1,700**	**6,755**	**10,533**	**13,712**	**16,351**	**16,351**

The figures above/below represent both system-wide Mental health benefits and also plans within LPT's CIP programme. They have been displayed together to remove the possibility of double counting between both sources. £5.688m of these schemes are specifically attributable to the system-wide element of the workstream and these are:

• Implementation of Crisis House	£2.8m
• Reduction in alternative health placement spend	£2.16m
• Reduction of IAPT staffing costs	£0.1m
• Additional urgent response clinics	(£0.15m)
• Productivity through new models of care	£0.778m
Total	£5.688m

7.11 Appendix 11: Mental health – transitional costs

Transitional Costs

Capital/Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Revenue	Multi-site staffing dur	Pay	Double running to support inpatient bed closures.	0	240	240	0	0	**480**
Revenue	Multi-site staffing dur	Pay	Double running to support tranformational change in delivery of crisis house and step down beds.	0	200	0	0	0	**200**
Revenue		Pay	Develop case management service within LPT to speed up journey through pathway with some AHP patients repatriated into LLR and some services re-tendered. Resource heavy initially, with a reduction in requirements over 3 years.	0	109	163	82	27	**381**
Revenue		Pay	Introduce additional 3 consultants across LLR to include 9-5pm telephone advice line for GPs to deflect referrals from CRHT and to ensure appropriate response from LPT community services. This requires initial investment, with the requirement to reduce outside of the 5 year strategy due to improved knowledge across primary care.	83	330	248	0	0	**660**
Revenue		Pay	Development of Qlikview dashboards to monitor performance	11	11	0	0	0	**22**
Revenue		Pay and Non-pay	Social prescribing roll out across 60 LLR GPs, based on pilot at Hedges Medical Practice	0	25	25	100	150	**300**
Revenue			Co-ordination of 3rd sector and voluntary contacts across LLR to increase health system knowledge of services available	0	74	37	0	0	**111**
Revenue		Pay	Additional clinical capacity for one year to clear backlog due to static waiting lists - 3 x clinical psychologists reviewing caseloads, developing new interventions, change practice and reduce backlog.	0	227	0	0	0	**227**
Revenue			Psychological Wellbeing Practitioners for 6 months within IAPT to reduce waiting times and improve access rates where appropriate.	0	47	0	0	0	**47**
CAPITAL				0	0	0	0	0	0
REVENUE				94	1,262	713	182	177	2,428
TOTAL COSTS				**94**	**1,262**	**713**	**182**	**177**	**2,428**

7.12 Appendix 12: Learning disability – benefits

Workstream Title:	Learning Disability
Implementation Lead:	Yasmin Surti
Senior Responsible Officer:	Sandy McMillan
Workbook Finance Lead:	Richard George

Net benefits (Benefits-Recurrent costs)

Benefit /Cost	Cost Type (Pay/Non-Pay where relevant)	Organisation Benefitting/Incurring Cost	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Benefit	Non pay	CCGs	Review of high cost CHC packages for LD patients / service users. Based on a 5% reduction in expenditure, dependent on further analysis around actual packages of care being commissioned	-	380	760	760	760	760
Cost	Mixed		IT software - cost of license for care funding calculator tool	-	(4)	(4)	(4)	(4)	(4)
Benefit	Mixed	CCGs	Reconfiguration of short break services for LD patients / service users. Current service is reprovided during 2016/17, with full year effect being seen in 2016/17. Additional savings in 2017/18 are revenue. No capital implications have been included. Cost of reprovision of short breaks in the independent sector included, and phasing for LPT cost reduction - net health economy saving shown	-	-	385	769	969	969
Benefit	Mixed		Implementation of an Outreach Team which will reduce admissions to inpatient units for patients with LD. Savings released through reduced staffing requirements in inpatient unit and staff will be redeployed in other areas of the services	-	556	556	556	556	556
Cost	Mixed		Implementation of an Outreach Team to include 0.6 Psychiatrist, 1 OT, 0.5 SALT, 0.5 Psychologist, 4 nurses plus non pay costs.	-	-	(422)	(422)	(422)	(422)
NET BENEFIT				-	932	1,275	1,659	1,859	1,859

7.13 Appendix 13: Learning disability – transitional costs

Transitional Costs

Capital/Revenue	Cost category	Pay/Non-Pay	Description	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Revenue		Pay	Market Development: Project Officer to develop the Market Strategy and write the position statement	13	13	0	0	0	26
Revenue		Pay	Short Break Transformation: Project Officer to lead on C4the LD Short Breaks strategy/implementation	0	23	45	23	0	90
Revenue		Pay	Target Reassessment Team: Review Officers to review CHC packages and users of the Health Short Breaks Service. Resource for 2 years. External resource crucial to the success of reviews and changing culture within LLR	0	149	149	0	0	298
Revenue		Pay	Workforce Development officer to embed skills and learning to commission services in a new way	0	19	0	0	0	19
Revenue		Pay	LD Outreach Team - pump priming for first year to implement team which is then funded recurrently from savings	0	422	0	0	0	422
Revenue		Mix	Development of Safeguarding "Circle of Support": training and expenses for volunteer carers	0	30	30	30	30	120
Revenue		Mix	Stakeholder engagement - based on current costs	-	15	15	15	15	60
Revenue		Mix	Community Health Facilitator - VCS to support people with LD and carers	-	60	50	50	50	210
CAPITAL				0	0	0	0	0	0
REVENUE				13	731	289	118	95	1,245
TOTAL COSTS				13	731	289	118	95	1,245

7.14 Appendix 14: UHL

Workstream Title: UHL Transition costs

Transitional Costs

Cap/Rev	Title	Pay/Non-Pay	Description/rationale	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	Capital Programme	Non-pay	17 individual business cases in order to move from 3 sites to 2 (inc. professional fees)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
Revenue	Capital Charges	Non-Operating	Cumulative depn, cost of capital and interest charges prior to site disposal		**6,236**	**9,399**	**12,122**	**12,949**	**40,706**
Revenue	Deficit funding	Non-pay	Financing UHL's deficit	**40,700**	**36,100**	**34,300**	**33,300**	**30,800**	**175,200**
Revenue	PMO	Pay	PMO support in relation to the beds reconfiguration	-	**2,300**	**2,300**	**2,300**	**2,300**	**9,200**
Revenue	Transitional support	Pay	Support to UHL during the bed reconfiguration programme	-	**6,577**	**3,953**	**1,976**	**1,328**	**13,835**
Revenue	Transitional support	Pay	Specific posts to support service reconfiguration		**2,100**	**2,100**	**2,100**	**2,100**	**8,400**
Revenue	Premium Staffing	Pay	Costs of maintaining premium staffing to keep vacancies	-	**1,294**	**1,838**	**2,048**	**1,953**	**7,133**
Revenue	Redundancy spend	Pay	Redundancy costs	**1,200**	**1,200**	**2,290**	**2,290**	**2,290**	**9,270**
CAPITAL				**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
REVENUE				**41,900**	**55,807**	**56,180**	**56,136**	**53,720**	**263,744**
TOTAL COSTS				**53,923**	**142,728**	**148,552**	**140,670**	**64,191**	**550,065**

7.15 Appendix 15: UHL transition costs – assumptions

Capital programme assumptions:

1. The extent of service change requires £482m in capital expenditure at UHL over the 5 years of the strategy.
2. The CRL of £167.7m and an anticipated land sale of £28.4m reduces the external capital funding required to £286.3m. Land sale assumed to be in 2018/19 (due to lack of detailed capital plans from 2019/20 onwards this has been shown as an advance in 2018/19 for the purposes of the calculation). The capital receipt value has been based on current estimates to provide a basis for planning. It is anticipated that best value will be sought at time of disposal and, as such, the final value is likely to be subject to variation.
3. It is assumed that the UHL capital strategy will drive delivery of deficit reduction from a 2014-15 (yr 1) starting point of £40m deficit to a 2019-20 (yr 6) breakeven.
4. It is assumed that the capital costs include professional fees at 13-17% which include project management of the builds, architects, financial support, quantity surveying and equipment:

UHL net capital requirement	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL
	£k	£k	£k	£k	£k	£k
Capital requirement in year	46,530	120,221	125,672	117,834	72,121	482,378
Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	167,707
External capital requirement (gross)	12,023	86,921	92,372	84,534	38,821	314,671
Receipts	-	-	-	-	28,350	28,350
External capital requirement (net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**

Deficit support assumptions:

1. It is assumed that the savings resulting from reconfiguration from three to two acute sites would bring a further £30.8m per annum net recurrent savings, estimated to deliver in year 6. Site reconfiguration would move UHL to a surplus position by 2019/20.
2. Deficit funding requirements are based on latest UHL projections discussed with TDA in week beginning 6 October 2014.
3. The breakdown of the funding required is illustrated in the below table:

	March 2015 (£m)	March 2016 (£m)	March 2017 (£m)	March 2018 (£m)	March 2019 (£m)	Total (£m)
Revenue deficit	(40.7)	(36.1)	(34.3)	(33.3)	(30.8)	**(175.2)**
Improvement in liquidity	(5.3)	0.0	0.0	0.0	0.0	**(5.3)**
Deficit funding cash required	(46)	(36.1)	(34.3)	(33.3)	(30.8)	**(180.5)**
Capital expenditure	(46.5)	(120.2)	(125.7)	(117.8)	(72.1)	**(482.3)**
Total funding required	(92.5)	(156.3)	(160.0)	(151.1)	(102.9)	**(662.8)**
CRL / depreciation funding	34.5	33.3	33.3	33.3	33.3	**167.7**
Capital receipts	0.0	0.0	0.0	0.0	28.4	**28.4**
Cash funding requirement	**58.0**	**123.0**	**126.7**	**117.8**	**41.2**	**466.7**

Transitional capital charge assumptions:

The extent of increased capital charges, driven by transformational capital investment, has been calculated through comparison of UHL's 2013/14 baseline capital charges figure to future figures which include transformational capital investment. The results are shown below:

Year	13/14 Baseline (£m)	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	Total (£m)
Depreciation/Amortisation modelled	**31.24**	33.00	34.89	35.25	35.11	33.76	
Depreciation/Amortisation funding required vs 13/14			3.63	4.01	3.87	2.51	**14.02**
Interest Payable modelled	**0.1**	0.71	0.85	0.89	0.93	0.90	
Interest Payable funding required			0.75	0.79	0.84	0.81	**3.18**
PDC modelled	**10.39**	10.43	12.24	14.99	17.81	20.02	
PDC funding required			1.86	4.60	7.42	9.63	**23.50**
Total Capital Costs requiring funding			**6.24**	**9.40**	**12.12**	**12.95**	**40.71**

Only figures relating to 2015/16 onwards have been built into this appendix as 2014/15 revenue support has already been applied for by the trust.

Premium staffing assumptions:

This requirement represents the double running of service and levels of vacancy expected but not possible to fill with substantive employees until redeployment is complete. UHL have provided an assessment of the total proportion of vacancies likely to be affected.

The cover for these posts has been costed at the trust's average substantive cost of £40k inflated by an additional 50% to represent the agency premium incurred through utilising more costly agency staff:

Year	2015/16	2016/17	2017/18	2018/19	Total (£k)
% of workforce	0.2%	0.3%	0.35%	0.35%	
WTE	22	31	34	33	
Cost per WTE (£'000)	60	60	60	60	
Total (£'000)	**1,294**	**1,838**	**2,048**	**1,953**	**7,133**

PMO support assumptions:

1. It is assumed that the recent trend of support costs will continue with projected costs of £1.5m from 2015 onwards, totalling £6m for 4 years. This support is required generally to support internal transformation and the delivery of the beds programme
2. "Change agents" will be required by UHL to offer targeted support to ensure the bed shift occurs in a timely manner. It has been assumed that 20 staff would be needed at band 7 over four years.

Year	PMO support (£k)	Change agents (£k)
2015-16	1,500	800
2016-17	1,500	800
2017-18	1,500	800
2018-19	1,500	800
Total	6,000	3,200
		9,200

Support for transformation plan:

1. UHL transitional support to cover loss in income due to reduction in inpatient activity whilst costs are being taken out of the organisation.

2. The cost of one bed per annum is assumed to be £51k based on figures provided by UHL.
3. UHL have assumed that they will be able to reduce cost following each bed closure based on the following: 30% in year 1 (non-pay) and 28% in year 2 (pay) with remaining costs taken out over years 3 and 4.
4. It is estimated that the non-pay costs will be removed in the first year – no transitional funding to support this.
5. Given the significant agency spend it is assumed that transitional funding only available for first 2 years following bed closure.
6. Staff turnover assumed to be 10%, reducing extent of transition support required.
7. The pay cost element of the £51k per bed is around £36k (70%). Given the 10% turnover rate it is estimated that 10% of this cost, £3.5k can be taken out each year through natural turnover. Transitional support for one bed assumed to be as follows:

Year following bed closure	Pay cost remaining in UHL	UHL estimate on how quickly this cost can be taken out	Before taking into account staff turnover	Reduced through 10% turnover per year	Transitional support required
1	£36k	0 in year 1	0	(3.6)	£32.4k
2	£32.4k	28% of total	(£10k)	(3.6)	£18.8k
TOTAL per bed					**£51.2k**

8. UHL will only be seeking support for the year 1 element of £32.4k per bed and as such the total transitional funding related to beds reduction per year is shown below:

Year	No. of beds reduced (cumulative)	Transitional funding needed (£k)
2015/16	203	6,577
2016/17	122	3,953
2017/18	61	1,976
2018/19	41	1,328
Total	427	**13,835**

Redundancy:

1. 250 of the 462 are shifting from UHL to LPT. Given current vacancy and turnover rates it is assumed that nursing staff who do not move with the activity will not require redundancy. The shift of any clinical staff will be dependent on a period of consultation.
2. Due to the loss of activity it is assumed that corporate (back office) functions will shrink in line with the activity reductions. It is assumed that this would entail a redundancy/voluntary severance scheme (VSS) spend for corporate and A&C staff across the 5 year period.

3. Based on 150 staff over 5 years (total of 10,500 WTE) it is assumed that £6m will be needed over the 5 years, phased equally. This assumes an average band 7 pay with 12 years' service (based on corporate staff averages) resulting in £40k per staff member. This figure is an assumption based on 70 staff being made redundant in UHL in 2014/15.
4. Additional redundancy costs expected to be incurred through the EPR programme, an enabler to the beds reduction. As patient records move to an electronic format, meaning the need for medical records staff is diminished.
5. It is assumed that 50% of medical records staff will be made redundant and 50% redeployed. For the 50% that are made redundant assumed an average pay-out of 12 months resulting in the total redundancy spend.
6. The breakdown of the transitional support required is illustrated in the below table:

Element of transitions support	£k
Normal redundancy	6,000
EPR	3,270
Total	**9,270**

Service reconfiguration assumptions:

UHL have undertaken an assessment of the short term support to provide clinical and managerial leadership throughout the period of transformation. These posts are summarised below;

Backfill for service time	WTE	2015-16 (£'000)	2016-17 (£'000)	2017-18 (£'000)	2018-19 (£'000)	Grade
Consultant	2.8	364	364	364	364	Cons
GM support/backfill	2.8	215	215	215	215	8c
Project manager	7.0	536	536	536	536	8c
Matron	2.8	150	150	150	150	8a
Project support	3.5	126	126	126	126	6
GRAND TOTAL		**1,392**	**1,392**	**1,392**	**1,392**	

Reconfiguration team	WTE	2015-16 (£'000)	2016-17 (£'000)	2017-18 (£'000)	2018-19 (£'000)	Grade
Reconfiguration director	1.0	112	112	112	112	9
HR support	2.0	107	107	107	107	8a
Communications and engagement	1.0	43	43	43	43	7
Finance	2.0	107	107	107	107	8a
Estates & technical project manager	3.0	230	230	230	230	8c
Estates & technical project support	3.0	108	108	108	108	6
GRAND TOTAL		**708**	**708**	**708**	**708**	
OVERALL TOTAL		**2,100**	**2,100**	**2,100**	**2,100**	

7.16 Appendix 16: LPT

Workstream Title: LPT Transitional Funding

Transitional Costs

Cap/Rev	Title	Pay/Non-Pay	Description/rationale	14/15 (£'000) Total	15/16 (£'000) Total	16/17 (£'000) Total	17/18 (£'000) Total	18/19 (£'000) Total	Overall Total (£'000)
Capital	Estates changes	Non-Pay	Existing estates changes	-	3,744	8,908	25,836	42,224	80,712
Revenue	Estate transformatic	Non-operating	Increased capital charges		246	694	2,075	995	4,010
Capital	New estates	Non-Pay	Mill Lodge replacement and permanent CHAMs solution			1,484	13,000		14,484
Revenue	Transitional Costs	Non-Pay	Cost of external expertise		100	200			300
Revenue	Transitional Costs	Pay	Estimated agency staff premium during initial recruitment	-	537	537	972	-	2,046
Revenue	Transitional Costs	Pay	Double running costs and training	70	560	956	-	-	1,586
Revenue	Transitional Costs	Pay	PMO	61	246	246	246	-	799
Revenue	Transitional Costs	Pay	Redundancy	-	1,925	1,925	1,925	1,925	7,700
CAPITAL				-	3,744	10,392	38,836	42,224	95,196
REVENUE				131	3,614	4,558	5,218	2,920	16,441
TOTAL COSTS				131	7,358	14,950	44,054	45,144	111,637

7.17 Appendix 17: LPT transition costs – assumptions

Capital funding:

1. LPT have planned capital expenditure of £153.6m over the five years.
2. It is assumed that the capital resource limit (£58.3m) will be used to reduce the capital requirement from £153.6m to £95.2m.
3. Capital spend is broken down between new estates and changes to existing estates.

