Integrating LLR Points of Access

Full Business Case

Status: Final

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1. Executive Summary

1.1. Background

The Leicestershire County, Leicester City and Rutland County Councils (LLR) Better Care Together Five Year Plan highlighted the need to consider how points of access across LLR could be simplified and reconfigured in support of demand management and the "left shift". The reason for this is so that professionals and service users make the best use of the most appropriate service in the most appropriate setting of care, and that the information and signposting provided is responsive and consistent with local pathways.

There are key drivers for this change. These are detailed in the Better Care Together Five Year Plan and are summarised below:

- The need to reduce waiting times by providing transparent and accessible data and advice about health and services
- The need to manage the impact of a predicted skills shortfall by effectively managing the workforce, through different ways of working and better supporting technology
- The need to meet rising demand for health and social care
- The need to drive better value for money and achieve financial sustainability
- The need to deliver integrated care by optimising the use of estates, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste

In addition, there is a requirement to improve patient outcomes, especially those that deliver better patient centered care. It is anticipated that the approach outlined within this business case will help to address the following key statements from the 'National Voices, A Narrative for Patient Centred Care', (May 2013):

- I am always kept informed about what the next steps will be
- The professionals involved with my care talk to each other
- When I use a new service, my care plan is known in advance and respected
- When I move between services or settings, there is a plan in place for what happens next
- I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact
- If I still need contact with previous services/professionals, this is made possible

1.2. Business Case Summary

This business case outlines how these objectives can be achieved through implementing a new Target Operating Model (TOM). It also examines the associated activities, costs, benefits, risks and mitigations that will be involved in delivering this new, more integrated

way of working. This document has been developed within the context of current levels of performance, the strategic direction of the in-scope services, aligned to the Better Care Together (BCT) Five-Year Plan and the Vanguard - Workstream 1 programme. In summary, the document details the following:

- An integrated TOM for Health and Adult Social Care (ASC) points of access across LLR
- A proposed approach and business case to achieve implementation of integrated services
- A financial appraisal of the current service delivery model versus the recommended TOM for Health and ASC including implementation costs, realisable financial and non-financial benefits
- The associated change activities required to deliver the overarching aims and objectives of the programme as detailed in *Section 5*
- Risks, Issues and Constraints associated with a programme of this scale across multiple organisations and the mitigating actions

The business case finds that there are significant advantages of moving to a single uniform way of operating, at a single or much reduced number of sites and under one management structure. At a high-level these are:

- Realisable savings that may be achieved through rationalisation of the management structures, teams and facilities that undertake contact centre activities in Health and Adult Social Care
- Savings that can be achieved through more effective ways of working in the teams that execute service requests
- A more effective, responsive and better experience for the recipients of the services (professionals, patients and service users) and
- Better information on which to make LLR wide decisions on demand management and targeted interventions

It is recognised that there are a number of challenges of moving to this model and the approach outlined in the business case seeks to address these through risk mitigation and effective programme management. The challenges are as follows:

- Each of the organisations involved, both politically and organisationally will want (or be able) to move at different speeds towards the optimal solution
- The ability to integrate the ways of working and the technology that supports it
- To be able to design and implement a cost effective approach that can effectively support the varying demographics across the LLR region

These challenges create a number of risks that will need to be mitigated and actively managed through the life of the programme if the LLR vision and the benefits are to be achieved. These major risks are:

- The organisations involved may not be able to reach agreement on progressing through the implementation phases
- The overall benefits may be diluted as the timelines for benefit realisation become extended and the economies of scale of running a concertinaed implementation phase are reduced
- The perception that those organisations that have more of a 'speed challenge' are reluctant to make changes and that those that can move faster are seeking to 'take over'
- The timelines for the IT integration and the Vanguard projects may have a material impact on the progress on this project
- As this level of integration has not been achieved before, the LLR system may not have confidence to move at the pace required to deliver the benefits identified in the business case

