NHS
Leicester, Leicestershire and Rutland

# Better Care Together Summary of the Five Year Strategic Plan, Strategic Outline Case and PID **November 2014**

20/11/2014

Version 1.5

Better care together

# Contents

# 1 Introduction

# Introduction

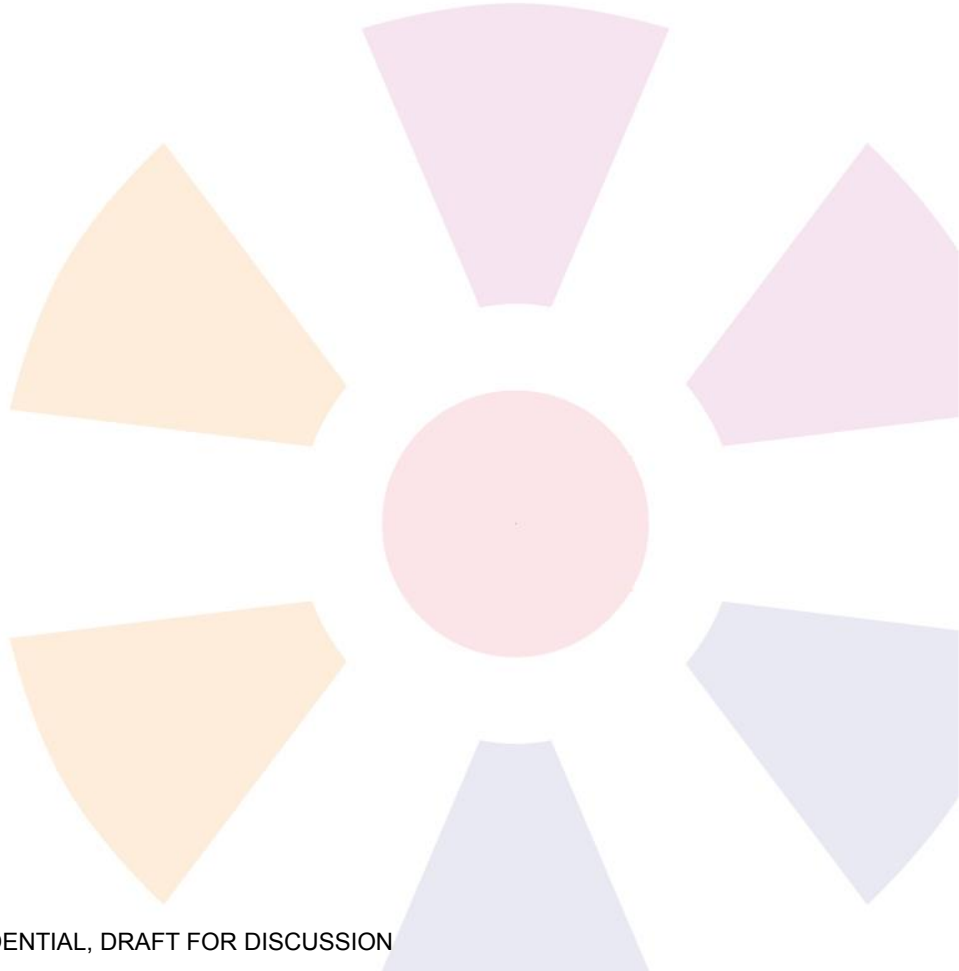
## Better Care Together vision

*'…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'.*

## What have we produced so far

(1) The BCT five year strategic plan, updated in September 2014, which describes our plans to reform health and social care services across LLR;
(2) The strategic outline case (SOC), published in October 2014, which sets out the case for the BCT programme as being the preferred way forward to deliver the plans set out in the five year strategic plan. The SOC is designed to be a "wrapper" for all the future transformation business cases which will be required for the system to realise its vision;
(3) The programme initiation document (PID), from November 2014, which defines the BCT programme and sets out the basis on which the programme is to be initiated, governed and delivered.

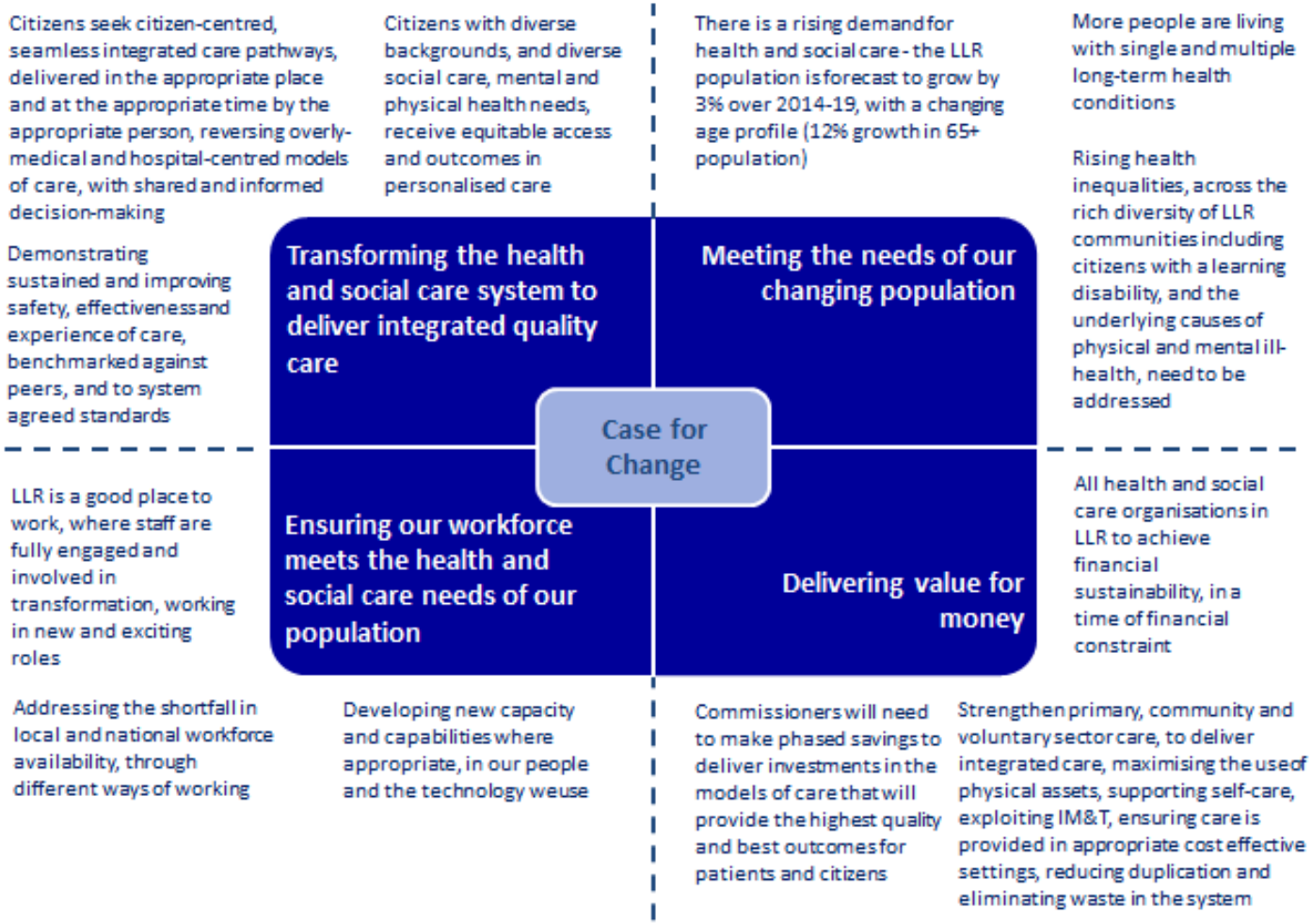
# 2
# The case for change



Better care together

# Case for change across Leicester, Leicestershire and Rutland

## The case for change was set out in the 5 year strategic plan



# Case for change across Leicester, Leicestershire and Rutland

## NHS savings continue to be under significant financial pressure

In 2011 the “Nicholson Challenge” set out the need to make £20bn of savings against a budget of £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.