	2014/15 (£k)	2015/16 (£k)	2016/17 (£k)	2017/18 (£K)	2018/19 (£K)	TOTAL (£K)
Capital Requirement in year	14,636	14,652	23,000	48,944	52,332	153,564
Use of internal capital resource limit	(14,636)	(10,908)	(12,608)	(10,108)	(10,108)	(58,368)
External Capital Requirement (Net)	**0**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**

Note: The 2014/15 CRL includes capital receipts of £3.3m through sale of former Tower Hospital site

4. Existing estates will incur £80m, to be spent on LPT community hospitals. This number is based on estimates included in the Meant report produced for LPT, to which have been added an optimism bias of 36%. This is to provide assurance since the community hospital capital transformation programme has not reached the Guaranteed Maximum Price stage.
5. Optimism bias has been estimated at the top of the range stated by Treasury guidance given uncertainties surrounding availability of labour in the construction sector, the renegotiation of the P21plus and the lack of detail around current plans.
6. The Guaranteed Maximum Price for the new development for Mill Lodge has been provided by LPT.
7. The Guaranteed Maximum Price for CAMHS has been provided by LPT.

New Estates

Mill Lodge

Category	£k
Build Cost	3,500
Design fees	540
Risk / Prelims / Overhead & Profit	470
Furniture & Equipment	100
Total	**4,610**

CAMHs

Category	£k
Build Costs	7,200
Design Fees	1,330
Risk/Prelims /Overhead & Profit	1,114
Furniture and Equipment	200
Total	**9,844**

Existing Estates Changes

Estates transformation Step 1 to 6

Category	£k
Build Cost	43,323
Planning and Design fees	8,902
Risk / Prelims / Overhead & Profit **(Optimism Bias)**	21,364
Furniture & Equipment	7,121
Total	**80,712**

Revenue funding:

Estates transformation revenue:

1. These costs relate to the revenue consequences of capital expenditure, undertaken as part of transformational change and have been offset against LPT's predicted savings through site rationalisation:

	2014/15 (£k)	2015/16 (£k)	2016/17 (£k)	2017/18 (£K)	2018/19 (£K)	TOTAL (£K)T
Transformational Capital Requirement in year		3,744	10,392	38,836	42,224	
Cumulative transformational capital spend		3,744	14,136	49,228	81,060	
Capital charges assumed at 6.5%		246	919	3,200	5,269	9,631
Expected savings from Estate rationalisation and disposal of surplus properties			(225)	(1,125)	(4,274)	(5,624)
External Funding Requirement (Net)	**0**	**246**	**694**	**2,075**	**995**	**4,010**

Corporate professional fees to develop estates strategy:

2. Estates strategy in development sets out plans to reduce estate by 25% and 40% over 5 years.
3. External expertise is required to deliver the strategy. Broad estimates of funding are set out below:

Capital*/ Revenue	Pay / Non-Pay	14/15 (£K)	15/16 (£K)	16/17 (£K)	17/18 (£K)	18/19 (£K)	Total (£K)
Revenue	Pay	100	200	0	0	0	**300**

PMO support:

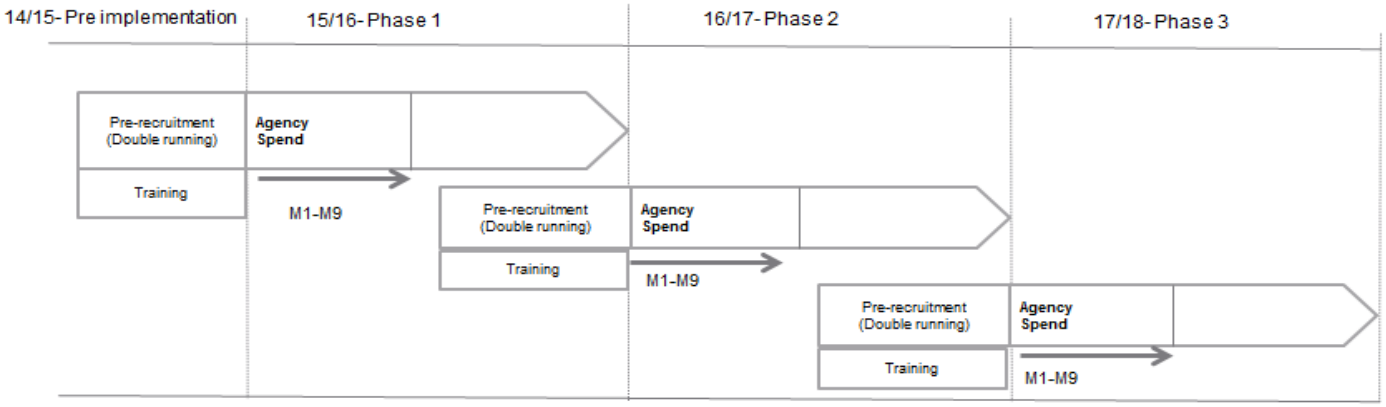
1. It is assumed that LPT will need PMO support funding for the cost that will be incurred to implement the left shift transformation.
2. A small in-house PMO team will be formed to oversee the left shift of beds.
3. The workings include projected cost of a workforce lead; beds shift project manager PMO support and a bed shift admin support. Bandings are as follows: Band 9, Band 8a, band 6 and Band 3 (assumed to cost as shown in the below table) and largely incurred over the three phases of the shift.

Position	Banding	Pre-Implementation 14/15 (£K)	Phase 1 15/16 (£K)	Phase 2 16/17 (£K)	Phase 3 17/18 (£K)	Total (£K)
Bed shift Workforce lead	Band 9	29.4	117.4	117.4	117.4	381.6
Bed shift Project Manager	Band 8a	14.1	56.2	56.2	56.2	182.7
PMO Support	Band 6	9.8	39.1	39.1	39.1	127
PMO Admin	Band 3	5.8	23.2	23.2	23.2	75.3
Non-Pay Costs		2.5	10	10	10	32.5
Total		**61.5**	**245.9**	**245.9**	**245.9**	**799.2**

4.

Beds programme:

1. LPT will need to increase staff numbers in the community to take on the new amount of activity and re-train/re-skill their existing staff in hospital to deal with a higher acuity of patient.
2. The 250 left shift will be phased as follows:
   - Phase 1, 60 beds to LPT community and 24 to LPT beds.
   - Phase 2, 60 beds to LPT community and 24 to LPT beds.
   - Phase 3, 130 beds to LPT community and 34 to LPT beds.
3. To deal with the transformation in service provision LPT will need 202 new WTE posts.
4. The flow diagram, comments and table below, outlines LPT bed left shift.
   - Pre implementation stage – financial year 2014/15



   - Phase 1:
     - Pre-recruitment/double running – 26 WTEs, with a mixed banding of between 2.5 and 6. The average spend will be £2.7k each per month which will cost £70k overall for a month.
     - Agency – 39 WTE which assumes that once the actual phase starts in the initial 9 months the other 50% of staff that could not be recruited substantially will cost an additional agency premium of 40% on top of the substantive cost.

Therefore agency cover will last 9 months over this phase, costing 537k. Agency assumed to then be subsequently covered by substantive staff.

- Phase 2:
  - Pre-recruitment/double running – 26 WTEs, with a mixed banding of between 2.5 and 6. The average spend will be £2.7k each per month which will cost £280k overall for 4 months.
  - Agency – 39 WTE which assumes that once the actual phase starts in the initial 9 months the other 50% of staff that could not be recruited substantially will cost an additional agency premium of 40% on top of the substantive cost. Therefore agency cover will last 9 months over this phase, costing 537k. Agency assumed to then be subsequently covered by substantive staff.
- Phase 3:
  - Pre-recruitment/double running – 49 WTEs, with a mixed banding of between 2.5 and 6. The average spend will be £2.7k each per month which will cost £396k overall for 3 months. This year has more WTE because pre-recruitment straddles financial years, and 2016/17 has 130 beds left shifting
  - Agency – 74 WTE which assumes that once the actual phase starts in the initial 9 months the other 50% of staff that could not be recruited substantially will cost an additional agency premium of 40% on top of the substantive cost. Therefore agency cover will last 9 months over this phase, costing 972k. Agency assumed to then be subsequently covered by substantive staff.
- Training: It is assumed that all 202 WTE new staff will require additional training during the three phases. This is assumed to be 1.5 months of non-productive time at the beginning of each phase, totalling £840k, which is £4.16k per employee (£2.7k a month).
- This transitional support is split by year below:

Transitional cost category	Pre-Implementation 14/15 (£K)	Phase 1 15/16 (£K)	Phase 2 16/17 (£K)	Phase 3 17/18 (£K)	Total (£k)
Double running	70	280	396		746
Agency spend		537	537	972	2,046
Training		280	560	0	840
Total	**70**	**1,097**	**1,493**	**972**	**3,632**

Redundancy:

1. Workforce efficiencies make a majority of LPTs efficiency schemes as pay makes up about 70-80% of LPT's cost base
2. Workforce reductions due to pay efficiencies are anticipated to continue in line with recent year spend. This cost has in the past been supported by transformation funds.
3. A 35 WTE annual reduction through redundancy, at an average redundancy cost of £55k (based on length of service estimates provided by LPT) has been assumed to 2018/19. The efficiencies will not affect front line staff needed for the 250 left shift but are assumed to impact on administrative staff and senior managers.

4. The breakdown of the cost is £1.9m a year between 2015/16 to 2018/19.

14/15 (£K)	15/16 (£K)	16/17 (£K)	17/18 (£K)	18/19 (£K)	Total (£K)
0	1,925	1,925	1,925	1,925	**7,700**

7.18 Appendix 18: Detailed capital breakdown

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Emergency floor LRI	3,100	27,100	10,000	-	-	**40,200**
	Reprovision of clinical services	7,800					
	Vascular GH	1,500	9,000	2,000	-	-	**12,500**
	OPDC hub GH (inc Womens' OP)	3,000	20,000	32,000	3,000	-	**58,000**
	Imaging GH	-	3,000	3,000	-	-	**6,000**
	MSCP LRI	-	4,000	-	-	-	**4,000**
	Childrens' cardiac GH	-	3,500	-	-	-	**3,500**
	Childrens' IP/OP LRI	-	-	3,000	4,000	9,000	**16,000**
	Outpatients LRI	-	-	-	3,000	2,000	**5,000**
	Inpatients LRI	1,500	2,000	8,000	10,000	2,000	**23,500**
	Theatres LRI	3,000	4,000	4,000	4,000	-	**15,000**
	Pathology GH	-	-	-	3,000	-	**3,000**
	Inpatients GH	-	6,000	9,000	15,000	-	**30,000**
	ITU LRI	500	-	-	14,000	2,000	**16,500**
	Maternity LRI	-	-	20,000	25,000	15,000	**60,000**
	LGH	1,000	-	4,000	4,000	-	**9,000**
	Entrance LRI	-	-	-	2,000	10,000	**12,000**
	EPR Programme	3,100	15,000	10,000			**28,100**
	IM&T (Excluding EPR)	8,300	5,050	2,500	2,000	2,000	**19,850**
	Other Projects	13,730	21,571	18,172	28,834	30,121	**112,428**
	Total Requirement	**46,530**	**120,221**	**125,672**	**117,834**	**72,121**	**482,378**
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	**167,707**
	External Capital Requirement (Gross)	**12,023**	**86,921**	**92,372**	**84,534**	**38,821**	**314,671**
	Receipts	-	-	-	-	28,350	**28,350**
	External Capital Requirement (Net)	**12,023**	**86,921**	**92,372**	**84,534**	**10,471**	**286,321**
LPT	Community Hospitals Estate Transformation: Step One	-	3,744	-	-	-	**3,744**
	Community Hospitals Estate Transformation: Step Two	-	-	1,976	-	-	**1,976**
	Community Hospitals Estate Transformation: Step Three	-	-	6,932	-	-	**6,932**
	Community Hospitals Estate Transformation: Step Four	-	-	-	25,836	-	**25,836**
	Community Hospitals Estate Transformation: Step Five	-	-	-	-	15,000	**15,000**
	Community Hospitals Estate Transformation: Step Six	-	-	-	-	27,224	**27,224**
	Permanent CAMHS Solution	-	-	884	9,000	-	**9,884**
	Mental Health Workstream: Mill Lodge Replacement	-	-	600	4,000	-	**4,600**
	Other Schemes	14,636	10,908	12,608	10,108	10,108	**58,368**
	Total Requirement	**14,636**	**14,652**	**23,000**	**48,944**	**52,332**	**153,564**
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	**58,368**
	External Capital Requirement (Gross)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
	Receipts	-	-	-	-	-	**-**
	External Capital Requirement (Net)	**-**	**3,744**	**10,392**	**38,836**	**42,224**	**95,196**
Primary Care	Total Requirement	**-**	**4,625**	**13,875**	**13,875**	**13,875**	**46,250**
Planned Care	Total Requirement	-	-	250	-	-	**250**
Urgent Care	Total Requirement	**-**	2,070	-	**-**	**-**	**2,070**
Long Term Conditions	Total Requirement	-	200	-	-	-	**200**
OVERALL	Total Requirement	**61,166**	**141,768**	**162,797**	**180,653**	**138,328**	**684,712**
	Combined CRL	49,143	44,208	45,908	43,408	43,408	**226,075**
	Combined Receipts	**0**	**0**	**0**	**0**	**28,350**	**28,350**
	External Capital Requirement (Net)	12,023	97,560	116,889	137,245	66,570	**430,287**