This business case, the approach that this phase of the programme has taken and the recommended implementation approach seeks to address these risks by:

- Ensuring that there is a commonly understood and agreed set of aims, objectives and Design Principles (see Appendix 1) that are aligned to the LLR overall vision. This has created a framework to guide the programme though the design and implementation phases
- Developing a set of reasonable assumptions that will allow the programme to move through each of the phases with known, unknown and managed risk
- A phased implementation approach to standardise and optimise the ways of working across all the organisations involved to drive out savings early in the programme to help build credibility and confidence
- The baselining and collection of more detailed, comparative information in the early stages of the programme. This, in conjunction with the detailed design stages, will allow the stakeholders to make the integration and co-location decisions in the later stages of the project and within the context of the framework
- Ensuring there is a detailed co-design stage at the start of the transition stage to both support decision making and start the engagement of the operational teams, service users and patients in the change
- Ensuring that the programme strategies that will support the change e.g. benefit management, stakeholder management, change and communications are developed and co-designed early in the project
- Ensuring that there are activities within the programme and in the operational teams that facilitates the collection of standardised data to allow the organisations to make good decisions over the 30-month programme period and beyond

- Ensuring that the key programme resources (as detailed in Section 5.5.3) with the necessary skills and capacity, from across the in scope organisations are identified early by undertaking a skills and capacity assessment to determine any skills gaps and plan for sourcing alternative programme resources if required

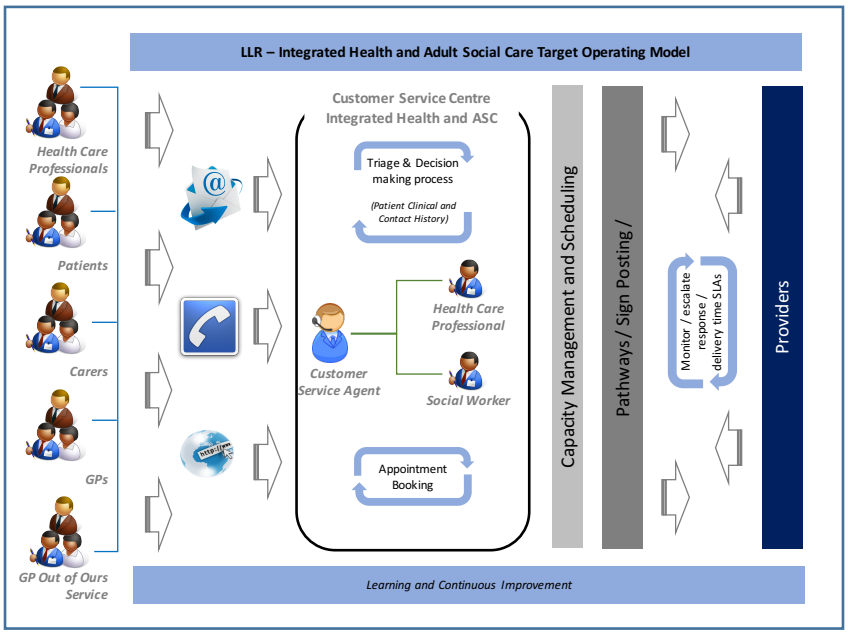
The approach taken in developing this business case provides the foundation for the next stage of the programme, as it was designed to engage the teams who will have responsibility for delivering the model and to begin the process of involving the wider Health and ASC services and stakeholder groups. These teams are an integral part of the proposed changes. Their intellectual capital combined with 4OC's experience have been used to co-design the proposed future TOM and the method for delivery, and hopefully, in the process has cemented their commitment to the upcoming changes.

The data gathering and co-design phases of the development of this business case have been characterised by a high degree of openness and enthusiasm from across all the in-scope services. There is an acceptance across the Health and ASC services of the need for change against a backdrop of increasing pressure to manage demand, reduce waste and associated cost in the system.