In NHS England's recently released *Five Year Forward View* , 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".

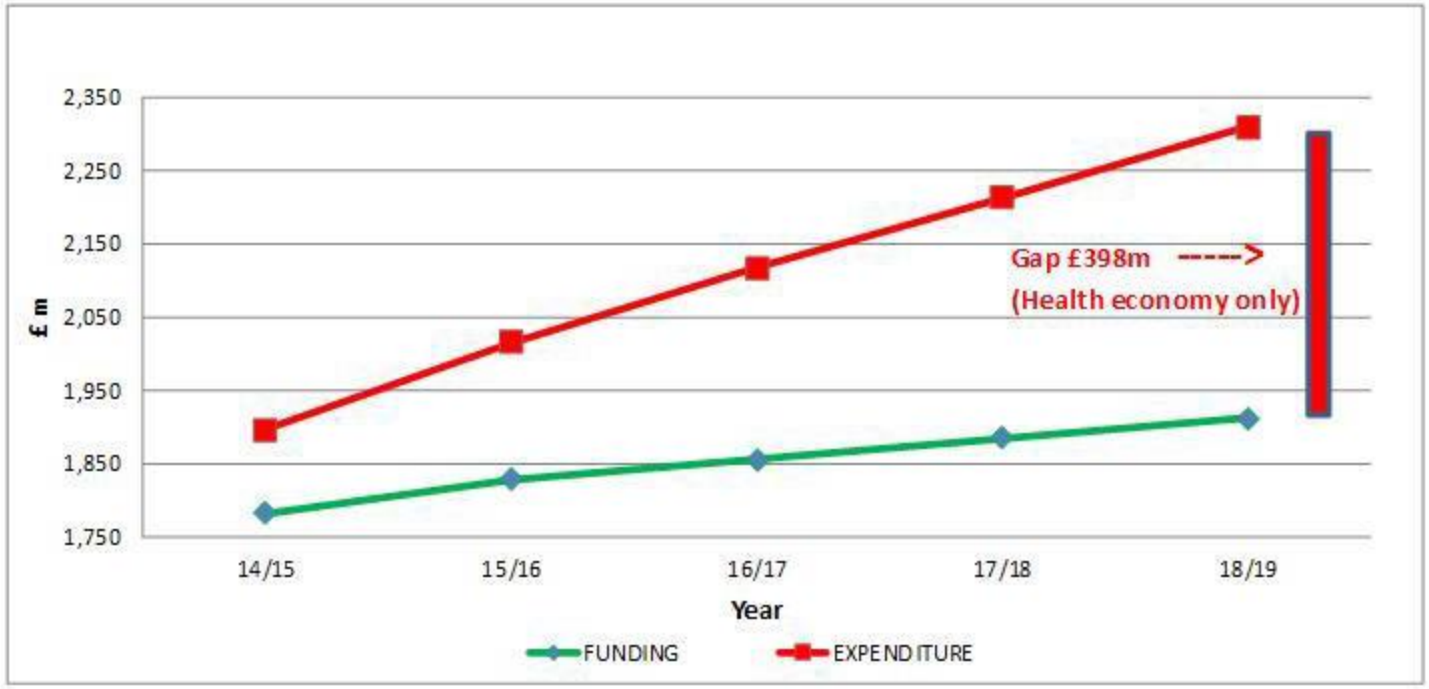
This requires organisations to find different ways of working to address these growing pressures and sets out a call for action on demand, efficiency and funding.

## Cuts to local government budgets are affecting adult social care

The government’s deficit reduction plan involves significant cuts in public spending. The 2010 Government Spending Review 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 a significant proportion (33-45%) of local authority spending, meaning that the pressure to reduce costs will inevitably impact on social care.

# These financial pressures translate into significant funding gaps

## The local NHS faces a shortfall of £398m by 2018/19

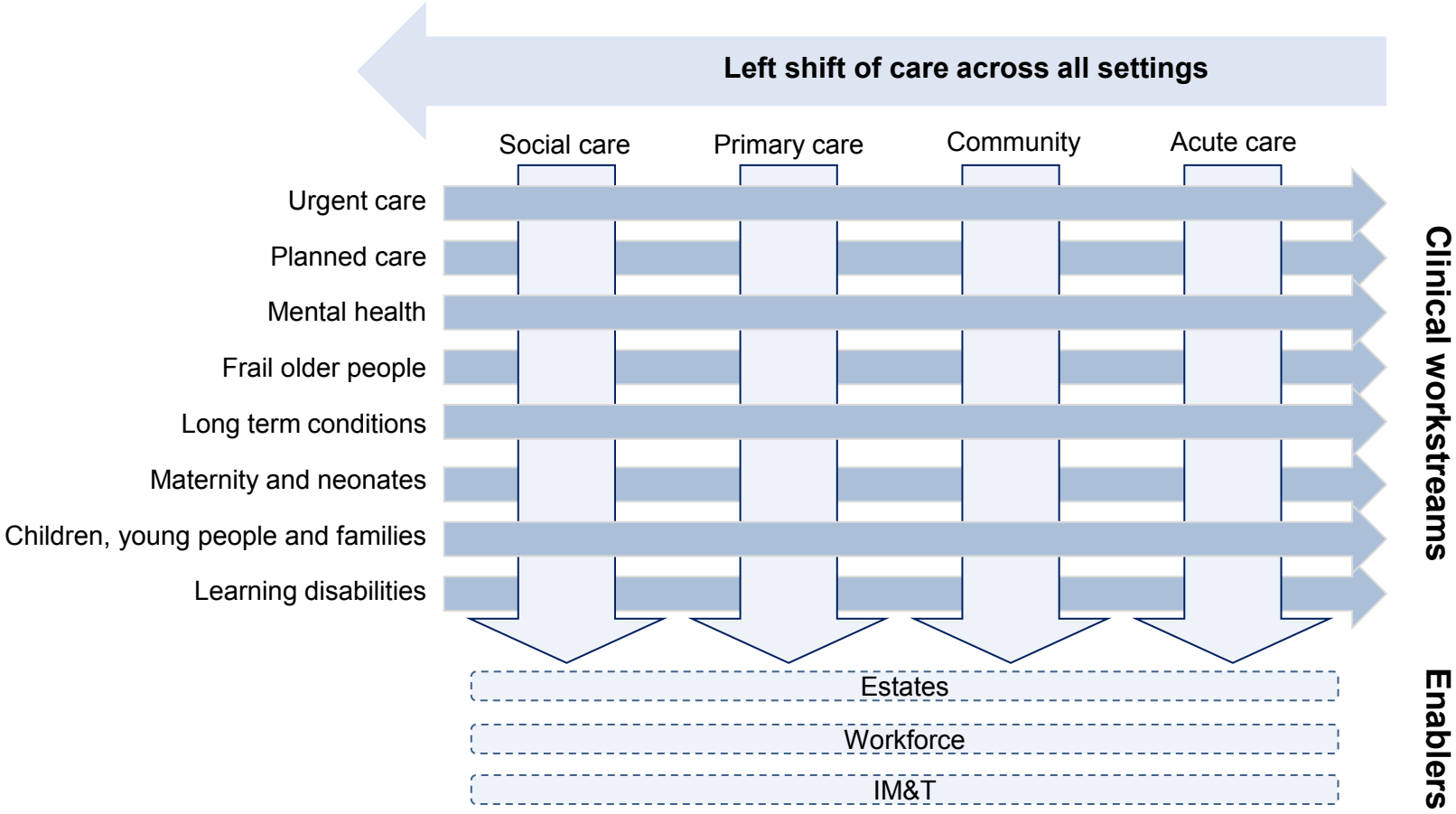



**Local authorities will require even more significant savings and the details of these are still being worked through. A collective savings requirement across the three local authorities of £177m is predicted.**