7.19 Appendix 19: NPC detailed BCT option

YEAR		14/15	15/16	16/17	17/18	18/19	19/20	20/21
QUARTER		Total	Total	Total	Total	Total	Total	Total
BENFITS		(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)
	Capital							
	Capital receipts	0	0	0	0	0	(28,350)	0
	Revenue							
	LTC Workstream	0	(255)	(847)	(591)	9	0	0
	FOP Workstream	0	0	0	0	0	0	0
	Children's Workstream	0	(55)	(245)	0	0	0	0
	LD Workstream	0	(932)	(341)	(384)	(200)	0	0
	Maternity & Neonatal Workstream	0	0	(378)	0	0	0	0
	MH Workstream	(680)	(2,936)	(1,295)	(389)	(389)	0	0
	Planned Care Workstream	0	(957)	(1,628)	(2,029)	(881)	0	0
	Urgent Care Workstream	0	295	(647)	(648)	0	0	0
	CIPs	(58,068)	(47,038)	(44,836)	(43,573)	(44,856)	(25,580)	(62,210)
	QIPP	(28,323)	(16,152)	(16,769)	(19,389)	(16,054)	(19,271)	(22,664)
	Bed reconfiguration	(1,102)	(3,148)	(3,253)	(1,947)	(1,570)	0	0
	UHL site running costs reduction	0	0	0	0	0	(23,200)	0
	Additional Efficiencies	246	(5,889)	1,564	3,094	(22,890)	0	0
	IT	0	(100)	0	0	0	0	0
	Estates	0	0	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
TOTAL BENEFITS		**(87,926)**	**(77,166)**	**(68,675)**	**(65,857)**	**(86,831)**	**(96,400)**	**(84,875)**
COSTS								
CAPITAL	UHL	12,023	86,921	92,372	84,534	10,471	0	0
	LPT	0	3,744	10,392	38,836	42,224	0	0
	Primary Care	0	4,625	13,875	13,875	13,875	0	0
	Urgent care Workstream	0	2,070	0	0	0	0	0
	Planned Care Workstream	0	0	250	0	0	0	0
	Long term conditions	0	200	0	0	0	0	0
	IT	0	0	0	0	0	0	0
	Estates	20	0	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
REVENUE								
Deficit funding	UHL	40,700	36,100	34,300	33,300	30,800	0	0
Beds reconfig (yr 1 only)	UHL		6,577	3,953	1,976	1,328		
Service reconfiguration	UHL		2,100	2,100	2,100	2,100		
Premium staffing	UHL		1,294	1,838	2,048	1,953		
PMO Support & Change Agents	UHL	0	2,300	2,300	2,300	2,300	0	0
	LPT General Transformation	70	1,097	1,493	972	0	0	0
	LPT PMO	61	246	246	246	0		
	LPT Prof Support	100	200	0	0	0	0	0
	Children's Workstream	0	172	100	50	0	0	0
	LD Workstream	13	731	289	118	95	0	0
	MH Workstream	94	1,262	713	182	177	0	0
	Planned Care Work stream	118	2,276	470	88	0	0	0
	Urgent Care Work Stream	0	0	0	0	0	0	0
	Maternity Work Stream	0	0	0	0	0	0	0
	Frail Older People Work Stream	0	0	0	0	0	0	0
	LTC Workstream	137	550	550	0	0	0	0
	IT	240	90	0	0	0	0	0
	Estates	126	254	224	224	224	0	0
	Workforce	0	272	222	0	0	0	0
Other	Administration costs	0	0	0	0	0	0	0
	CCG Primary Care Support	0	3,000	6,000	3,000	3,000	0	0
	Consultation Costs	0	200	200	100	100	0	0
	PMO Costs	1,539	997	997	997	997	0	0
TOTAL COSTS		**55,241**	**157,278**	**172,884**	**184,945**	**109,594**	**0**	**0**
NET BENEFITS		**(32,685)**	**80,112**	**104,209**	**119,088**	**22,763**	**(96,400)**	**(84,875)**
DCF		**0.97**	**0.93**	**0.90**	**0.87**	**0.84**	**0.81**	**0.79**
NPC		**(31,580)**	**74,785**	**93,990**	**103,778**	**19,166**	**(78,422)**	**(66,711)**

Overall Value	**115,007**

7.20 Appendix 20: NPC comparator option

YEAR		14/15	15/16	16/17	17/18	18/19	19/20	20/21
QUARTER		Total	Total	Total	Total	Total	Total	Total
BENFITS		(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)
	Capital							
	Capital receipts	0	0	0	0	0	(28,350)	0
	Revenue							
	LTC Workstream	0	0	(255)	(847)	(591)	9	0
	FOP Workstream	0	0	0	0	0	0	0
	Children's Workstream	0	0	(55)	(245)	0	0	0
	LD Workstream	0	0	(932)	(341)	(384)	(200)	0
	Maternity & Neonatal Workstream	0	0	0	(378)	0	0	0
	MH Workstream	0	(680)	(2,936)	(1,295)	(389)	(389)	0
	Planned Care Workstream	0	0	(957)	(1,628)	(2,029)	(881)	0
	Urgent Care Workstream	0	0	295	(647)	(648)	0	0
	CIPs	(58,068)	(47,038)	(44,836)	(43,573)	(44,856)	(25,580)	(62,210)
	QIPP	(28,323)	(16,152)	(16,769)	(19,389)	(16,054)	(19,271)	(22,664)
	Bed reconfiguration	0	(1,102)	(3,148)	(3,253)	(1,947)	(1,570)	0
	UHL site running costs reduction	0	0	0	0	0	0	(23,200)
	Additional Efficiencies	246	(5,889)	1,564	3,094	(22,890)	0	0
	IT	0	(100)	0	0	0	0	0
	Estates	0	0	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
TOTAL BENEFITS		(86,145)	(70,960)	(68,028)	(68,503)	(89,788)	(76,232)	(108,075)
COSTS								
CAPITAL	UHL	12,023	86,921	92,372	84,534	10,471	0	0
	LPT	0	3,744	10,392	38,836	42,224	0	0
	Primary Care	0	4,625	13,875	13,875	13,875	0	0
	Urgent Care Workstream	0	0	2,070	0	0	0	0
	Planned Care Workstream	0	0	0	250	0	0	0
	Long term conditions	0	0	200	0	0	0	0
	IT	0	0	0	0	0	0	0
	Estates	0	20	0	0	0	0	0
	Workforce	0	0	0	0	0	0	0
REVENUE								
Deficit funding	UHL	40,700	36,100	34,300	33,300	30,800	0	0
Beds reconfig (yr 1 only)	UHL		6,577	3,953	1,976	1,328		
Service reconfiguration	UHL		2,100	2,100	2,100	2,100		
Premium staffing	UHL		1,294	1,838	2,048	1,953		
PMO Support & Change Agents	UHL	0	2,300	2,300	2,300	2,300	0	0
	LPT General Transformation	70	1,097	1,493	972	0	0	0
	LPT PMO	61	246	246	246	0		
	LPT Prof Support	100	200	0	0	0	0	0
	Children's Workstream	0	172	100	50	0	0	0
	LD Workstream	13	731	289	118	95	0	0
	MH Workstream	94	1,262	713	182	177	0	0
	Planned Care Work stream	118	2,276	470	88	0	0	0
	Urgent Care Work Stream	0	0	0	0	0	0	0
	Maternity Work Stream	0	0	0	0	0	0	0
	Frail Older People Work Stream	0	0	0	0	0	0	0
	LTC Workstream	137	550	550	0	0	0	0
	IT	240	90	0	0	0	0	0
	Estates	126	254	224	224	224	0	0
	Workforce	0	272	222	0	0	0	0
Other	Administration costs	0	6,000	6,000	6,000	0	0	0
	CCG Primary Care Support	0	3,000	6,000	3,000	3,000	0	0
	Consultation Costs	0	200	200	100	100	0	0
	PMO Costs	1,539	997	997	997	997	0	0
TOTAL COSTS		55,221	161,028	180,904	191,195	109,594	0	0
NET BENEFITS		(30,924)	90,068	112,876	122,691	19,807	(76,232)	(108,075)
DCF		0.97	0.93	0.90	0.87	0.84	0.81	0.79
NPC		(29,878)	84,079	101,808	106,918	16,677	(62,014)	(84,946)

Overall Value	132,644

7.21 Appendix 21: BCT programme risk register - template

No	Date ID'd	Risk Description	Risk Owner	Assessment		Controls	Assessment		Review Date
				Likelihood	Impact		Likelihood	Impact	
Strategic Risks									
Clinical Risks									
Financial Risks									
People, Engagement and Leadership Risks									
Programme Management Risks									

Risk Scoring Matrix

Likelihood	Impact				
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	**2**	**3**	**4**	**5**

Risk Severity	
Score	**RAG**
20-25	RED
14-19	AMBER
8-13	YELLOW
1-7	GREEN

7.22 Appendix 22: Financial positions by organisation

The below figures detail the outputs of the original economic modelling work undertaken.

Current views on work stream delivery have been included within benefits breakdowns in the Economic and Financial cases but the tables below set out work stream plans as existed at the time of modelling. Once more detailed breakdowns exist of specific organisation level benefits of work streams the below tables can be updated.

Leicestershire and Lincolnshire AT - Q59

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	430.0	430.0	432.7	434.7	436.4
Revenue limit (non recurrent)	27.9	27.9	27.9	27.9	27.9
Acute services from activity model	(218.2)	(218.5)	(223.0)	(225.6)	(227.9)
Acute services Other	6.8	6.8	6.9	7.0	7.1
MH services from activity model	(7.1)	(7.2)	(7.3)	(7.4)	(7.5)
MH services Other	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Community services from activity model	-	-	-	-	-
Community services other	-	-	-	-	-
Continuing care services from activity model	-	-	-	-	-
Continuing care services other	-	-	-	-	-
Primary care services from activity model	-	-	-	-	-
Primary care services other	(203.3)	(204.5)	(205.8)	(207.0)	(208.2)
Other programme services from activity model	(24.4)	(24.5)	(25.0)	(25.3)	(25.5)
Other programme services other	(11.2)	(11.3)	(11.4)	(11.4)	(11.5)
Underlying surplus/(deficit)	**0.2**	**(1.5)**	**(5.1)**	**(7.3)**	**(9.5)**
QIPP	2.7	4.6	6.7	8.8	10.9
Surplus/(deficit) after projects	**2.9**	**3.1**	**1.5**	**1.5**	**1.4**

NHS East Leicestershire and Rutland CCG - 03W

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	327.3	342.2	353.4	363.4	371.7
Revenue limit (non recurrent)	3.0	3.3	3.5	3.6	3.7
Acute services from activity model	(152.0)	(148.7)	(151.9)	(153.6)	(155.4)
Acute services other	(11.1)	(11.1)	(11.3)	(11.4)	(11.6)
MH services from activity model	(18.7)	(18.7)	(19.1)	(19.3)	(19.5)
MH services other	(14.6)	(14.6)	(14.9)	(15.1)	(15.2)
Community services from activity model	(25.6)	(25.7)	(26.2)	(26.5)	(26.8)
Community services other	(14.6)	(14.6)	(14.9)	(15.1)	(15.3)
Continuing care services from activity model	0.0	0.0	0.0	0.0	0.0
Continuing care services other	(24.9)	(27.0)	(29.8)	(32.6)	(35.7)
Primary care services from activity model	0.0	0.0	0.0	0.0	0.0
Primary care services other	(54.8)	(59.1)	(63.7)	(68.7)	(74.2)
Other programme services from activity model	(6.7)	(6.7)	(6.9)	(7.0)	(7.1)
Other programme services other	(19.0)	(39.6)	(47.8)	(56.8)	(64.2)
Underlying surplus/(deficit)	**(11.7)**	**(20.3)**	**(29.7)**	**(39.3)**	**(49.5)**
Adjustment to investment plan	10.1	11.8	12.5	12.9	13.6
Revised surplus/(deficit)	**(1.6)**	**(8.4)**	**(17.2)**	**(26.4)**	**(35.9)**
Children's services workstream	0.0	0.0	0.0	0.0	0.0
Maternity and neonates workstream	0.0	0.1	0.1	0.1	0.1
LTC/FOP workstream	0.1	0.1	0.2	0.2	0.3
Planned care workstream	0.0	1.8	1.9	1.9	1.9
Urgent care workstream	0.0	0.0	1.1	1.1	1.2
MH workstream	0.0	1.7	1.8	1.8	1.8
LD workstream	0.0	0.0	0.3	0.4	0.4
Bed reconfiguration	0.3	1.3	2.3	2.8	3.1
New contracting models	0.0	0.0	0.0	0.0	4.2
QIPP	7.7	17.0	20.8	24.6	28.5
Surplus/(deficit) after projects	**6.5**	**13.6**	**11.3**	**6.5**	**5.6**

NHS Leicester City

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	392.1	409.3	417.2	425.0	433.0
Revenue limit (non recurrent)	7.6	7.6	4.2	4.2	4.3
Acute services from activity model	(171.7)	(167.3)	(170.1)	(171.7)	(173.0)
Acute services other	(10.3)	(10.3)	(10.5)	(10.6)	(10.7)
MH services from activity model	(38.4)	(38.3)	(38.9)	(39.3)	(39.6)
MH services other	(16.1)	(16.1)	(16.4)	(16.5)	(16.6)
Community services from activity model	(29.2)	(29.2)	(29.6)	(29.9)	(30.1)
Community services other	(3.8)	(3.8)	(3.8)	(3.9)	(3.9)
Continuing care services from activity model	0.0	0.0	0.0	0.0	0.0
Continuing care services other	(32.7)	(37.1)	(39.6)	(42.0)	(44.4)
Primary care services from activity model	0.0	0.0	0.0	0.0	0.0
Primary care services other	(59.7)	(63.3)	(67.8)	(72.6)	(77.8)
Other programme services from activity model	(16.1)	(16.1)	(16.3)	(16.5)	(16.6)
Other programme services other	(28.7)	(53.6)	(57.6)	(61.9)	(66.3)
Underlying surplus/(seficit)	**(7.2)**	**(18.2)**	**(29.3)**	**(35.6)**	**(41.6)**
Children's services workstream	0.0	0.0	0.0	0.0	0.0
Maternity and neonates workstream	0.0	0.1	0.1	0.1	0.1
LTC/FOP workstream	0.2	0.5	0.7	1.0	1.2
Planned care workstream	0.0	2.5	2.5	2.6	2.6
MH workstream	0.0	2.7	2.7	2.8	2.8
LD workstream	0.0	0.0	0.3	0.3	0.3
Bed reconfiguration	0.3	1.3	2.3	2.7	3.1
New contracting models	0.0	0.0	0.0	0.0	4.1
QIPP	11.8	20.1	24.6	29.1	33.7
Surplus/(deficit) after projects	**5.2**	**8.9**	**4.0**	**3.0**	**6.2**

NHS West Leicestershire

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Revenue limit (recurrent)	380.7	396.1	405.6	414.9	424.2
Revenue limit (non recurrent)	5.3	5.3	4.3	4.4	4.5
Acute services from activity model	(163.2)	(160.1)	(163.5)	(165.3)	(167.0)
Acute services other	(17.6)	(17.6)	(18.0)	(18.2)	(18.4)
MH services from activity model	(24.6)	(24.6)	(25.1)	(25.4)	(25.7)
MH services other	(16.6)	(16.6)	(16.9)	(17.1)	(17.3)
Community services from activity model	(31.6)	(31.6)	(32.3)	(32.6)	(33.0)
Community services other	(20.2)	(20.3)	(20.7)	(20.9)	(21.1)
Continuing care services from activity model	0.0	0.0	0.0	0.0	0.0
Continuing care services other	(28.2)	(29.9)	(32.4)	(34.7)	(37.2)
Primary care services from activity model	0.0	0.0	0.0	0.0	0.0
Primary care services other	(63.7)	(67.4)	(71.3)	(75.5)	(79.9)
Other programme services from activity model	(8.2)	(8.2)	(8.4)	(8.5)	(8.5)
Other programme services other	(17.0)	(34.6)	(39.5)	(47.8)	(56.6)
Underlying surplus/(deficit)	**(4.9)**	**(9.7)**	**(18.1)**	**(26.9)**	**(36.0)**
Children's services workstream	0.0	0.0	0.0	0.0	0.0
Maternity and neonates workstream	0.0	0.1	0.1	0.1	0.1
LTC/FOP workstream	0.1	0.1	0.2	0.3	0.3
Planned care workstream	0.0	1.5	1.6	1.6	1.6
Urgent care workstream	0.0	0.0	1.2	1.2	1.2
MH workstream	0.0	2.2	2.2	2.2	2.3
LD workstream	0.0	0.0	0.4	0.4	0.4
Bed reconfiguration	0.3	1.3	2.3	2.8	3.1
New contracting models	0.0	0.0	0.0	0.0	4.2
QIPP	9.4	8.5	14.2	22.6	27.2
Surplus/(deficit) after projects	**4.9**	**4.0**	**4.0**	**4.3**	**4.5**