1.3. A New Operating Model

Figure 1 below outlines the proposed end-vision operating model for the Integrated Points of Access for LLR. To achieve this end state, the business case outlines a phased approach to implementation, building upon the work that has already been done and ensuring that the current services are working effectively and have been sufficiently aligned ahead of initiating any deeper integration.

Figure 1 - Future Target Operating Model for LLR Integrated Health and ASC



1.4. Proposed Approach

Section 5 outlines further detail on a potential approach for the phased implementation. It is anticipated that, based on the level of complexity (including the interdependencies) of the programme, the total programme could be delivered over a maximum of a 30-month period.

The phasing and the overall timeline will need to be finalised through detailed programme planning at the start of the mobilisation phase (and subsequently refined as part of detailed co-design activities in Phase 1) and managed through the implementation phases. The business case also outlines the critical features of a successful change programme of this nature as well as the skills required to execute it, the cost of implementation and the risks that need to be managed.

1.5. Financial Appraisal

It is estimated that implementation of the recommendations could save £4.3m at a cost of £2.2m over 5 years. In order to provide a like for like assessment we have assumed no growth in demand for service across the system. The recommendations within this report will provide an infrastructure that will allow the area to address growth more cost effectively.

There are a number of assumptions that underpin the calculation of the cost and benefits, further detail of these can be found in Section 7 – Financial Assessment. At a high-level these are:

Costs

- The changes will be delivered over a 30 - 36 month timeframe
- Costs are split, broadly equally, between programme management, change management and technology costs
- Technology costs have been scaled back from original assumptions on the basis that the existing investment in case management and telephony solutions will be leveraged for the future solution
- We have assumed the programme will be run through a consolidated programme team, through existing governance arrangements
- We have provided an indicative cost breakdown by organisation, pro-ratad against the benefits profile with some smoothing to allocate costs to smaller organisations where benefits are low due to the overheads associated with the implementation of best practice

Benefits

- The benefits profile is based on savings over a five year period from the start of the project
- Most savings are headcount based, through a more efficient set of services, driven by scale, automation and implementation of best practice
- We have assumed a level of non-cashable savings (£0.5M) for deskpace reduction which is relatively marginal compared to overall savings. This is also based on a reduction in the number of locations from over 8 to 2
- We have assumed a single management team with a standard management span of control which yields a contribution to the savings profile (almost 20%)

These changes will need to be underpinned by a Quality and Performance framework that will have sufficient management controls to identify service delivery issues and service user outcomes and to plan for continuous improvement initiatives that will ultimately enhance the commissioning of quality services.

1.6. Non-Financial Benefits

In summary the following non-financial benefits will be achieved by implementing the recommended TOM:

- Multi-skilled workforce serving Health and ASC services across LLR
- Improved experience for service users and professionals alike
- Consistent approach to service delivery and application of standards and pathways
- One single view of the service user/customer journey
- Reduction in failure demand across the system
- A professionalised, well equipped and confident workforce at the point of access for Health and ASC services
- Greater job satisfaction and reduction in attrition rates and associated costs (although these have not been a measured in the financial assessment), which have been highlighted as an issue across services
- Time saved by professionals no longer having to progress chase individual cases
- The collation of structured and timely data that will allow informed decision making at a local and system level

1.7. Enabling Future Benefits

This approach to the implementation of the programme is predicated on building capacity and capability across the existing Health and ASC teams (i.e. the teams that manage the calls into the services only). The programme provides an opportunity to develop, at system level, the in-house capability to deliver complicated system change programmes, as this delivery is likely to be one of many.

Developing structured and standardised ways of working in operational areas and across programme and change management will allow for easier integrations in the future. As part of the implementation of this programme, the processes and service costs will be baselined allowing the LLR system to better understand the impact of any future decisions they will need to make.