# 3
# Our response to the case for change

# Better Care Together

## The Better Care Together Programme sets out plans for eight clinical workstreams, and within four different care settings



# Clinical pathway workstreams

**Each of eight clinical pathway workstreams has worked to the same format of describing our existing service, the interventions we intend to make and the resulting outcomes.**

Urgent care example…

# The ten components of care

## The urgent care, frail older people and long-term conditions workstreams used the Kings Funds' Ten Components of Care to frame service transformation

Urgent care example…


| | | | | |
|---|---|---|---|---|
| 1 Age well and stay well | 2 Live well with one or more long term conditions | 3 Support for complex co-morbidities / frailty | 4 Accessible, effective support in crisis | 5 High quality, person centred acute care |
| FOP LTC | FOP LTC | FOP | FOP LTC UC | UC |
| 6 Good discharge planning and post discharge support | 7 Effective rehabilitation and reablement | 8 Person centred, dignified, long term care | 9 Support, control and choice at end of life | 10 Integrated services to provide person centre care |
| FOP | FOP LTC | FOP | FOP LTC | FOP LTC UC |

# Clinical workstreams

## The clinical workstreams have drawn on existing plans and newly developed interventions to set out a strategic direction

| Learning disabilities | Urgent care | Long term conditions | Frail older people |
|---|---|---|---|
| • Review team to benchmark and analyse the cost and content of high cost packages of care<br>• Reconfiguration of short break services for LD patients / service users<br>• Implementation of an Outreach Team that will work between the community and the Agnes Unit for challenging individuals LLR approach to enable carers to be involved in service development and planning<br>• Flexible LLR wide provision of short term intensive crisis support<br>• Pooled personal budgets and personal health budgets | • New emergency floor at LRI to ensure there is sufficient space to support the flow of "majors" and to offer dignified care and create a positive working environment.<br>• Improving system navigation by boosting NHS111, out of hours medical cover and local single point of access<br>• Increasing the availability of ambulatory care options<br>• Boosting the urgent out of hospital options for at risk patients;<br>• A "Choose Well" public campaign to help people to make the right urgent care choices. | • Based around principles of "Education", "Prediction", "Care planning", "Ambulatory pathways", "Innovation", "Services available when required", and "Choices and plans at the end of life"<br>• Specific interventions include: integrated COPD team cover primary, community and acute care avoiding hospital admissions, including ambulatory care wherever possible.<br>• Exercise medicine to improving levels of activity, giving people access to integrated reablement services<br>• Workplace wellness proof of concept in UHL | • Primarily based on existing BCF plans<br>• Age well and Stay well: Introduce Unified Prevention Offer<br>• Risk stratification, Early diagnosis and referral, and the increase in the number of quality care plans<br>• Care Navigators, Local Area co-ordinators and the development of integrated pathways for Dementia.<br>• Clinical Response team, the Falls service, Integrated Crisis response<br>• Assistive technology.<br>• Good discharge planning and post discharge support |



*Note: End of life will be taken forward by a new workstream from November 2014*

# Clinical workstreams

**The clinical workstreams have drawn on existing plans and newly developed interventions to set out a strategic direction**

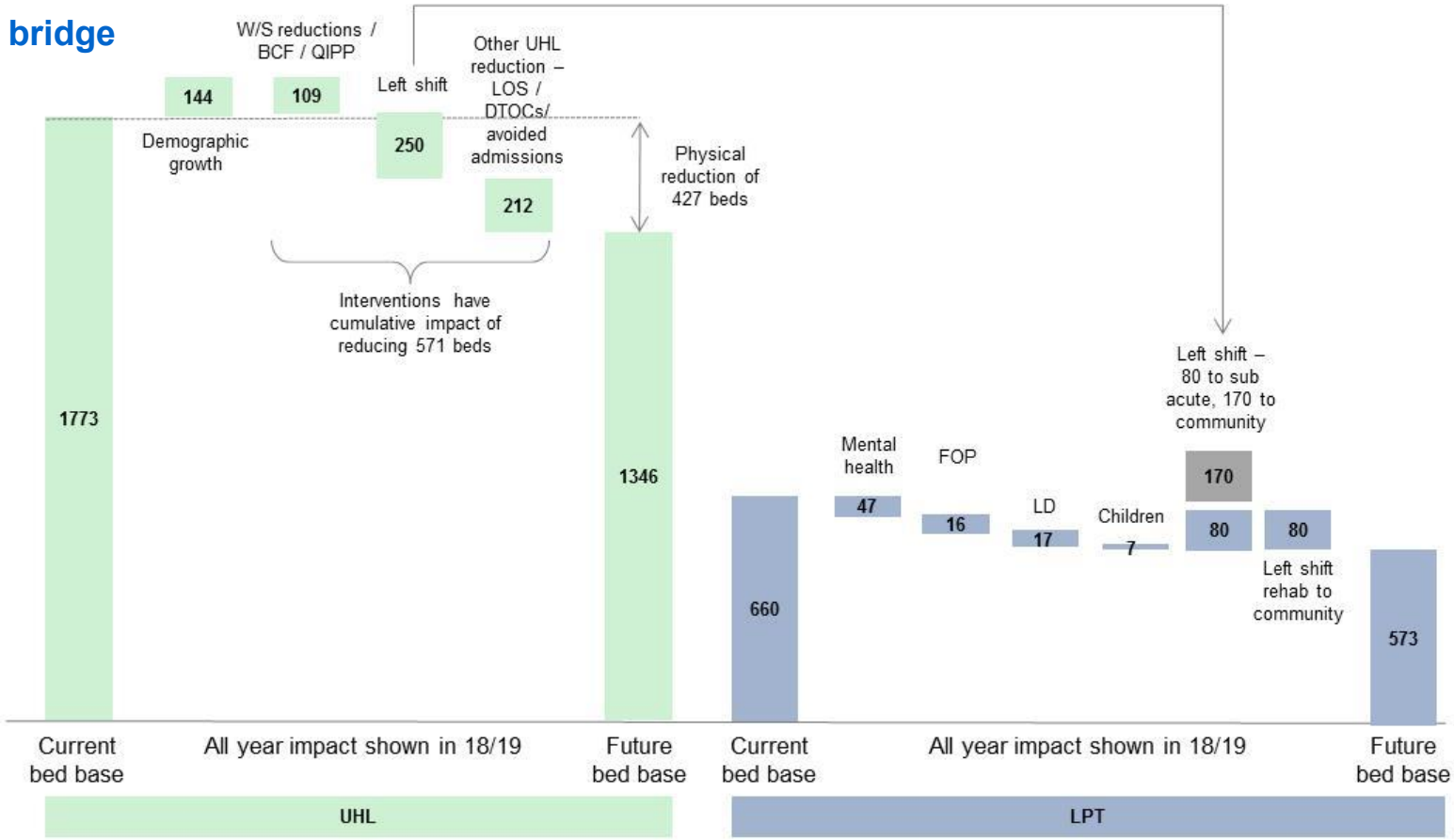
| Planned care | Mental health | Maternity and neonates | Children and young people |
|---|---|---|---|
| • Implementation of PRISM system to improve referral quality<br>• 40% left shift of acute activity into community<br>• 10% of outpatient activity attendances will be decommissioned<br>• 50% of out of county OP/DC repatriated to LLR (excluding City CCG).<br>• Reviewing pathways for 18 specialties<br>• Introduce non-face to face where appropriate<br>• Full compliance with BADS<br>• UHL OP and daycase elective care hub | • Strengthen prevention and self-help services to improve resilience<br>• Implement Crisis House, step down beds, discharge team and changes to inpatient pathway to reduce out of county placements<br>• Increased access to alternative services, for example through IAPT;<br>• Reduce alternative health placements by 40%,<br>• Providing more step-down support post-discharge, for example step down beds and crisis house facilities. | • Development of single obstetric unit at UHL<br>• Maximise the uptake of midwifery led care options by promoting home births and midwife-led provision – the key system intervention is redesigning how community based midwife led services are delivered to ensure that there is a sustainable model for community based midwife care<br>• Continue with the multi-agency programme to improve perinatal outcomes in Leicester.<br>• Develop an integrated maternal mental health pathway | • Merger of Children's ED and CAU to become a single Ambulatory care unit and deliver Children's acute care provision from a single site<br>• Increasing the provision of counselling and emotional health and wellbeing services to reduce the number of children escalating to tier 3 CAMHS<br>• Reduce out of area placements<br>• Redesigning the hepatitis B pathway to shift 100% of activity from to primary care<br>• Develop options to deliver integrated provision |

# 4
# The impact on our providers

# The beds programme and left shift

Acuity reviews carried out by UHL and LPT have identified a significant number of patients who do not require treatment in an inpatient setting, and the workstreams are developing further interventions to provide better quality care in a community setting including home.