Leicestershire Partnership NHS Trust

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Operating revenue from activity model	267.6	267.8	273.0	276.1	278.8
Operating revenue other	0.0	0.0	0.0	0.0	0.0
Operating expense – pay from activity model	(169.2)	(176.2)	(186.1)	(193.8)	(201.8)
Operating expense – pay other (excl PFI)	(36.7)	(37.6)	(39.1)	(40.1)	(41.1)
Operating expense – non-pay from activity model	(18.1)	(19.3)	(20.5)	(21.8)	(23.2)
Operating expense – non-pay other (excl PFI)	(41.2)	(43.2)	(45.3)	(47.4)	(49.7)
Operating expense (PFI)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)
EBITDA	**2.0**	**(8.9)**	**(18.4)**	**(27.6)**	**(37.6)**
Interest (excl PFI)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
Interest (PFI)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)
Depreciation and amortisation	(6.4)	(6.4)	(6.4)	(6.4)	(6.4)
PDC	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)
Underlying surplus/(deficit)	**(9.6)**	**(20.5)**	**(30.0)**	**(39.2)**	**(49.2)**
Children's services workstream	(0.0)	0.0	(0.0)	0.0	0.1
LD workstream	0.0	0.1	0.1	0.1	0.2
MH workstream	0.0	(1.6)	(1.5)	(1.3)	(1.1)
Bed reconfiguration	0.7	2.4	3.8	4.3	4.3
New contracting models	0.0	0.0	0.0	0.0	3.9
QIPP	(0.1)	(0.5)	(0.6)	(0.6)	(0.6)
CIPs	13.8	22.1	30.4	37.7	45.6
Surplus/(deficit) after projects	**4.7**	**2.0**	**2.1**	**1.0**	**3.1**

University Hospitals Leicester NHS Trust

Type	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Operating revenue from activity model	695.8	689.9	708.2	721.0	733.6
Operating revenue other	114.2	112.0	110.3	108.6	107.0
Operating expense – pay from activity model	(320.2)	(330.3)	(349.2)	(363.9)	(379.3)
Operating expense – pay other (excl PFI)	(200.0)	(205.1)	(213.5)	(218.8)	(224.3)
Operating expense – non-pay from activity model	(230.3)	(239.5)	(254.9)	(271.7)	(289.6)
Operating expense – non-pay other (excl PFI)	(97.9)	(102.6)	(107.5)	(112.7)	(118.1)
Operating expense (PFI)	0.0	0.0	0.0	0.0	0.0
EBITDA	**(38.4)**	**(75.5)**	**(106.7)**	**(137.6)**	**(170.7)**
Interest (excl PFI)	0.0	0.0	0.0	0.0	0.0
Interest (PFI)	0.0	0.0	0.0	0.0	0.0
Depreciation and amortisation	(31.0)	(31.0)	(31.0)	(31.0)	(31.0)
PDC	(10.7)	(10.7)	(10.7)	(10.7)	(10.7)
Underlying surplus/(deficit)	**(80.0)**	**(117.1)**	**(148.3)**	**(179.2)**	**(212.3)**
Children's services workstream	0.0	(0.0)	(0.0)	0.1	0.2
Maternity and neonates workstream	0.1	0.0	0.0	0.0	0.0
Planned care workstream	0.0	(0.5)	(0.5)	(0.6)	(0.6)
Urgent care workstream	0.0	0.0	(0.3)	(0.3)	(0.2)
LTC/FOP workstream	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Bed reconfiguration	(0.6)	(2.2)	(3.2)	(3.1)	(2.6)
QIPP	(3.1)	(5.2)	(4.5)	(3.8)	(3.0)
CIPs	44.3	83.0	119.6	155.8	192.8
Surplus/(deficit) after projects	**(39.4)**	**(42.1)**	**(37.4)**	**(31.2)**	**(25.9)**

Overall

	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)
Underlying surplus/(deficit)	**(113.2)**	**(187.3)**	**(260.6)**	**(327.5)**	**(398.1)**
Adjustment to investment plan	10.1	11.8	12.5	12.9	13.6
Revised surplus/(deficit)	**(103.1)**	**(175.5)**	**(248.1)**	**(314.6)**	**(384.5)**
Children's services workstream	(0.0)	(0.0)	0.0	0.2	0.3
LD workstream	0.0	0.1	1.1	1.2	1.2
MH workstream	0.0	4.9	5.2	5.4	5.7
Bed reconfiguration	1.1	4.2	7.5	9.4	11.0
QIPP	28.3	44.5	61.2	80.6	96.7
CIPs	58.1	105.1	149.9	193.5	238.4
Maternity and neonates workstream	0.1	0.2	0.2	0.2	0.2
Planned care workstream	0.0	5.4	5.4	5.5	5.5
Urgent care workstream	0.0	0.0	2.0	2.0	2.1
LTC/FOP workstream	0.3	0.6	1.0	1.3	1.7
NHS England	0.0	0.0	0.0	0.0	7.0
New contracting models	0.0	0.0	0.0	0.0	16.4
Surplus/(deficit) after projects	**(15.2)**	**(10.6)**	**(14.5)**	**(15.2)**	**1.8**

7.23 Appendix 23: Primary care appendix

Capital programme assumptions:

1. East Leicestershire and Rutland CCG estimates a total capital funding requirement of £29m, broken down as follows:
    a. £20m on 2/3 new hubs combining/merging up to 10/12 geographically adjacent practices in new large premises, which will include a wider range of diagnostics, specialist and community care.
    b. £1m on 3 hubs in existing premises, that require upgrading/development to maximise services available for a wider population.
    c. £2m on 2 hubs requiring expansion and development both within their surgeries due to population expansion, but also in adjacent community hospital development to provide a base for hub level services.
    d. £6m on 3 hubs requiring development of existing estate to enable the new methods of providing greater out of hospital care.
2. Leicester City CCG estimates that £8m will be required, made up of £2m for each of four planned Health Need Neighbourhoods.
3. West Leicestershire CCG estimates total capital funding required to be £9.25m, broken down as follows:
    a. £2.5m in Charnwood to support expansion of 3 high risk premises and consolidate services at Loughborough community hospital.
    b. £2m in South Charnwood to support expansion of 2 high risk premises.
    c. £2.75m in NWL to develop Coalville, expand Ashby Health Centre, support Whitwick and Coalville practices.
    d. £2.5m in H&B to consolidate current single handed practices to one site, expand Burbage and potential Hinckley health centre development.
4. Capital costs assumed to be 90% in years 3-5 and the remainder in year 2:

CCG	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL
	£k	£k	£k	£k	£k	£k
East Leicestershire and Rutland	0	2,900	8,700	8,700	8,700	**29,000**
Leicester City	0	800	2,400	2,400	2,400	**8,000**
West Leicestershire	0	925	2,775	2,775	2,775	**9,250**
Total	0	4,625	13,875	13,875	13,875	**46,250**

Revenue support assumptions:

1. CCGs are planning to increase recurrent spend in primary care services over the next four years as part of the move to increase capacity and treat more people in community and home settings. The plans anticipate increased nursing numbers whilst keeping GP numbers steady, with more staff in the community to help prevent the need for acute care.

2. This increase in recurrent expenditure is expected to take place during 2016/17 and 2017/18, with a period of double running in 2015/16 and 2016/17 to support this expansion during the period where new services models are being developed and collaborative working between GP practices is strengthened.
3. Transitional funding to support this programme is focussed on the non-recurrent revenue support CCGs will require to set up the new services and models of collaboration in the community before these systems are fully up to capacity. Specific costs have been developed by each CCG, which include:
    a. Education and training;
    b. IM&T improvements and alignment to support development of hubs;
    c. Management costs, including legal;
    d. New equipment;
    e. Time and motion studies to enhance the model.
4. Estimates from CCGs have been developed, however the health economy has taken a view that primary care should be in line with the funding to support other settings of care within the BCT programme, and therefore that around £3m per year (approx. 0.8% of the recurrent primary care budget across LLR) will be required during the double running period.
5. Individual assumptions from CCGs range from an estimate of £150,000 per hub per year for East Leicestershire and Rutland, to £600k per locality per year for the first two years in West Leicestershire, dropping to £400k per locality in the final two years.
6. The overall likely sums required have deliberately been spread between each of the three CCGs and therefore may not reflect exact spending over the four remaining years of the plan. Funding requirements have been weighted towards 2015/16 and 2016/17 based on likely recruitment and development timescales. Further details on exact spending patterns will be developed over the next six months.

CCG	2014/15	2015/16	2016/17	2017/18	2018/19	TOTAL
	£k	£k	£k	£k	£k	£k
East Leicestershire and Rutland	0	1,000	2,000	1,000	1,000	**5,000**
Leicester City	0	1,000	2,000	1,000	1,000	**5,000**
West Leicestershire	0	1,000	2,000	1,000	1,000	**5,000**
Total	0	3,000	6,000	3,000	3,000	**15,000**

7. The costs above will also include IM&T development costs, including £0.3m for Leicester City to increase access to virtual consultations and prepare systems for move to hub-based working. For West Leicestershire CCG IM&T costs are estimated as being £0.5m for all practices to move towards a single system, and a further £0.15m to increase access to virtual consultations.
8. A further £80k is set aside for an initial county wide estates audit, and any further primary care estates work will be assumed to be part of the £15m required.

Better care together

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

THE BETTER CARE TOGETHER PROGRAMME

PROGRAMME INITIATION DOCUMENT

02 December 2014

CONTENTS

Executive Summary

This Programme Initiation Document (PID) provides a single source of reference to quickly and easily find what the Better Care Together (BCT) Programme is about. BCT is a partnership of health and social care organisations across Leicester, Leicestershire and Rutland (LLR). The partnership conducts business through a BCT Partnership Board. The BCT Delivery Board will oversee the delivery of the Programme on behalf of the BCT Partnership Board. In June 2014, the Partnership Board set out its vision of health and social care services across LLR for the next five years. That vision has driven the formulation of 'Better Care Together: The Five-Year Strategic Plan 2014-2019'.

The BCT Programme is the strategic vehicle through which the five year strategy has been jointly developed with the Partnership Board. The Programme covers areas of work that cut across existing boundaries of health and social care provision, many areas of work being LLR or system-wide. This whole system change will require a new operating model of health and social care services across LLR. The new model, and the transition to it, requires extensive reconfiguration of our clinical service pathways and their supporting functions. The transition will re-orientate care from an emphasis on buildings to an emphasis on integrated health and social care services delivered closer to home or in the community.

The aim of the BCT Programme is to deliver the blueprint of a new operating model of integrated health and social care across LLR in order to realise the vision for the Programme by autumn 2019. The Programme initially consists of: eight clinical workstreams; five enabling groups; primary, community and social care; and finance. The Programme will be the vehicle for the alignment, coordination and delivery of those four large bodies of work.

The approach of the Programme will be based on the Five-Year Strategic Plan, direction from the BCT Partnership Board, and the Office of Government Commerce (OGC)'s guidance on best practice for the management of projects, programmes and portfolios. The main guidance that the Programme will follow will be that for managing successful programmes. It will be supplemented, where appropriate, by the OGC's guidance for managing portfolios of change. Underpinning successful delivery of the Programme will be a shared understanding of relevant terms. Managing the Programme will focus on a shared vision of the Programme's desired outcome, focussing on the benefits and the threats to realising them, coordinating the main bodies of work, and optimising the use of our resources.

The aim of the PID is to provide the authoritative definition of the BCT Programme that sets out the basis on which it is to be initiated, governed and delivered. The PID sets out the policy of the Partnership Board for the management of the Programme. The PID applies best practice for the management of programmes and portfolios to the LLR's circumstances and requirement. The Five-Year Strategic Plan 2014-2019, the 'wrapper' Strategic Outline Case and the PID are a suite of three complementary documents. The structure of the PID is: introduction; top level requirements; execution; supporting functions; resources; and appendices.

The PID will be reviewed annually by the BCT Partnership Board.

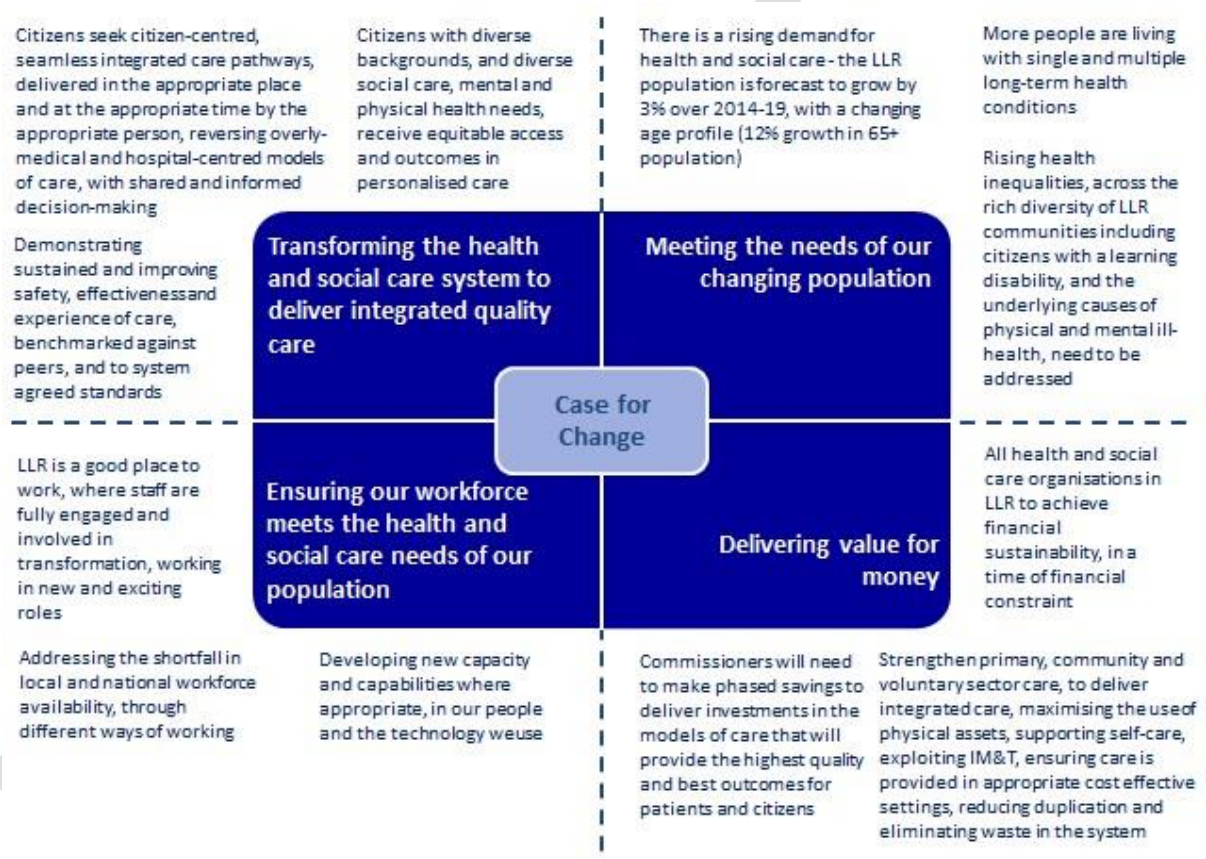
Introduction	
1.1	**Aim of the document** The aim of the Programme Initiation Document (PID) is to provide the authoritative definition of the BCT Programme that sets out the basis on which the Programme is to be initiated, governed and delivered. In doing so, the PID sets out the policy of the Partnership Board for the management of the BCT Programme. The PID provides the single source of reference for stakeholders to quickly and easily find what the Better Care Together (BCT) Programme is about.
1.2	**Purpose** The PID will be used as the benchmark by the Partnership Board to assess the success of the BCT Programme. The BCT Delivery Board is the board tasked with driving the Programme to deliver on behalf of the Partnership Board. The BCT Delivery Board will use the PID to review the continuing viability of the Programme. The PID will be reviewed annually by the Partnership Board, or more frequently if recommended to do so by the joint SROs of the BCT Programme. The PID is designed to be an 'enduring document' over the life of the BCT Programme. This is in contrast to the BCT Programme Plan which will need to adapt as circumstances change over the life of the Programme.
1.3	**Terminology** See Appendix 1 for a glossary of terms. The BCT Delivery Board approved the following definitions for the BCT Programme: • **Programme**: A management structure that coordinates, directs and oversees the implementation of a set of related projects and activities, in order to deliver outcomes and benefits of strategic importance to stakeholder organisations. • **Workstream**: A sub-programme of work beneath the BCT Programme. A workstream incorporates projects that contribute to the delivery of the Programme. • **Project**: A group tasked with the delivery of one or more outputs to a set quality, within time constraints and cost limits. The Project assists in the delivery of workstream objectives.

Top Level Requirements

2.1 **Case for Change and Background**

The Five Year Strategic Plan sets out the case for change in detail. It culminates in an understanding of the opportunities to redesign a sustainable local health and social care system around the future needs of patients. The work that led to this understanding was clinically led. The case for change was co-produced with the Patient and Public Involvement Reference Group.

The case for change is summarised in the diagram below.



To meet this need for change a vision has been shaped for LLR health and social care in 2019. This vision, and a plan to realise that vision, is set out in the June 2014 document, 'Better Care Together: The Five-Year Strategic Plan 2014-2019'.

The Strategic Plan is a directional plan setting out a system-wide solution for the provision of health and social care services across LLR.

Realising system-wide change will rely on five main management disciplines: clinical; financial; workforce; communications and engagement (including Patient and Public Involvement); and programme management.

2.2	**Stakeholders** The main stakeholder groups of the BCT Programme are: • patients, service users and their carers, including the voluntary and community sector; • the BCT Partnership's health and social care staff, practitioners and clinicians; • the wider public and communities; • political representatives, local government and regional administration; and • partner organisations in the BCT Partnership across LLR.
2.3	**Aim of the BCT Programme** The aim of the BCT Programme is to deliver the blueprint of a new operating model of integrated health and social care across LLR in order to realise the vision for the Programme by autumn 2019.
2.4	**Success Criteria** Successful management of the BCT Programme will be defined by: • a clear, commonly understood and shared vision of the Programme's desired outcome; • a focus on the benefits and the threats to delivering them; • effective coordination of multiple workstreams and projects, their interdependencies and aggregated risk; and • leadership and management of the transition to the desired outcome, including cultural change. These success criteria will be monitored by the Programme Director, supported by the BCT PMO. The criteria will be reflected in the Programme's performance management as it is developed and refined in the light of experience.

2.5	**Vision and Objectives**
2.5.1	**Vision** The Five-Year Strategic Plan sets out the vision for the LLR health and social care system as to 'maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring of safe, high quality services into the most efficient and effective settings.' For the BCT Programme, this vision can be broken down into three parts: • improved LLR citizens' health and wellbeing outcomes; • safe, high quality services restructured into the most efficient and effective settings; and • an enhanced quality of care and cost reduced to within allocated resources. Realising the vision will involve a shift in how and where health and social care will be delivered. This will see the following: • health and social care services becoming more integrated; • physical and mental healthcare becoming more integrated; • an expanded primary, community and social care offering reshaped to support more care closer to home; • acute care services provided from a smaller estate footprint, where services focus more on specialist care, teaching and research; • a shift in the emphasis of care from treatment to prevention; and • an overall health and social care estate reconfigured to be more effective. This has been collectively described as 'Left Shift' (Appendix 2) and will be subject to the appropriate public consultation processes. 'Left Shift' represents the necessary programmes of system-wide change. Together, they represent a new operating model for the delivery of health and social care services across LLR. The nature of the change means extensive reconfiguration of our clinical service pathways and supporting functions. It changes the orientation of care from an emphasis on buildings to one of integrated health and social care services delivered closer to home or in the community.

2.5.2	**Objectives** There are six strategic objectives. They are to: • deliver high quality, citizen-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital; • reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions; • increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings; • optimise the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost-effective settings, reducing duplication and eliminating waste in the system; • all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile when appropriate; and • improve the utilisation of our workforce and develop new capacity and capabilities where appropriate, in our people and the technology we use.
2.6	**Funding and Investment** A 'wrapper' SOC is being completed for November 2014. This will set out the case for external financial funding to support the total investment that will be required for the system change to take place. The SOC is expected to cover the following: • the Strategic Case – takes the case for change and explores why the proposed investment is necessary and how it fits the local and national strategy; • the Economic Case – considers and evaluates the value for money offered by the BCT solution against alternative solutions; • the Commercial Case – reviews different commercial arrangements to funding the Programme; • the Financial Case – asks whether the proposed investment is affordable and set out the requirement for non-recurrent funding; and • the Management Case – demonstrates that the proposed solution is deliverable.

2.7	**The Roles of the BCT Partnership Board and the Programme Management Office**
2.7.1	**The Role of the BCT Partnership Board** The BCT Partnership Board represents the partnership of health and social care organisations across LLR. The Partnership Board is the vehicle through which the partnership conducts business and through which the BCT Programme is directed. The Partnership Board is the conduit between the partner organisations and the Programme. The terms of reference of the BCT Partnership Board will be approved by partner organisations. The Partnership Board is ultimately accountable for the success of the BCT Programme. Its other responsibilities are detailed under 'Governance and Organisation' in Section 3.2.2. The Partnership Board recognises that its confidence in the BCT Programme being successfully delivered will be increased by there being a supportive LLR environment for the Programme. The Board will play its part in achieving this supportive environment by promoting the principles of: • good leadership at all levels, paying adequate attention to the cultural factors in leading clinical and non-clinical staff through transformative change to adopt different ways of working; • good communication inside and outside the Programme; • balancing the requirements of current operations ('business as usual') with those of change; and • good engagement with the Programme's external stakeholders. The Partnership Board recognises that the BCT Programme may need to change significantly over its five year life, whereas the vision is not expected to change. Therefore, our success in realising the vision for the Programme will depend on the Delivery Board's ability to adjust the Programme Plan to meet the reality of present circumstances, especially threats and opportunities. The BCT Programme will need to be agile. The Partnership Board will support the joint SROs of the BCT Programme in cultivating the agility of the Programme. Agility comprises responsiveness, flexibility and adaptability. • Responsiveness will enable the Programme to respond to a change in the Partnership environment or the wider political, economic, social, technological or legal environment. The responsiveness of the Programme will have important links to good information management, clear accountability and effective communication up and down the line management chain. • Flexibility will enable the Programme to overcome the unexpected and avoid failure. It will do this by keeping options open as long as possible and by avoiding a course of action that becomes unviable as circumstances change. The flexibility of the Programme will have important links to Programme planning, benefits realisation and risk management. • Adaptability will enable the Programme to recognise the arrival of new circumstances, especially unexpected ones, and to recognise the need to change or reconfigure the Programme's organisation, processes, plan or priorities.

2.7.2	**The Role of the Programme Management Office (PMO)** The PMO will be a central office that coordinates the Programme on behalf of the partner organisations. Across the Programme, it will plan and control work, track and communicate progress, facilitate benefits realisation and risk management, and optimise our use of resource. The PMO will have four core roles. They will be to: • be the information hub of the Programme; • establish and maintain programme management processes and set standards; • give decision support to the Programme Director and BCT Delivery Board; and • establish programme processes, conduct performance management of programme delivery, and promote best practice in programme, workstream, project and risk management. The PMO will carry out the functions of: coordination and integration; information management; strategic alignment, planning and interdependencies; progress monitoring, reporting and forecasting; communications and stakeholder engagement; benefits management; risk management and issue resolution; business cases and investment appraisal; programme budget; change control; version control; and secretarial support to the BCT Implementation Group and the BCT Delivery and LLR Partnership Boards.

Execution	
3.1	**Approach** The approach of the BCT Programme will be based on: the Five-Year Strategic Plan endorsed by the LLR health and social care partners; direction from the BCT Partnership Board; and the Office of Government Commerce (OGC) guidance for the successful management of projects, programmes and portfolios. The BCT Programme will be successfully delivered by following the OGC's guidance for managing successful programmes and, where appropriate, managing portfolios of change. The Programme will follow the principles, governance themes and processes of programme management. For appropriate aspects of system-wide coordination, synchronisation and decision-making, the PMO, Delivery Board and Partnership Board will use the OGC's guidance for portfolio management on the cycles of portfolio definition and portfolio delivery, linked by organisational energy, and on how to sustain progress. Underpinning successful delivery at the workstream, programme and portfolio levels will be a shared, consistent understanding of the terminology of project, programme, portfolio and risk management.
3.2	**Governance and Organisation**
3.2.1	**Governance** The LLR partner organisations own the BCT Programme. The levels of accountability are: • the partner organisations; • the LLR Partnership Board; • the BCT Delivery Board; • the BCT Implementation Group; • Clinical Workstreams and Enabling Groups; and • projects and project team staff. The Terms of Reference of the LLR Partnership Board, BCT Delivery Board and BCT Implementation Group will be aligned. The LLR Partnership Board will be ultimately accountable for the success of the Programme. It will recommend the investment in the BCT Programme to partner organisation boards, cabinets and Executives. The LLR Partnership Board will ensure that the BCT Programme has adequate risk management and assurance processes in place. The BCT Delivery Board will oversee the delivery of the Programme on behalf of the Partnership Board. The joint SROs will chair the Delivery Board and will ensure that the Programme realises the vision and achieves its objectives. The joint SROs will direct the Programme Director. The PMO will carry out its four core roles (Section 2.7.2) across all the levels of accountability above, except for partner organisations.

3.2.2 **Organisation**

A summary of the responsibilities of the key roles in the BCT Programme is as follows.

Role	Responsibility
LLR Partnership Board	Ultimately accountable for the success of the Programme. Recommending the investment in the BCT Programme to partner organisation boards, cabinets and Executives. Ensuring the Programme remains aligned to LLR strategy. Directing the BCT Delivery Board through the joint SROs. Ensuring the Programme remains worthwhile and viable. Representing and promoting the Programme. Authorising the closure of the Programme.
Chief Officers	Leading their staff through the turbulence and emotion of transformative change. Delivering the BCT Programme outcomes within their organisations. Supporting the Chair of the Partnership Board in providing a supportive LLR environment for the BCT Programme.
Joint SROs	Ensuring the Programme realises the vision and achieves its objectives. Directing the Programme, through the Programme Director.
BCT Delivery Board	Supporting the joint SROs. Driving the Programme forward to deliver the changes and benefits required to achieve the Programme's objectives. Ensuring that Programme planning and control is satisfactory. Authorising the Programme Director to progress to the next stage. Obtaining adequate external assurance. Monitoring and, if necessary, correcting the progress of the Programme.
Programme Director	Managing the Programme, day-to-day, on behalf of the Delivery Board Leading Programme staff.
Chief Financial Officers	Planning and managing financial aspects of the system-wide change to a new operating model of health and social care.
Partner Organisations	Committing resource. Maintaining delivery of routine services while delivering change. Through the workstreams and projects: • delivering the changes required by the Programme; • realising the benefits from the changes; • incorporating the benefits into their new routine services.
Clinical Workstreams and Enabling Groups	Planning and delivering the changes in their area of responsibility that will yield the benefits required for the Programme to achieve the six system objectives (Section 2.5.2).
Political, Clinical and PPI Reference Groups, other stakeholder fora and User Groups	Engaging with and supporting the LLR Case for Change, providing assurance and user input to help the Programme deliver successfully and meet user needs and expectations.
The PMO	Providing control of the Programme to the Programme Director. Facilitating successful delivery of the Programme by coordinating and synchronising Programme resources, work and achievement of objectives. Establishing processes, setting standards and promoting best practice.

Responsibilities in managing the BCT Programme, by role and process, are shown in Appendix 3.

The organisational structure of the BCT Programme is set out in Appendix 4. The structure reflects the main areas of work:

- primary, community and social care;
- the clinical service workstreams;
- the enabling groups; and
- finance.

3.3 **Programme Processes and Stages**

Processes. The BCT Programme will follow the OGC guidance for managing successful programmes. This guidance sets out the 'Transformational Flow' that defines the lifecycle of a programme. This transformational flow is a sequence of processes. It is the programme journey. There is a close relation between the processes in the transformational flow and the governance themes. The BCT Programme's processes will be:

- identifying the Programme;
- defining the Programme;
- managing the Stages:
  - delivering the new operating model of health and social care;
  - realising the benefits of the new operating model;
- closing the Programme.

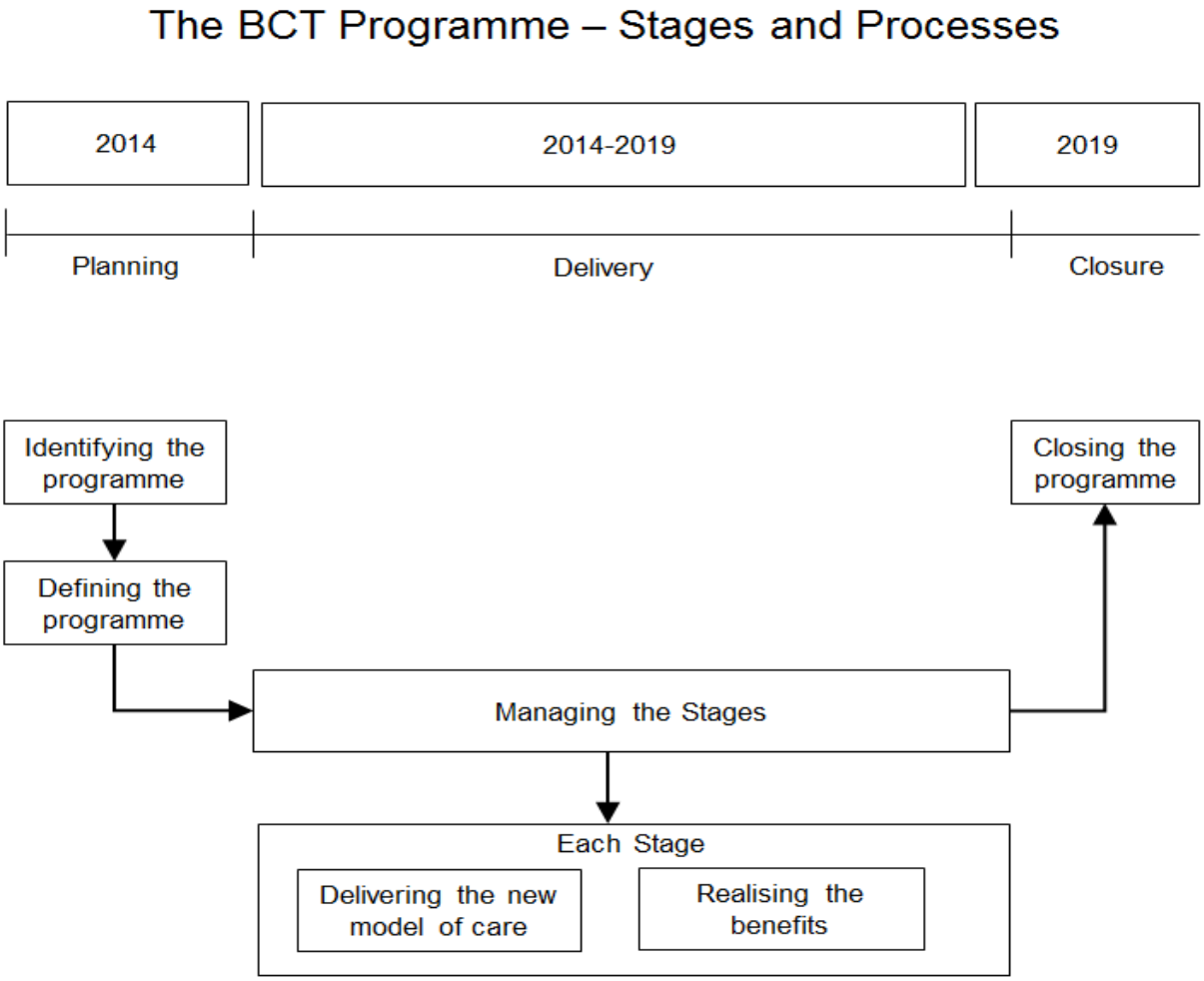
Stages. Delivery of the BCT Programme will be split into Stages. The end of each Stage will be a major review point for the Partnership Board. The start of a new Stage will be a step change in the transition to the new LLR model of health and social care. The Programme Director will present their End of Stage Report and a detailed plan for the next Stage of the Programme to the BCT Delivery Board for its approval. Before giving its approval, the BCT Delivery Board will satisfy itself that the changes planned in the current stage, and the benefits from those changes, have been successfully delivered, and that the plan for the next Stage is sufficient and realistic. Once the Delivery Board has approved progression to the next Stage, the joint SROs will seek the approval of the Partnership Board.