## Beds bridge



# UHL plans

## Vision

"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."

## Major service changes over the five years

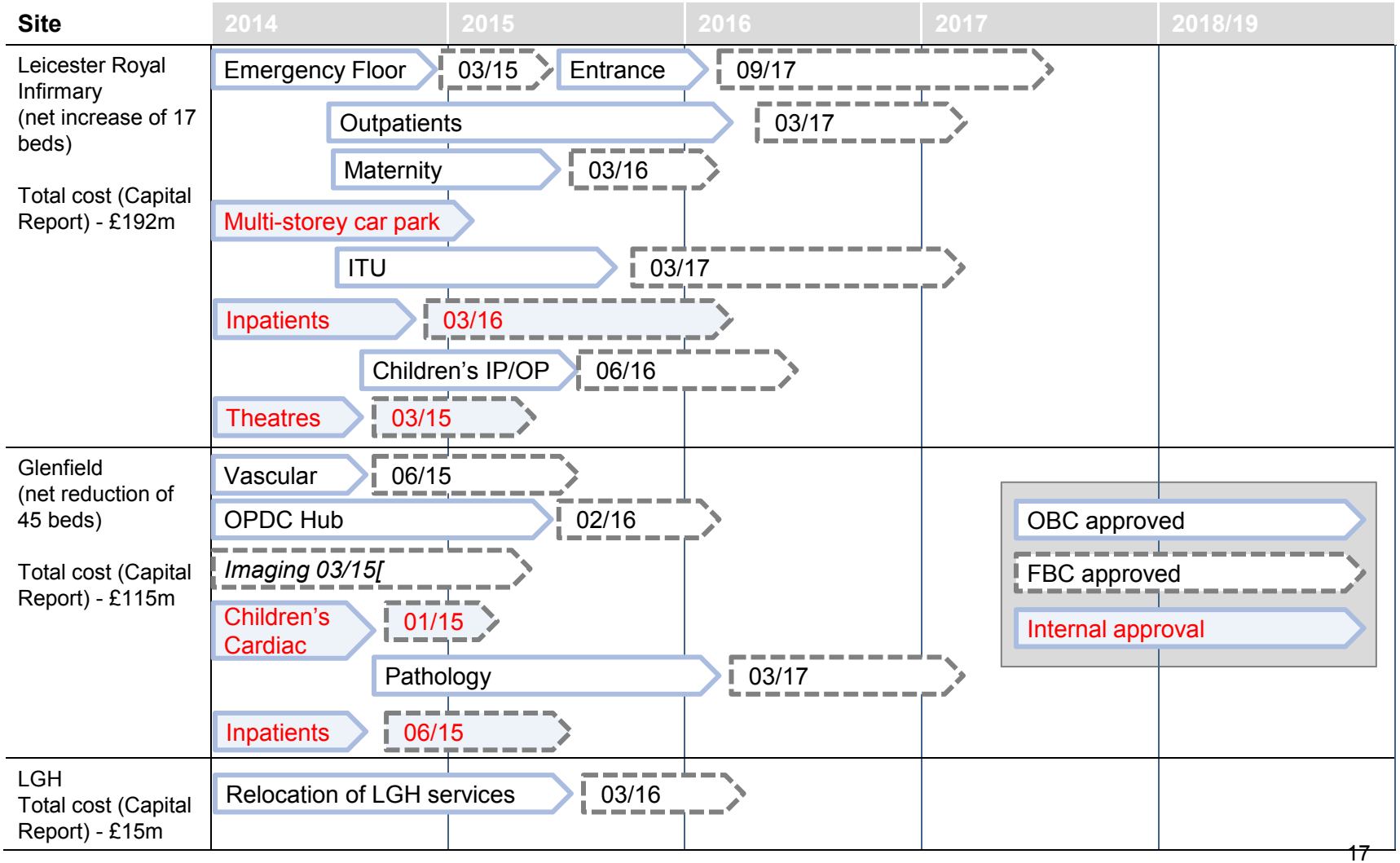
- New emergency floor
- Obstetric hub at the LRI
- OP/DC hub created
- Shift 40% of OP/DC to a non-acute setting

## Beds programme

- The shift of activity to community settings involves the health economy taking actions that will reduce the need for 571 beds at UHL
- Once the additional growth expected in the system is taken into account this will require a physical reduction of beds at UHL of 427 beds

# UHL plans – capital programme

UHL's financial recovery plan requires moving from 3 to 2 acute sites by 2019. The key business cases planned for UHL are laid out below:



# LPT plans

## Vision

"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".

## Three major service programmes over 5 years

- 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.

## Beds programme

- 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.

# LPT beds reconfiguration

## The beds reconfiguration will take place over three phases

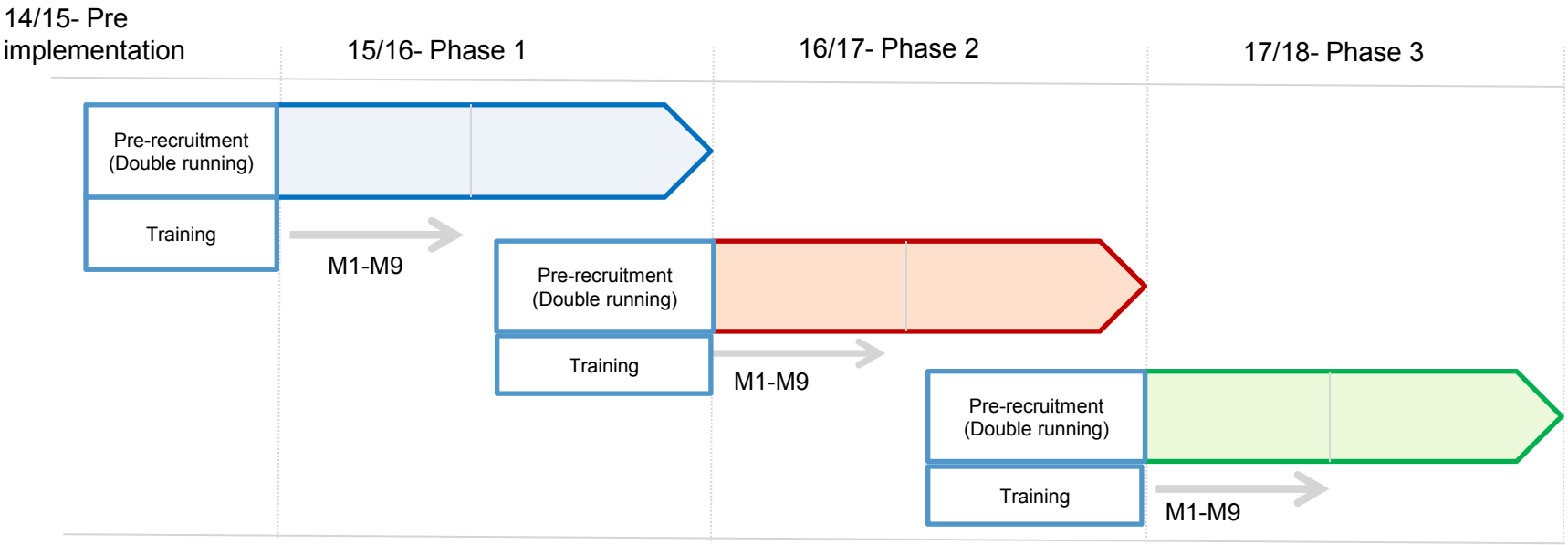
LPT have identified three separate phases:

The left shift will entail shifts as follows:

**Phase 1:**
24 Beds shift from LPT beds to LPT community;
36 Beds shift from UHL to LPT community
24 Beds shift from UHL to LPT Hospitals

**Phase 2**:
24 Beds shift from LPT beds to LPT community;
36 Beds shift from UHL to LPT community
24 Beds shift from UHL to LPT Hospitals

**Phase 3:**
34 Beds shift from LPT beds to LPT community;
96 Beds shift from UHL to LPT community
34 Beds shift from UHL to LPT Hospitals



# Primary care plans

## Key themes emerging for strategies across LLR

- Each CCG has developed a primary care strategy following wide engagement with GPs across LLR
- 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.
- The core role of primary care will remain but there will be a range of additional services available to patients with the most complex needs

## How the primary care model could change

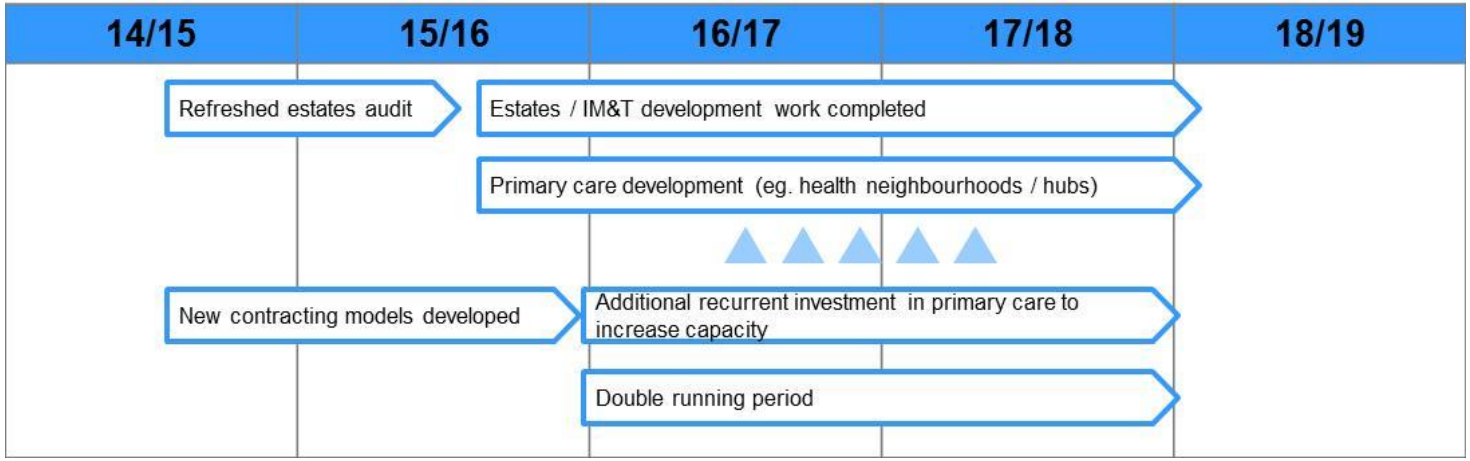
- Any new model will require a broader range of clinical skills both within general practice and in the ancillary services.
- There will need to be more highly trained nurses and GPs with broader skills for both planned and complex care
- A significantly greater number of patients could be empowered to self-care
- Changes to the model of care 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
- 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

# Primary care plans

## Transformation plan

- 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:

## Provisional timeline




## External funding requirements

- CCGs have requested up to £46m for new capital projects to support the development of estate to make it fit for purpose in the future
- In addition to this it is expected that the development of new capacity will require a transition period where £15m of non-recurrent revenue funding will be required

# Social care plans

## Development of a social care strategy

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.
A social care strategy has been produced setting out a broad direction of travel, but highlights significant financial risk associated with delivery

## Financial pressure

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.

## The Better Care Fund

Adult social care is contributing to the reduction in need for care through a clear integration agenda, and this is primarily being driven by the Better Care Fund. BCF 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

# Social care plans – interdependencies between health and social care

## Financial impact of changes to health and social care services

- 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.

- 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 made across health and social care will inevitably have an impact on each others' 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. 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.

- 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.

# Critical path for programme

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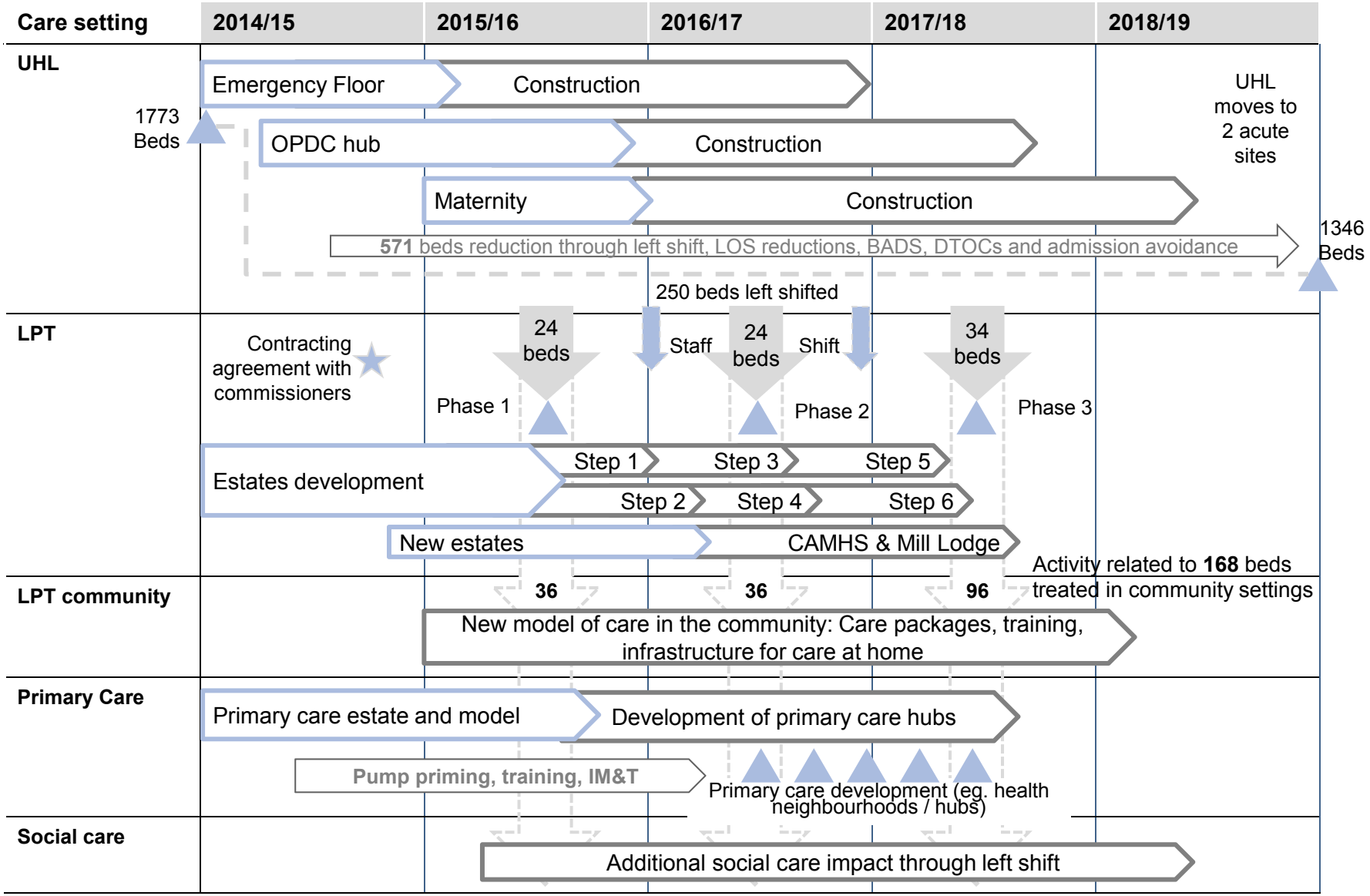


# 5
# Enabling change

# Enablers – our plans for workforce and the estate

## Workforce – ensuring LLR:

- Employs the right workforce with the right skills, in the right place, at the right time and with the right numbers;
- Employs 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 estate – delivering:

- A smaller but more specialised acute estate, with consolidation of services onto two sites;
- An adapted community bed base reflecting the transfer of “sub-acute” patients from UHL to LPT;
- A hub and spoke model for the community estate;
- An adapted primary care estate which may include the development of hubs as well as the refurbishment of existing premises;
- A more efficient and better utilised estate;
- A smaller health care estate footprint.