Processes and Stages. The processes in the Programme are expected to be spread over six to eight stages, as follows.

Process	Time	Output
Programme Identification	Apr - Jul 2014	Five Year Strategic Plan
Programme Definition	Aug - Dec 2014	PID, SOC and Programme Plan for Oct 2014 – Mar 2015
Programme Delivery – 3 to 5 stages (TBC in further planning)	Jan 2015 - Feb 2019 (TBC)	Major programme changes and the benefits from the changes
Programme Closure	Mar - Oct 2019 (TBC)	Programme Closure

The Programme Plan to move from the Programme Definition process to the first Delivery Stage over October 2014 - March 2015 is shown in Appendix 5. The first Delivery stage will start in January 2015.

Planning the Programme's Delivery stages between Mar 2015 - Feb 2019 has been started as part of the Strategic Outline Case. Further detailed planning will be conducted over this winter. This planning is expected to be split into three broad areas: deciding the timing of each Programme Delivery stage in line with major step-changes in the partnership's transition to the new model of care; planning the next Delivery stage in detail; and planning the following Delivery stage in outline. The broad timing of the Programme's stages and processes is shown in the following diagram.



3.4 **Planning and Control**

Programme planning and control will be central to successful delivery of the BCT Programme. Planning and control will be treated as complementary functions that depend upon each other for their effect; successful delivery needs them both. Planning and control will both be supported by performance management, which will look at the past, present and future performance of the Programme. Performance management will measure, manage and communicate actual and forecast performance against planned performance and the metrics of success.

Responsibility for planning and control will be held by the PMO, under the direction of the Programme Director. The Programme Director will manage, on behalf of the Delivery Board, the realisation of benefits, the management of risk, and the use of resources across the BCT Programme as a whole.

	The PMO will coordinate, synchronise and align work to achieve the benefits desired from each Stage of the Programme.
3.4.1	**Programme Planning** The BCT Delivery Board is to recognise the key distinction between plans and planning. The plan may change but the planning process will remain essential. The Programme Plan will be a product. Programme planning will be the process that produces the Programme Plan. The role of programme planning will be to: • gather, understand and assess large amounts of information; • consult extensively with subject matter experts and key stakeholders; and • build, maintain and adjust the Programme Plan to deliver success however circumstances change over the life of the Programme. To build and maintain the Programme Plan, the planning process will be to work backwards from the vision for the Programme (Section 2.5.1) and the new operating model of care (Appendix 2). In outline, Programme planning will analyse the blueprint of the new model of health and social care, will identify the changes necessary to realise it, plot the sequence in which those changes will best be achieved, and identify the work necessary to achieve those changes. The Programme Plan will: • provide authoritative clarity on the outcome of the Programme – the vision to be realised; • show the route, or journey, for the partnership to change from the present to the 2019 vision, including the schedule for the main step-changes in the transition and how the step-changes are to be linked together; • show the main bodies of work, and the resourcing, timescale, outputs/outcomes and dependencies of each. These main bodies of work may include not only clinical workstreams and enabling groups but also the migration of infrastructure, culture and organisational development and working practices to more integrated health (physical and mental) and social care; • anticipate the most likely and damaging sources of 'friction' (what may throw the Plan off-course) by considering the major assumptions, risks, control points and contingency measures that may affect the achievement of the Plan; • show how work and the Programme-wide allocation of resources are to be coordinated and directed across time and benefits/outcomes; and • show how the Plan will be reviewed and adjusted in the light of changing circumstances. The Programme Plan is to be realistic (resourced and practicable), timely and understood by those who will play key roles in executing it. The Plan is to command the confidence of those who will execute it. As illustration, and subject to more detailed programme planning, the link between the main activities of the BCT Programme and realising the vision for the Programme is shown at Appendix 6.

3.4.2 **Programme Control and the Use of Business Cases**

Programme Control. The BCT Delivery Board will apply programme controls outside and inside execution of the Programme.

Outside execution of the Programme, the Delivery Board will observe the controls of:

- legislation, relevant regulations and endorsed standards;
- OGC best practice for the management of projects, programmes and portfolios of change; and
- LLR partnership and BCT Programme governance arrangements, including assurance.

Inside execution of the Programme, the Delivery Board will use the controls of:

- programme planning, the Programme Plan and criteria for prioritising work and allocating resource, Programme-wide;
- the use of business cases to control new work being added to the Programme: whether that work should be started, continued or stopped (this is covered in 'The Use of Business Cases' sub-section below);
- the information management and performance management function, including reporting, monitoring and forecasting;
- reviewing the three topics of benefits realisation, risk management and allocation of resource as standing items for the BCT Delivery Board and the Partnership Board;
- the Change Control function, using Requests For Change (Section 4.7); and
- End of Stage reports by the Programme Director when seeking the Delivery Board's 'permission to proceed' to the next Programme Stage.

LLR partner organisations, public and patient groups have agreed the criteria by which work across the BCT Programme will be prioritised and resource allocated. The criteria will be:

- business needs, or its criticality to realising the new operating model;
- strategic fit in the Programme – does it: enable; provide mutual support; or achieve synergy?;
- Return On Investment and Value For Money - how quickly and how much will savings be realised or quality be improved, or the cost-benefit balance;
- affordability and achievability within the allocated time, resources and circumstances;
- impact on clinical quality – the six dimensions of high quality care (Section 4.5.2); and
- impact on access – the ease with which the patient uses the health or social care service, including: choice and speed of communication; transport; opening times and availability; language; gender; and cultural factors.

For programme control purposes, any addition to the BCT Programme will be either a workstream or a project. The first step in proposing any such new work to join the Programme will be to write a Mandate or Brief. A Brief will outline what the work is to do and its context, output, timeframe and cost. To be adopted as part of the BCT Programme, the Brief has to receive approval in principle by the BCT Delivery Board. The Brief will be sent to the PMO for information, central coordination and preparation for the Delivery Board. Once the Brief has been approved it is likely that the planning for the workstream/ project will be further developed. In due course, the Delivery Board will recommend to the Partnership Board the further process for the workstream/ project to seek full approval.

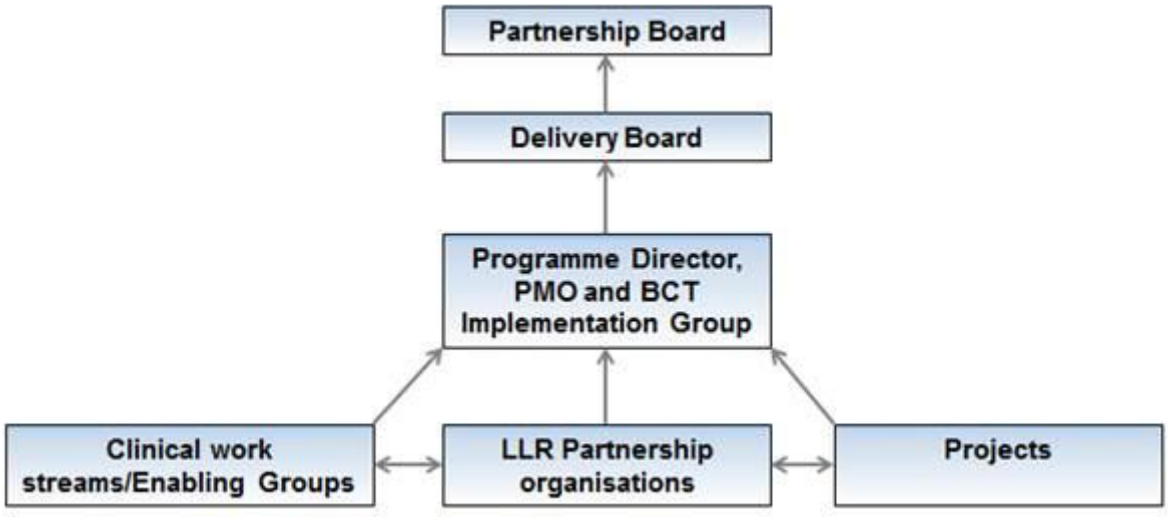
The Use of Business Cases. A business case is the justification for starting or continuing the work, whether it is a project, workstream or programme. The business case will make the case for the validity and viability of the work and the investment of resource. It will be used to assess the merit of any proposed addition to the BCT Programme and its value relative to other uses of that resource. Change to work already part of the Programme will be assessed and controlled through the Change Control function (Section 4.7).

There will be three types of business case used, depending upon the financial cost of the proposed work and its impact on the whole Programme. The types of business case will be a Request For Funding (RFF), an Outline Business Case (OBC) and a Full Business Case (FBC). The difference between them is in the number of elements of the Treasury's 'Green Book' that are to be completed and in the degree of detail they contain. A summary is below.

Use of Business Cases for Workstreams and Projects in the BCT Programme							
Value of work (draft)	**Type of Business Case**	**The Treasury's 'Green Book' 5 Case Model**					**Comment**
		Strategic	**Economic**	**Commercial**	**Financial**	**Management**	
£0-£250k	RFF	Yes	No	No	Yes	Yes	Subject to Delivery and Partnership Board direction
£250-£500k	OBC	In outline	In outline	In outline	In outline	In outline	
Over £500k	OBC and FBC	In detail	In detail	In detail	In detail	In detail	

The detail of the format of an RFF, OBC and FBC, any distinction between revenue and capital, and any other necessary governance arrangements will be resolved by the PMO in consultation with relevant parties. Until the RFF, OBC or FBC is approved, there is no authority to conduct the work or use any resource. Once a project has had its RFF approved, it can move from 'Starting Up' the project to 'Initiating' the project. Whichever type of business case is written, it will specify and appraise the balance of advantage in conducting and resourcing the work, taking account of the criteria set out in the 'Programme Control' sub-section above, what new risks would have to be managed or existing risks would be compounded.

The relation between the business case and planning will be as follows. An outline plan will be included, in progressively greater detail, in the RFF, OBC or FBC respectively. Once the work has been approved, more detailed planning will be done, both for the work as a whole (such as a project plan) and for the next stage of the work (such as a stage plan). Throughout the life of the work, the business case will be maintained and updated, often in End Stage Assessments, and the plans will be adjusted to take account of changes in the Programme or partnership environment, changing higher level priorities, changing levels of resource or developing threats and opportunities.

	Consistent, rigorous and appropriate use of business cases by the Delivery Board will: • guard against the BCT Programme starting and resourcing workstreams or projects that do not make a net contribution to achieving the Programme's objectives; • provide an objective scrutiny of a workstream or project that may be a personal enthusiasm; • put the workstream or project on a defined basis and will promote a shared understanding of what it is for, what is in and out of its scope, what it will cost and when it will end; • produce the optimum balance of benefits, costs, timescale and risks; • guard against scope-creep of the workstream or project, once it has been approved; and will • facilitate the objective assessment of the work's value to the BCT Programme relative to other workstreams or projects, thus helping to optimise use of the Programme's resources. Throughout the life of the project, workstream or BCT Programme, the business case for it will need to be continually maintained and updated. If the business case becomes no longer valid, the Delivery Board or workstream SRO must stop the work, close the workstream or project and release the resource.
3.5	**The Core Escalation Mechanism** In delivering the Programme, the Delivery Board will oversee a core escalation mechanism for: information and performance management; benefits realisation; risk management and issue resolution; quality (programme management and clinical quality); and change control. The escalation mechanism will be as follows. 

3.6	**Learning From Experience** The Programme will continually seek to learn lessons in how it can improve its own performance and how it can find opportunities to realise benefits. The PMO is to be the custodian, focus and disseminator of lessons learned throughout the BCT Programme. This dovetails with the PMO's roles in being the information hub of the Programme and in setting standards for the Programme. The Partnership Board will cascade good leadership throughout the Programme to create a climate conducive to the good two-way communication that facilitates learning from experience. As part of the Programme Closure Stage, the Partnership Board will arrange for a Post Implementation Review (PIR) of the Programme. The PIR will assess the benefits delivered by the Programme and how well the partnership has learned from experience during and after the Programme. The PIR may be conducted as part of a larger OGC Gateway Review.

Supporting Functions

4.1 **Information and Performance Management**

Performance management will depend upon information management and much of the value of good information will be in enabling performance management. The Delivery Board will use performance management in a proactive way to make it easy for the programme's workstreams to deliver the desired outcomes and deliver their outputs to time, cost and quality.

Information Management. The BCT Programme will follow three principles for successful information management. It will:

- create and maintain a 'single version of the truth' to engage the BCT Programme's large number of stakeholders and to coordinate and manage its wide range of activity;
- obtain enough relevant information, and make it available, to manage progress, realise benefits, control risk and make optimum use of our resources – this is the heart of programme management; and
- regulate the volume and flow of information so that it is adequate to control the Programme and to manage quality without the Programme 'drowning in data'.

Those principles will be applied through the PMO in partnership with the other key stakeholders of information management, notably information from BCT partner organisations. Through this coordinated approach, the PMO will be the information hub of the Programme.

On behalf of the Programme Director, the PMO will be responsible for meeting the information requirement to direct, plan and control the Programme. In certain circumstances this may also involve the PMO stating what information is required.

Performance Management. The role of performance management will be to turn information into business intelligence in order to inform decisions by the Programme Director and Delivery Board. Performance management is the function that turns:

- information into business intelligence;
- business intelligence into informed decisions;
- informed decisions into effective action;
- effective action into learning from experience and increased capability.

Performance management will look at the past, present and future. One of its key functions is to forecast future performance and give warning if performance is forecast to fall below that required for the Programme. The Delivery Board will direct the Programme Director to develop a performance management capability that:

- measures, manages and communicates past, present and future performance;
- progressively improves the accuracy of forecast performance;
- promotes a common sense of purpose and working together across the partnership;

	• accurately understands and shows the cause and effect relation of the metrics of programme success and what will lead to success; an example is the relation between the success criteria (Section 2.4) and the six strategic objectives (Section 2.5.2). • promotes accelerated action to rectify shortfalls in performance or forecast shortfalls; and • encourages learning from experience throughout the life of the Programme.
4.2	**Communications and Stakeholder Engagement** Effective communications and engagement will be necessary to ensure understanding of the need for radical change by stakeholders, including patients, service users, carers and the staff delivering services. Our communications and engagement activity is to comply with formal consultation processes, any other mandatory requirements and the Four Tests set out in the 2014/15 Mandate by the Government. The Four Tests are that proposed service changes should be able to demonstrate evidence of: *"strong public and patient engagement; consistency with current and prospective need for patient choice; a clear clinical evidence base; and support for proposals from clinical commissioners."* LLR Partnership lead communicators will develop a strategic plan to ensure delivery of consistent 'best practice' communications and engagement. This will be a 'Marketing, Communications and Engagement Plan', which will be reviewed by Healthwatch and the PPI Reference Group. The objectives of the Plan are to: • raise awareness and understanding of the BCT Programme and its work; • increase public and political acceptance of the need for radical service change; • manage and mitigate any reputational risks arising from the BCT Programme; • respond consistently across the LLR economy to requests for information about the Programme; • ensure all key stakeholders are fully engaged and informed at an appropriate level; • create advocates for the BCT Programme across the LLR economy; • ensure and demonstrate meaningful patient and public involvement in the BCT Programme; • provide suitable reassurance to NHS England and other agencies that the Programme has conducted the right level and quality of communications and engagement; and • plan and implement effective public consultation as required, supporting the successful implementation of proposed service change. The Programme's clinical workstreams and enabling groups will contribute to these objectives through their workbooks. The framework will include the resource requirement, the engagement plan and the mechanism to measure its effectiveness and adjust as necessary. The PMO will coordinate communications and engagement with other supporting functions of the Programme like information management, benefits and risk management, and change control.