# Enablers – our plans for IM&T

## IM&T – using technology to transform health and social care delivery:

- Transforming how care is delivered – IM&T is a powerful tool for automation and standardisation of processes;
- Transforming where care is delivered – IM&T can be used to reduce reliance on physical healthcare locations and minimise unproductive travel time for patients and practitioners;
- Transforming who delivers care – 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;
- Transforming when care is delivered - e-mail and social network-type sites allow asynchronous communication removing the need for both parties to be available at the same time.

# 6
# Delivery options

# Delivery options appraisal

## The economic appraisal

The economic appraisal conducts a qualitative and quantitative appraisal of the options to deliver the required transformation.

## After discussion with stakeholders across LLR three initial listed options were developed:

1. Delivery through the BCT strategy
2. Delivery of financial balance through organisational efficiency alone (Do Minimum option)
3. Ceasing delivery of non-agreed services to regain financial balance

## Each option was appraised against six investment objects and six critical success factors

| Investment objectives | Critical success factors |
|---|---|
| Quality of Care out of Acute Hospitals | Business Needs |
| Reduction in Inequalities | Strategic fit |
| Improved Patient Experience | Affordability |
| Efficient delivery of Care | Achievability |
| Financial Sustainability | Impact on clinical quality |
| Developed workforce | Impact on access |

# Qualitative Appraisal of three Delivery options - results

| Ref | Criteria | Option 1 – Better Care Together | Option 2 – organisational efficiency alone | Option 2 – 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** | | | | |

# Delivery options appraisal continued

**The BCT option was deemed to be the only viable way to achieve financial balance based on a qualitative discussion:**

- 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
- In addition this would pose significant risks to the integrated working which has underpinned the programme so far
- 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 health and social care economy to take on.

# Economic assessment on shortlisted options

- 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
- This 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 | (31,566) | 74,778 | 93,994 | 103,734 | 19,166 | (78,422) | (66,711) | 114,139 |
| Do Minimum Option | 2 | (29,864) | 84,072 | 101,811 | 106,875 | 16,677 | (62,014) | (84,946) | 132,610 |

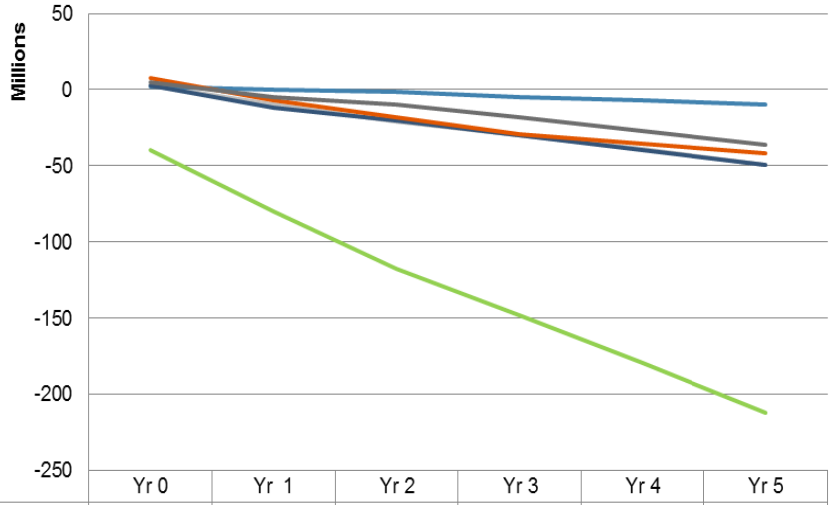
**The economic case therefore concluded that the BCT programme had a lower net present cost than the next best alternative option and that this should be the preferred way forward for the health and social care economy. This remained the case after applying sensitivities.**

# 7
# Financial impact

# The BCT Programme will address a £398m funding shortfall for LLR

**Whole health economy modelling work undertaken alongside the 5 year strategy demonstrated the total gap between LLR income and expenditure in 2018/19 is £398m before any CIP/QIPP/ BCT interventions are modelled.**

The gap cannot be closed by 'general' organisational savings of 3-4% p.a. alone.




| | 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 |

If BCT cross system initiatives, aligned and linked to organisation savings initiatives, deliver according to the initial plans, 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.

The programme requires **transitional** capital, revenue and cash support to deliver all required benefits

# How the £398m gap will be delivered by 2018/19

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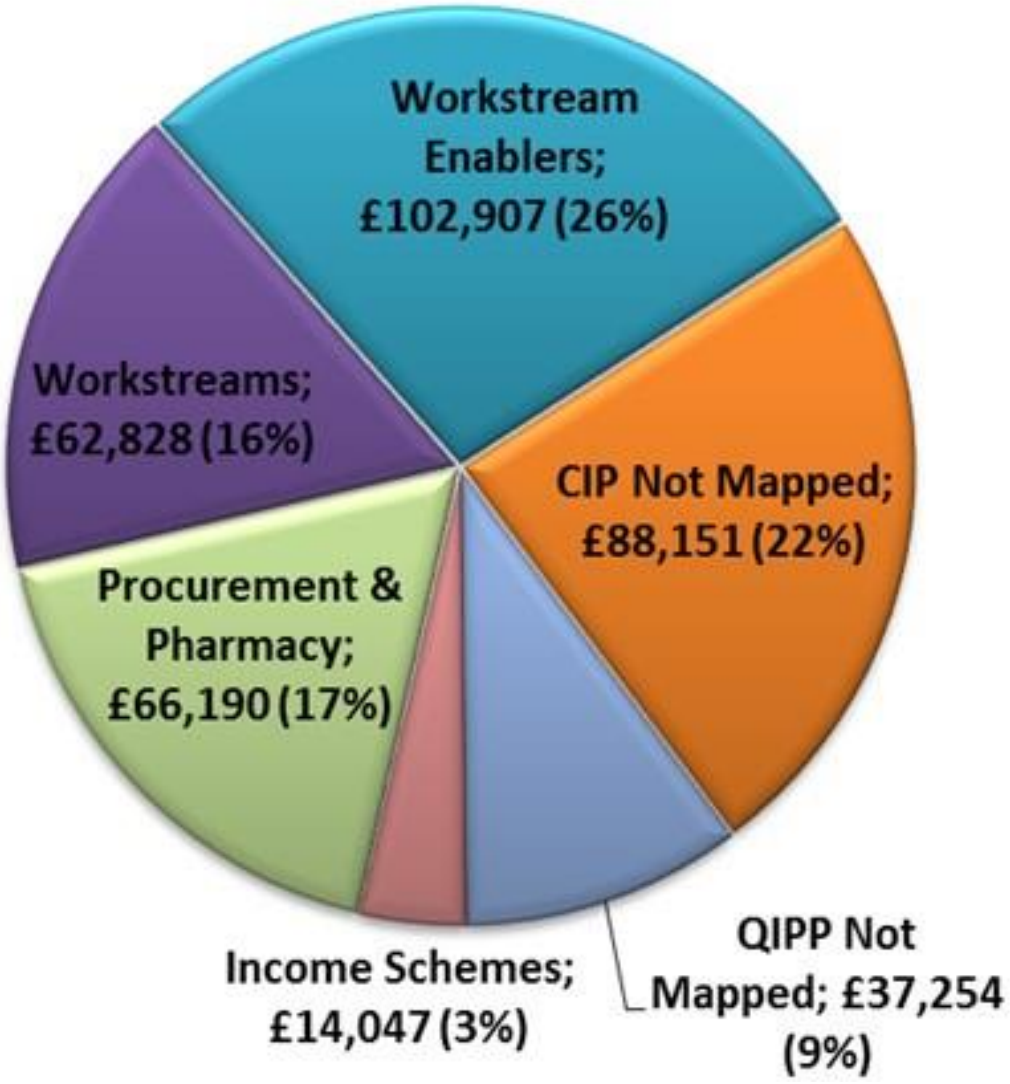
The following table sets out savings information provided by LLR organisations combined with the BCT workstream savings. Together these components describe 94% of the total 5 year opportunities. The balance is bridged by (a) additional workstream opportunities, identified but not yet developed into detailed initiatives; (b) CCG allocation growth believed to be higher than that modelled based upon NHS England's Five Year Forward View.

Further work is required to ensure that robust pan-health economy plans are developed to ensure all interdependencies and risks are mapped through and testing as to whether some of the proposals could be accelerated.

| | Reported Savings @ Oct 14 (Cumlative) | | | | |
|---|---|---|---|---|---|
| | 14/15 (£'000) | 15/16 (£'000) | 16/17 (£'000) | 17/18 (£'000) | 18/19 (£'000) |
| LD Pathways | 0 | 316 | 1,225 | 1,609 | 1,859 |
| MH Pathways | 2,625 | 8,605 | 12,383 | 15,562 | 18,201 |
| LTC Pathways | 1,293 | 3,183 | 5,084 | 6,980 | 8,574 |
| FOP Pathways | 6,023 | 12,784 | 12,784 | 12,784 | 12,784 |
| Urgent Care Pathways | 1,852 | 2,407 | 5,014 | 6,512 | 7,362 |
| Planned Care Pathways | 3,105 | 6,443 | 8,571 | 10,700 | 11,731 |
| Maternity Pathways | 0 | 0 | 378 | 378 | 378 |
| Children's Pathways | 300 | 355 | 600 | 600 | 600 |
| End of Life Pathways | 892 | 1,338 | 1,338 | 1,338 | 1,338 |
| **Workstream Total** | **16,090** | **35,431** | **47,377** | **56,463** | **62,828** |
| UHL-LPT Bed Reconfiguration | 1,102 | 9,840 | 17,423 | 25,441 | 29,114 |
| Estates | 6,929 | 8,904 | 10,962 | 12,565 | 19,476 |
| Workforce | 12,886 | 24,358 | 36,386 | 46,158 | 54,317 |
| **Workstream Enablers Total** | **20,917** | **43,103** | **64,771** | **84,164** | **102,907** |
| Clinical Income(Non-LLR) | 250 | 650 | 729 | 807 | 884 |
| Clinical Income (Non-NHS) | 0 | 250 | 417 | 582 | 745 |
| Other Income | 2,178 | 4,738 | 7,298 | 9,858 | 12,418 |
| **Income Schemes Total** | **2,428** | **5,638** | **8,444** | **11,247** | **14,047** |
| Procurement | 4,904 | 10,222 | 15,836 | 21,432 | 27,019 |
| Pharmacy | 7,946 | 14,874 | 22,988 | 30,957 | 39,171 |
| **Procurement & Pharmacy Total** | **12,850** | **25,096** | **38,824** | **52,389** | **66,190** |
| **Total** | **52,284** | **109,268** | **159,417** | **204,263** | **245,972** |
| **CIP Not Mapped** | **30,101** | **47,795** | **61,525** | **76,951** | **88,151** |
| **QIPP Not Mapped** | **7,273** | **14,052** | **17,240** | **20,480** | **23,617** |
| **Disclosure Adjustment relating to model** | **0** | **0** | **0** | **0** | **13,637** |
| **Total** | **37,374** | **61,847** | **78,765** | **97,430** | **125,405** |
| **(Cumlative) Grand Total** | **89,658** | **171,115** | **238,181** | **301,693** | **371,377** |

This financial analysis set out above is shown separately as a pie chart overleaf.

# Analysis of £371m reported savings



# The programme requires transitional capital, revenue and cash support to deliver all of the required benefits

**Capital Requirements**: In addition to existing capital funds available, an extra £430.3m of capital investment is required to support existing and new capital developments.

## The table below shows each organisation's projected capital spend and the external funding required where this is in excess of existing Capital Resource limits (CRLs)

The capital spend will predominantly drive the following major service changes in the system:

- UHL's complex capital programme to move from three acute sites to two
- LPT's Community Hospital Strategy to develop modern fit for purpose community hubs to support the changing model of care
- Primary Care development of existing and new estate in support of the transformation
- These estimates will require further testing

| 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) | **-** | **4,825** | **16,195** | **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** |

# The programme requires transitional capital, revenue and cash support to deliver all of the required benefits (continued)

**Revenue/ Cash Requirements**: In addition to existing revenue funds available, an extra £255.9m of non recurrent cash/ revenue investment is required to support the transition period during which services are changing.

| 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 | 376 | 5,045 | 2,176 | 438 | 272 | **8,307** |
| 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** | **44,312** | **70,417** | **70,335** | **66,113** | **59,733** | **310,910** |
| **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 | **3,612** | **67,137** | **66,851** | **62,429** | **55,848** | **255,877** |
| | 44,312 | 70,417 | 70,335 | 66,113 | 59,733 | **310,910** |

The overall requirement of **£255.9m** shown above is net of £14.3m of local CCG transformation funds.

The revenue funding required by the programme will be used to support;

- UHL's remaining deficit funding (**£134.5m**) which would be required anyway
- Programme revenue costs (**£121.4m**)

# 8 Engagement

# Continuous engagement to ensure we meet needs and expectations

## Our approach to engagement

Our stakeholders are well defined:

- patients, service users, carers and the Voluntary and Community Sector
- staff, practitioners and clinicians
- the public and communities
- political representatives, local government and regional administration
- LLR partner organisations

We have established formal links with the key stakeholder groups:

- Health and Wellbeing Boards
- Healthwatch
- the Patient and Public Involvement (PPI) Reference Group
- the Clinical Reference Group (CRG)
- Voluntary Sector

Equality and Diversity (including Equality, Inclusion and Human Rights)
This is built in to our plans for delivery and will be ongoing.

Formal consultation is being planned for commencement post-May 2015.

# 9 Governing and delivering the programme

# Approach to managing the programme

## Our approach is based on:

- The Five Year Strategic Plan
- Direction from the LLR Partnership Board
- The Office of Government Commerce (OGC)'s guidance on best practice

The Five Year Strategic Plan has led to the SOC and the PID.