4.3	**Benefits Realisation** The BCT Programme will apply the following principles: • LLR system-wide change and BCT Programme-wide change will be benefits-driven; • benefits will be clearly linked to the six strategic objectives (Section 2.5.2); • benefits will be measured, tracked and recorded through appropriate performance management arrangements; and • oversight of benefits delivery is discharged through the BCT Delivery Board. The BCT Programme will realise benefits through a sequence of: • planning benefits and resourcing their realisation; • delivering change (elements of transitioning to the new model of integrated health and social care); • realising the benefits from those changes and embedding the new configuration of infrastructure, organisation, workforce, working practices and relationships; and • further developing or exploiting those benefits to the advantage of the partnership and its capability to serve its stakeholders. The Delivery Board will oversee benefits realisation through: • a benefits plan that maps out the system-wide impact and identifies key dependencies; • a benefits profile that describes how benefits will be attributed to partner organisations; • a description of how benefits will be measured, tracked and realised including the name of the responsible owner for delivery; and • the PMO monitoring the actual realisation of benefits against those planned.
4.4	**Risk Management and Issue Resolution** **Risk Management.** There will be a close relationship between effective risk management and sound governance of the BCT Programme in that risk management will be a subset of the Programme's internal controls. The BCT Programme will adopt a risk management strategy that embraces the principles, approach, and processes of risk management. This strategy will be underpinned by communication and embedding and reviewing the management of risk. Communication will be carried out throughout the whole risk management process. Embedding and reviewing embraces all the steps in the risk management process and reviews the overall effectiveness of the whole process. This strategy will have two main benefits: first, effective management of Programme risks, and second, the Delivery and Partnership Boards being able to assure themselves of the effectiveness of the Programme's risk management. The PMO will link Programme risk management and assurance for the Boards. The PMO will ensure appropriate risk reporting and risk management processes are in place across the BCT Programme.

In outline, the BCT Programme will apply the following principles when managing risk.

- The risk management process will feed back to LLR partner organisations.
- The BCT Partnership and Delivery Boards will use a Board Assurance Framework (BAF). The BAF will allow those Boards to assess for themselves the adequacy with which Programme risks are being managed. This assurance of risk management will inform the view of those Boards on the overall deliverability of the Programme.
- Risks in well-defined areas will be owned by the relevant or appropriate body in the Programme governance structure, such as clinical risks being owned by the Clinical Reference Group.
- Risk will be managed at the lowest possible level of the organisational structure. An escalation and de-escalation mechanism will link the levels of projects, workstreams and the BCT Programme. The Programme's reporting of risk will be compatible with the reporting mechanism used by LLR partner organisations.

The risk management process will be a sequence of four steps.

- Identify the context of the risk and the risk. The risk may be a threat or an opportunity. The objectives or benefits determine the relevance of a threat or opportunity.
- Assess the risk. This step may be divided into estimating the likelihood and impact (together the severity) of the threat or opportunity and evaluating the net effect of the aggregated threats and opportunities on an activity. The proximity of the risk may be added to the estimating step.
- Plan the response to the risk. Responses to a threat can be categorised as: Remove; Reduce; Transfer; Retain or Share. A combination of responses may be possible to reduce the risk to a level at which it can be tolerated. Responses to an opportunity can be categorised as: Realise; Enhance; and Exploit. 'Realise' seizes an identified opportunity. 'Enhance' improves on realising the opportunity by achieving additional gains. 'Exploit' seizes multiple benefits.
- Implement the response to the risk. This step ensures that the planned response(s) is implemented and monitors its effectiveness. If a response to a risk does not achieve the expected result, corrective action will be taken as part of this step.

The Programme will manage risk in a consistent way at three levels: workstream, BCT Programme and Delivery Board. Clinical workstreams and enabling groups will identify risks through their workbooks. Those risks of concern beyond the workstream will be escalated to the Programme risk register. In the Programme risk register, risks of concern to the Delivery Board will be escalated in the Delivery Board BAF. Any risks of concern to the Partnership Board will be escalated in the Partnership Board BAF. The core escalation mechanism for risk management is that shown in Section 3.5.

Clinical workstreams, enabling groups and the BCT Programme will all operate a risk register as the basic tool for managing risk. The PMO will be the custodian of the Programme risk register. The format for the Programme risk register is shown at Appendix 7.

There will be a coherent risk review cycle. Although the Chair of the Partnership Board and joint SROs can initiate a risk review whenever they see fit, this routine cycle will link the BCT Implementation Group, the BCT Delivery Board, special interest groups such as the CRG and PPI Reference Group, and the LLR Partnership Board. The cycle will be a logical progression that matches the rhythm of meetings. Subject to trial and adjustment in the light of experience, this cycle will be:

Board/Group	Frequency of Reviewing Risk
LLR Partnership Board	Quarterly
Special interest Groups (eg CFOs, CRG, PPI)	Quarterly
BCT Delivery Board	Quarterly
BCT Implementation Group	Monthly
BCT PMO	Continual

The Programme risk register will inform the BAF for the Delivery Board. The distinction between the Programme risk register and the Delivery Board BAF is that whereas the Programme risk register is a tool to manage an individual risk in the Programme, the BAF is a tool used for the Board to assure itself, or not, that risk management across the Programme is adequate.

Issue Resolution. The Programme Director will develop an issue resolution process for projects, workstreams and the BCT Programme to capture, assess and resolve issues in a coherent, prompt and effective way. The PMO will maintain a Programme Issue Log to help assess the effectiveness of our risk management. In the event of any dispute in the Programme, the Programme Director will be the arbiter unless the dispute requires escalation to the joint SROs or, in an extreme case, to the Partnership Board.

4.5 **Quality**

Quality is defined in Appendix 1. There are variations in applying quality between the programme management and the clinical domains. The Programme's management of quality will be based on continuous quality improvement.

The Programme will make and implement a Quality Improvement Strategy that embraces the approach, standards, processes and responsibilities for planning and delivering quality across the Programme. This Strategy will link quality in the areas of programme management and clinical quality. As an introduction to the Quality Improvement Strategy, quality in the programme management domain is covered in Section 4.5.1 and quality in the clinical domain in Section 4.5.2.

The effectiveness of quality management will be reviewed and assured by the Partnership and Delivery Boards, together with any external assurance those bodies may commission such as the OGC and the Clinical Senate, and throughout the BCT Programme governance structure.

Responsibilities for quality management in the BCT Programme will be as follows.

Role	Responsibility
Partnership Board	Accountable for all aspects of quality improvement in the Programme.
Joint SROs	Responsible for all aspects of quality improvement in the Programme.
BCT Delivery Board	Supporting the joint SROs.
Programme Director	Responsible for developing and implementing the Programme's Quality Improvement Strategy.
Partner Organisations	Building quality improvement in to every aspect of the Programme, especially though workstream and project workbooks.
The Clinical Senate	Providing clinical assurance external to the LLR Partnership.
The CRG	Providing clinical assurance internal to the LLR Partnership.
The PMO	Facilitating effective management of quality across the Programme. Drafting the Quality Improvement Strategy. Ensuring the Programme complies with relevant regulation and standards. Promoting best practice and setting standards for quality improvement. Arranging the review process, as directed by the Programme Director. Obtaining appropriate assurance, as directed by the Programme Director.

4.5.1	**Programme Management Quality** Programme management quality in the BCT Programme will be the standards, processes and responsibilities that control the Programme's delivery of its changes and benefits. The Programme will apply quality management at the project, workstream and programme levels. It will make quality management integral to its daily activities, supported by information management and version control. Programme management quality will ensure that the BCT Programme's stakeholders are satisfied that the benefits they expect will be realised. Quality management in the BCT Programme will: • support LLR policy and strategy and meet agreed standards; • meet the expectations of the Programme's stakeholders; • optimise the use of resources across LLR partner organisations; and • make consistent use of best practice processes, tools and techniques. Quality will be managed differently at the programme and workstream/project levels. At the BCT Programme level, quality management will focus on achieving the six strategic objectives (Section 2.5.2). During the Programme, these objectives may change in response to LLR circumstances and priorities. In contrast, quality management at the workstream/project level will focus on ensuring that the changes to services meet the business case or the quality criteria defined in the workbooks. The BCT Programme will: • define the expectations of stakeholders, especially those of patients, their carers, clinicians, Commissioners and the public; • define quality or acceptance criteria for the main products of workstreams and projects, such as a redesigned pathway, and will develop service changes against these criteria; • review the proposed service change against the quality or acceptance criteria, and test it through independent internal assurance, such as the CRG, or external assurance, such as the Clinical Senate; • plan flexibly so the plan can be adjusted, if necessary, during delivery of the service change; and • test its delivery of the benefits of change on stakeholders such as patients and the public.
4.5.2	**Clinical Quality** There are several definitions of clinical quality and they have much in common. The Programme will recognise the following definitions. Lord Darzi defined the three domains of clinical quality as patient safety, clinical effectiveness and patient experience. The Institute of Healthcare Improvement has adopted the 'triple aim' of: • improving the experience of care for the individual; • contributing to population health; and • reducing the per capita cost of care.

The six dimensions of clinical quality are that care and treatment is:

- safe;
- clinically effective;
- timely;
- patient-centred;
- efficient; and
- equitable.

These dimensions are supplemented by the five domains of the NHS Outcomes Framework.

NHS Outcomes Framework	
Domain	**Illustration**
Preventing people from dying prematurely	How the proposal helps people to live longer; how it reduces premature mortality.
Enhancing quality of life for people with long-term conditions	How the proposal directly impacts on people living with long-term conditions.
Recovery from episodes of ill health or injury	How the proposal helps people to recover following ill health (including mental illness) or injury.
Ensuring a positive patient experience	How the proposal results in: personalised and compassionate care; meets patient needs; and positive survey results from patients.
A safe environment free from avoidable harm	How the proposal reduces risk to patient safety and wellbeing, including through reduced 'hand-offs'. How having staff trained and systems in place to safeguard patients prevents harm.

Clinical quality will drive the BCT Programme's redesign and reconfiguration of its health and social care services. Two of the system objectives of the BCT Programme are to deliver high quality, citizen-centred, integrated care pathways and to increase the number of citizens reporting a positive experience of care across all health and social care settings. Clinical quality will be embedded in all work streams and contractual arrangements. The Programme's service reconfiguration plans will demonstrate an improving quality of health and social care, benchmarked against agreed standards.

The Programme will follow current best practice for clinical quality. It will adopt these principles.

- Clinical quality is the degree of excellence in health and social care. Clinical quality has to be measured, using shared indicators. The indicators will be one or more of: patient-reported outcome indicators; clinical outcome indicators; and process outcome indicators.
- Quality improvement gives a better patient experience and better clinical outcomes.
- The Programme will approach quality through quality improvement and not through the previous approach of quality control and quality assurance.
- Clinical quality will be delivered using a patient-centred approach. Usually, it will be implemented by working collaboratively in multi-disciplinary teams of health and social care professionals and staff, both clinical and non-clinical.
- Clinical quality does not 'fall out' of systems. It is produced by individuals behaving well, working systematically and basing their clinical work on scientific knowledge and evidence.

	• The keys to improving clinical quality are adaptive leadership and the behaviour of individuals. Adaptive leadership shows the ability to live with unpredictability and to exploit opportunity. The BCT Programme's clinical workstreams will build upon the integrated approach to service planning and delivery already established locally. This will underpin the changes in culture and approach we need. Each workstream lead will ensure that a proposed service change will result in a positive impact for patients and staff. They will test proposed clinical changes on the internal assurance of the Clinical Reference Group and, if appropriate, on the external assurance of the Clinical Senate. Each clinical workstream workbook will address the six dimensions of clinical quality. Workbooks will be assessed against the 'Duty of Quality' outlined in the five domains of the NHS Outcomes Framework.
4.6	**Equality and Diversity** The BCT Partnership Board requires the Delivery Board to ensure that the undertakings for Equality, Inclusion and Human Rights (EIHR) set out in the Five-Year Strategic Plan are met and that LLR Equality and Diversity policy is implemented in the BCT Programme. The Delivery Board will oversee effective execution of all Equality and Diversity responsibilities. The Delivery Board, supported by the PMO, will be the focus for the Programme's implementation of LLR Equality and Diversity policy. Consideration will be given to the needs of the whole LLR community, including those communities whose interests are specifically protected under law. Consideration will be given to assessing and, where required, mitigating the impact of the BCT Programme on the workforce as well as on patients, service users and carers. The Partnership Board's undertakings include: agreeing an Equality Statement; using the evidence base of the three Joint Strategic Needs Assessments; engaging with special interest and 'seldom heard' groups; overseeing the production of Equality Impact Assessments (EIA) as appropriate; ensuring that EIA findings are reflected in the operational plans for clinical changes; and ensuring that those operational plans are updated on an appropriate basis. The Equality Statement for the BCT Programme is shown at Appendix 8. The Delivery Board will be the authority for approving EIAs and mitigation plans. Clinical Workstream and Enabling Group SROs are accountable for addressing Equality and Diversity early on in their workstream. A forum of Equality leads will assure the Delivery Board on workstream EIAs, the aggregated impact of clinical changes in the BCT Programme, and suitable mitigation.
4.7	**Change Control** Change control is a supporting function closely related to Programme Control and the Use of Business Cases (Section 3.4.2) and Version Control (Section 4.8). Change control will provide the Programme a single means of capturing and considering change requests, suggestions, ideas or concerns, and ensuring appropriate action is taken and the decision communicated back to the originator. Throughout the life of the Programme anyone with an interest in the Programme, or its outcomes, may wish to request a change, raise a concern or express a dissatisfaction with work already done. Collectively, these 'programme issues' will be most efficiently addressed though change control. The PMO will be the focus for change control in the BCT Programme. The PMO will capture change requests, assess them and communicate decisions on them to the source that raised them. The authority for deciding what action is to be taken will be, depending upon the scale and significance of the change request, either the Delivery Board, the Programme Director or the workstream SRO. Whatever level of authority takes the decision, they will follow the process of:

	• capturing and logging the change request; • analysing the change request and assessing the implications of implementing it; • proposing the action to be taken; • deciding the action to be taken (approve, reject or defer); and • implementing the action to be taken. In step 2 of the process above, assessing the implications of implementing the change request will consider the overall balance of advantage of: • the benefits from the change against the time, cost, added complexity, and risk of obtaining them; • the relative priority of this change against the priority of work already in the Programme – is the new work a higher priority than any work we are already conducting? The overall assessment will be a product of the impact of the change on the: • whole Programme; • business case for the workstream; • benefits to be derived from the workstream; • risks to the Programme and the workstream, including the possible creation of new risk(s) and the impact on existing risk(s); and • allocation of Programme resource, including the possible dissipation of effort and multiplication of priorities. In deciding the action to be taken, the change request can be approved, rejected or deferred, perhaps to be modified and resubmitted.
4.8	**Version Control** Version control is the activity that controls critical documentation in the BCT Programme. This will be the responsibility of the PMO. It will ensure that version control links closely with the Programme's processes for information and performance management, planning and control, quality management, communications and engagement and change control.

Resources	
5.1	**Resource Allocation** Resource for the BCT Programme concerns funding, staff, skills, time and space. The Partnership Board recognises that this resource is owned by partner organisations, under Chief Officers. Following completion of the SOC, and on an ongoing basis, the Partnership Board will review the existing resource allocation in order to satisfy itself that: • resource is adequate to deliver the Programme's changes and benefits and thereby to achieve the six strategic objectives (Section 2.5.2); • the Programme's allocation of resource is aligned with Programme-wide priorities; and • the use of resources is optimised across the Programme. The Partnership Board will regularly review the Programme's benefits, risks and allocation of resources, including the relation between them, as outlined in Section 4.4.

APPENDIX 1 – GLOSSARY OF TERMS

Term	Meaning
Assurance	All the systematic actions to provide confidence that the object of the assurance is appropriate. Assurance has a level of independence from that being assured.
Benefit	The measurable improvement from a change perceived as an advantage by one or more stakeholders.
Blueprint	A model of the inside of the future organisation, showing its working practices, processes, information flow or contractual arrangements necessary to realise the vision. The blueprint is a design document derived from the vision.
Business as Usual	The way the organisation normally achieves its objectives. Portfolio management seeks to find the optimum balance of business as usual and organisational change.
Coordinate	Bring the different elements of a complex activity or organisation into an efficient relationship. Move the different parts of the body smoothly and at the same time.
Governance	The functions, responsibilities, processes that define how the Programme is set up, managed and controlled.
Issue	An event or development that has happened, that is affecting the Programme and needs to be actively dealt with and resolved.
Portfolio	All the programmes, workstreams and projects being undertaken by the organisation or group of organisations. The totality of the organisation's investment in change.
Programme	A management structure created to coordinate, direct and oversee the implementation of a set of related workstreams, projects and activities in order to deliver outcomes and benefits of strategic importance to the organisation.
Programme Management Office	A central office that coordinates the Programme on behalf of senior management. The information hub and standards custodian for the whole Programme. Across the Programme, it plans and controls work, tracks and communicates progress, facilitates benefits realisation and risk management, and optimises use of resource.
Project	A temporary organisation created to deliver one or more new or changed products or services according to a specified business case.
Quality	All the features and factors that affect the ability of a product, process or service to meet expectations or stated needs, requirements or specification.
Risk	An uncertain event or set of events which, should they occur, will have an effect on the achievement of objectives. A risk can be either a threat or opportunity.
Senior Responsible Owner	The individual with overall responsibility for ensuring that the Programme achieves its objectives and delivers the projected benefits. The owner of the overall business change.
Stage	A section of the Programme's life which produces a step change in the impact of benefits delivered or in the organisation's capability. The end of a stage is a major control point for the Board and milestone for the Programme.
Stakeholder	Any individual, group or organisation that can affect, be affected by, or perceive itself to be affected by, the Programme.
Stakeholder group	A group of stakeholders who share broadly similar interests, influence and disposition towards the Programme.
Transformation	A distinct change to the way in which the organisation conducts its business. The change may affect its 'look and feel', its organisation, its character or its output.
Vision	A picture of the better future, from outside the organisation. The end-goal of the Programme.
Workstream	The level of work beneath the BCT Programme and above the project level. A workstream incorporates a number of projects.

APPENDIX 2 – THE LEFT SHIFT: A BLUEPRINT OF THE LLR 2019 SYSTEM - INTEGRATED HEALTH AND SOCIAL CARE

A financially sustainable LLR system of integrated health and social care that meets the future needs of patients and maximises value for money through safe, high quality services in the most efficient and effective settings

<table>
<tr><td colspan="6">The Clinical Settings of Care</td></tr>
<tr><td colspan="6">The ‘Left Shift’ completed</td></tr>
<tr><td rowspan="2">Self-Care, Education and Prevention</td><td rowspan="2">Primary Care</td><td rowspan="2">Community and Social Care services</td><td rowspan="2">Urgent Care</td><td colspan="2">Acute Care hospital-based services</td></tr>
<tr><td>Secondary Care</td><td>Tertiary Care</td></tr>
<tr><td colspan="3">Primary, Community and Social Care expanded and reshaped to support care at home. The Voluntary Sector well engaged and supportive</td><td>Crisis response, reablement and discharge</td><td colspan="2">Acute Care reduced and reshaped into two hospitals, with fewer beds, that focus more on specialist care, teaching and research</td></tr>
<tr><td colspan="6">Physical and mental health integrated</td></tr>
<tr><td colspan="6">Health and Social Care integrated</td></tr>
</table>

Commissioning that emphasises prevention rather than treatment

The health and social care estate reconfigured and used more effectively

Improved utilisation of our workforce and new capacities and capabilities developed where appropriate

All LLR partner organisations financially sustainable

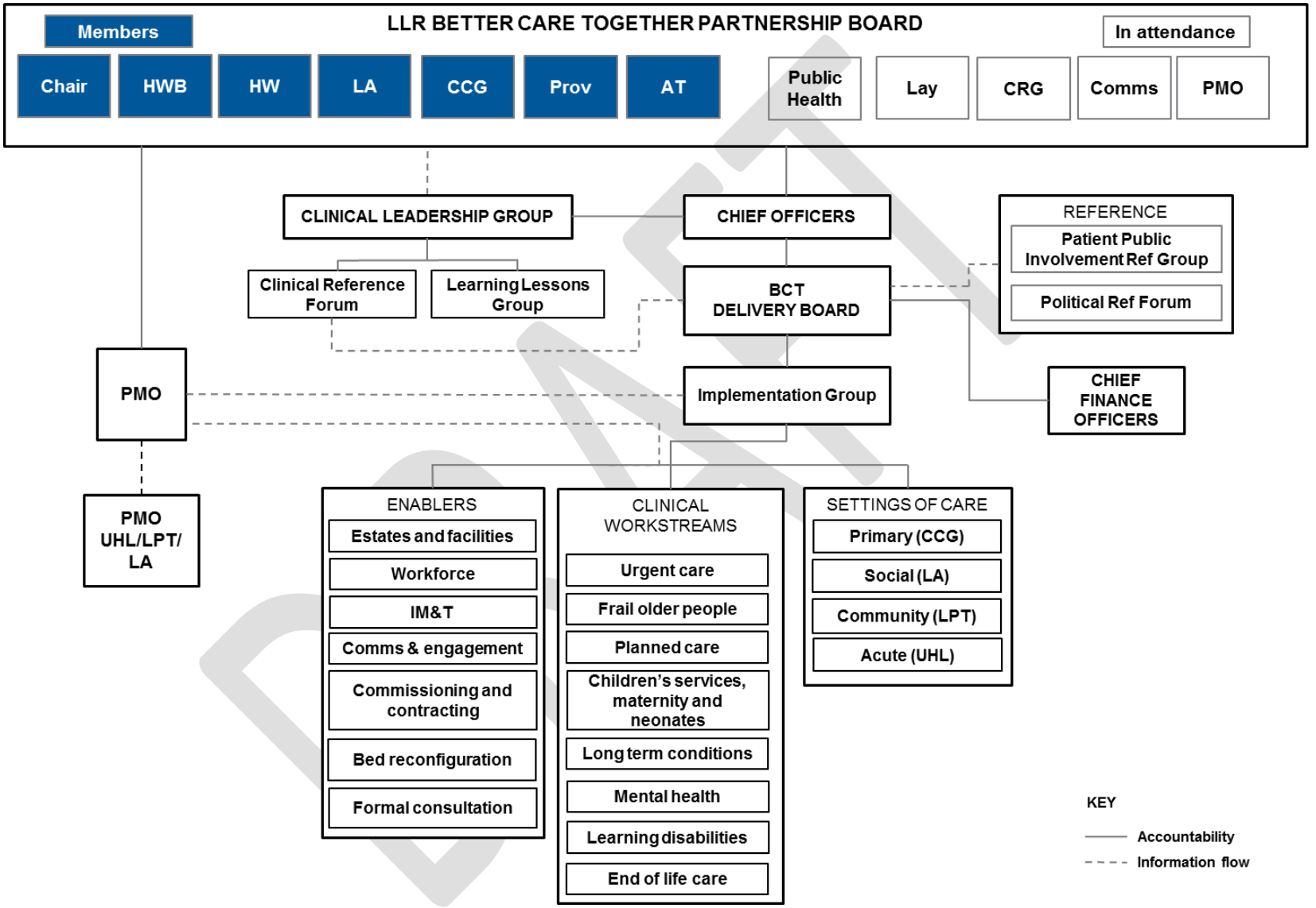
APPENDIX 3

RACI - ROLES AND RESPONSIBILITIES IN BCT PROGRAMME MANAGEMENT BY PROCESS

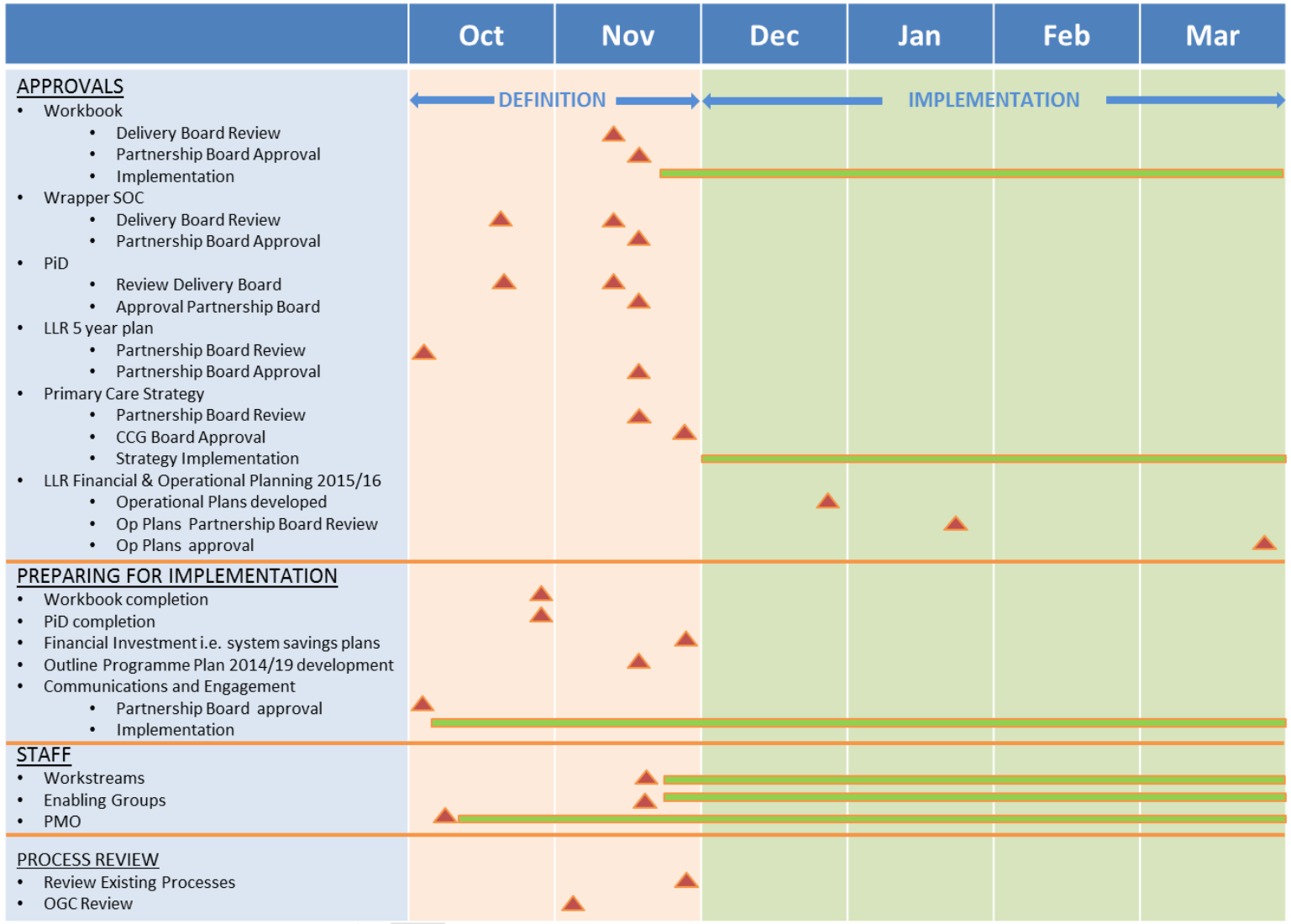
Programme Process	Partnership Board	Joint SROs	Delivery Board	Programme Director	PMO
Defining the Programme					
- establish the infrastructure		A		R	C
- establish the programme team		AR	C	I	C
- develop the Blueprint		A	C	R	C
- develop benefit profiles		A	C	R	C
- select the Stages		A	C	R	C
- design the Programme organisation		A	C	R	C
- develop governance arrangements		A	C	R	C
- make the Programme Plan		A	C	R	C
- prepare for the first Stage		A	C	R	C
- approval to proceed to the first Stage	A	R	C	I	I
Managing each Stage					
- direct work		A	C	R	C
- manage risks and issues		A	C	R	C
- control and deliver communications		A	C	R	C
- manage information		A	C	C	R
- manage people and other resources		A	C	R	C
- monitor, report and control		A	C	R	C
- prepare for the next Stage	C	A	C	R	C
- review at end of Stage and close the Stage	C	A	C	R	C
Delivering the new Operating Model					
- start workstreams and projects		A	C	R	C
- engage stakeholders		A	C	R	C
- align workstreams with Programme objectives		A	C	R	C
- align workstreams with Programme benefits		A	C	R	C
- control and manage delivery		A	C	R	C
- close workstreams and projects		A	C	R	I
Realising the Benefits					
- manage pre-transition		A	C	R	C
- manage transition		A	C	R	C
- manage post-transition		A	C	R	C
Closing the Programme					
- notify Programme about to close	I	A	C	R	I
- review Programme	C	AR	C	C	C
- finish Programme information		A	C	R	C
- confirm redeployment of all Programme resource		A	C	R	C
- approve Programme closure	A	R	C	I	C
- disband Programme organisation and team		A	C	R	

Key
R – Responsible; gets the work done; **R reports to A**
A – Accountable; decides
C – Consulted; supports; has capability required
I - Informed; notified but not consulted

APPENDIX 4 – BCT PROGRAMME ORGANISATION



APPENDIX 5 – BCT PROGRAMME PLAN FOR OCTOBER 2014 TO MARCH 2015



Better care together
A partnership of Leicester, Leicestershire & Rutland Health and Social Care

APPENDIX 6 – THE LINK BETWEEN BCT ACTIVITIES AND VISION

Line of Activity	The Five Year Strategic Plan's Six System Objectives	Blueprint for 2019	Vision
Primary, Community and Social Care	High quality integrated care pathways, delivered in more appropriate settings, reducing time spent avoidably in hospital	A healthcare operating model that emphasises integrated services delivered closer to home and community	Maximise value for the citizens of LLR by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring of safe, high quality services into the most efficient and effective settings.
Clinical Workstreams (x 8)	Reduce inequalities in physical and mental care across and within LLR resulting in additional years of life for those with treatable mental and physical health conditions Increase reporting of positive experience of care across all health and social care settings		
Enabling Groups (x 5)	Optimise opportunities for integration and use of physical assets across the health and social care economy, providing care in appropriate cost-effective settings, reducing duplication and eliminating waste Improve utilisation of our workforce and develop new capacity and capabilities where appropriate, in people and our technology		
Finance, including CIP, QIPP & Local Authority saving plans	All LLR partner organisations achieve financial sustainability		

APPENDIX 7 – FORMAT FOR BCT PROGRAMME RISK REGISTER

No	Date ID'd	Risk Description	Risk Owner	Assessment		Controls	Residual Assessment		Review Date
				Likelihood	Impact		Likelihood	Impact	
Strategic Risks									
Clinical Risks									
Financial Risks									
People, Engagement and Leadership Risks									
Programme Management Risks									

Risk Scoring Matrix

		Impact				
Likelihood	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5

Risk Severity	
Score	RAG
20-25	RED
14-19	AMBER
8-13	YELLOW
1-7	GREEN

APPENDIX 8 – EQUALITY STATEMENT

The Better Care Together (BCT) Programme is committed to ensuring that equality considerations are embedded in all our actions as part of the Programme. We are committed to: addressing inequality in healthcare; avoiding discrimination against individuals, especially those in 'protected groups'; promoting equality in employment; and complying with Equality, Inclusion and Human Rights legislation.

We will meet our equality responsibilities by:

- assessing the impact of our decisions on different groups of people;
- being clear how we assess and meet individual need;
- not tolerating discrimination that affects our employees or our communities.

We recognise that equality and diversity is fundamental to delivering high quality health and social care that meets the needs of individuals across LLR. We also recognise that equality and diversity is essential in recruiting and retaining the best staff.

We will ensure that the BCT Programme treats LLR service users, patients, carers, visitors, volunteers and employees fairly and with respect. We will ensure that the Programme does not discriminate against individuals or groups on the basis of any of the 'protected characteristics' outlined in the Equality Act 2010. This includes the grounds of disability or by reason of a person's association with a disabled person, gender, marital or civil partnership status, race, colour, ethnic or national origin, age, sexual orientation, gender reassignment, pregnancy and maternity, religion or belief, or any other unjustifiable conditions or requirements.