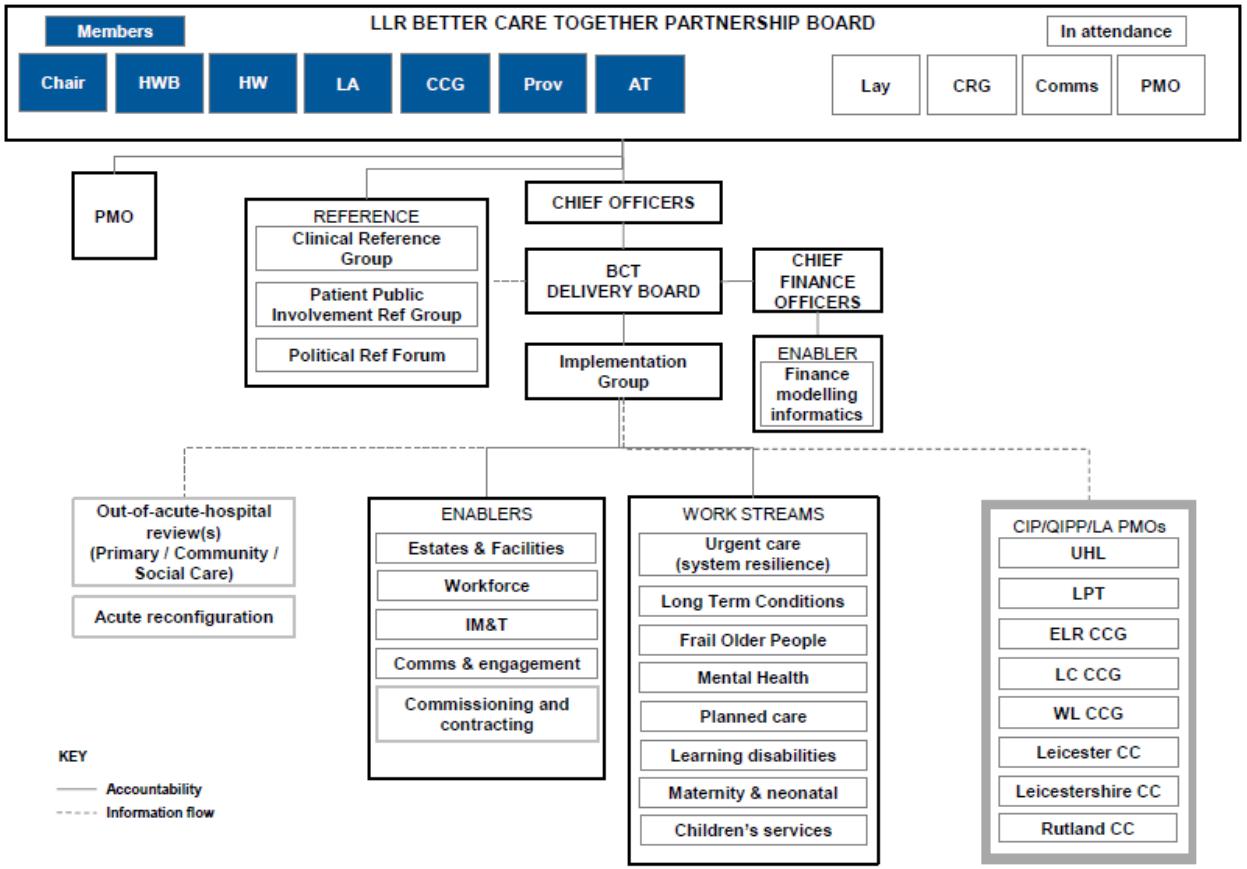
Ultimate accountability for the success of the Programme lies with the LLR Partnership Board. The Partnership Board will meet in public from January 2015.

The BCT Delivery Board, under the joint SROs, will oversee delivery of the Programme on behalf of the Partnership Board.

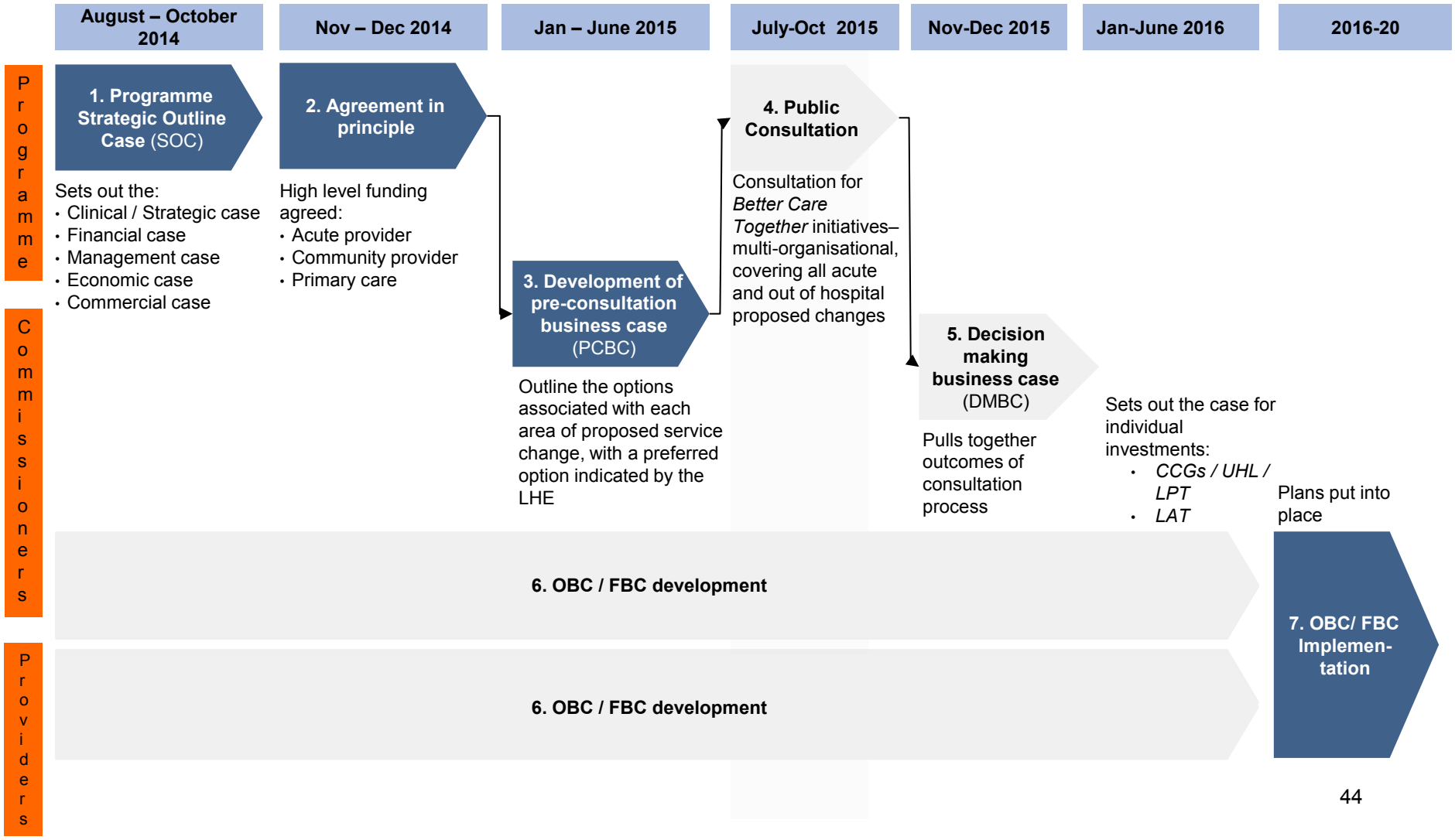
The Programme Director will manage the Programme, day-to-day, on behalf of the joint SROs.

The Programme will be coordinated and synchronised by the Programme Director, supported by a LLR Programme Management Office (PMO).

# Programme governance structure



# Overall OBC/FBC approval timeline
(re major schemes subject to public consultation)



# 10
# Next Steps

# Next steps

- Agreement of PID and SOC at each local Governing Body
- Submission of SOC to NHSE/TDA
- Workstreams to be fully mobilised and commence implementation
- Detail work up of primary and social care to commence
- Joint Programme SROs to:
  - establish timescales and approval requirements for external support and evaluate the consequences of not securing this support
  - clarify decision making authority and a scheme of delegation
  - ensure the further development of clinical leadership and engagement
  - review workforce plans to mitigate risks and prioritise actions
  - consider current contractual arrangements
  - determine the scope and strategy for consultation
  - review the risk management process work and ensure it is embedded into day to day programme activity