As this programme may lead the integration of technology, this experience can and should be used in other programmes. It is critical that a structured programme is mobilised with the right level of resource and experience to deliver this business case and the associated change management activities. (see Appendix 2 – Why Programmes Fail).

Another major benefit from the approach is the systematic collection of data, which will allow for the redesign of pathways, identify failure demand at a system level quickly and provide evidence for further investment.

What has not been quantified at this stage are the benefits for those who use the service and the impact this may have on patients and service users. It is anticipated that there will be significant time saved through users no longer having to chase service requests. The collection of data that informs the design of services could create additional efficiency benefits across the LLR system.

The impact of this implementation should also increase service resilience as there are currently multiple single points of failure (across the system) as service knowledge is retained in individuals' heads. As part of the baselining and data collection, it is recommended that further analysis of these benefits is examined.

2. Introduction and Background

Within the Leicestershire Better Care Fund (BCF) plan submitted in September 2014, the Leicestershire partners identified the need to consider further developments in relation to Points of Access specifically within the County as part of the joint vision of integration. This included reviewing options for the integration of the various existing Points of Access and Customer Service Centres across the Health and ASC economy.

Since the BCF plan was submitted, the development of the LLR Better Care Together Five Year Plan also highlighted the need to consider how Points of Access across LLR could be simplified and reconfigured in support of demand management and the "left shift". The reason for this is so that professionals and service users can make the best use of the most appropriate service in the most appropriate setting of care, and that the information and signposting provided is responsive and consistent with local pathways.

2.1. Project Aims and Objectives

The overarching aim of the programme is to deliver a business case outlining options and recommendations for a new Target Operating Model (TOM) for integrated Health and ASC across the various Points of Access within LLR. The approach focused on positive engagement with key stakeholders from across the Points of Access in the scope of the programme, the co-design of ideas and solutions and clear and open paths of communication.

It is important to note that the programme focused on how service users and professionals accessed services and pathways (i.e. the 'front door') and not the delivery of services across partners.

The overall aims of the Integrating LLR Points of Access programme are, to:

- Support the delivery of 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
- Support the reduction of inequalities in care (both physical and mental) across and within communities in LLR
- Support the improvement of health and well-being outcomes for citizens across LLR
- Optimise the opportunities for integration and the use of physical assets across the health and social care economy
- Support the achievement of a more appropriate use of health, social and community services
- Ensure that services are easily accessible through appropriate access channels to as many people as possible within the community

- Support the drive for financial sustainability across all health and social care organisations in LLR, by adapting resource, as a result of the new model, where appropriate
- Improve the utilisation of the in scope workforce and develop new capacity and capabilities, in our people and the technology we use

2.2. Project Scope

The following seven Points of Access were included in the original project scope:

- Leicester City, Single Point of Contact
- Leicestershire County, Customer Service Centre
- Public Health Leicestershire County Council, First Contact Plus
- Rutland, Customer Service Team
- LPT CHS, Community Health SPA
- LPT AMH, Adult Mental Health SPA
- LLR Wide, Bed Bureau

As the project progressed, the Leicester City Incident Crisis Response Service (ICRS) was added to the scope of the project through a formal change control process approved by the Project Board, increasing the number of in-scope Points of Access to eight.

2.3. Approach

The following section summarises the approach undertaken by 4OC and LLR resources to achieve the agreed project aims and objectives.

2.3.1. Stage 1 - Mobilisation

The Mobilisation stage took place over a two-week period and was used to complete detailed planning and preparation for the subsequent stages of project delivery. This was achieved through a combination of:

- Meetings with the Project Sponsor and key stakeholders
- Clarifying project aims, objectives and expected outcomes
- Agreeing project governance
- Identifying key stakeholder groups and individuals
- Identifying existing information to be considered as part of the project analysis and recommendation stage, for example, Vanguard - Workstream 1

Key Outputs

- Updated Project Plan
- Project Governance

- Stakeholder Engagement Plan
- Situation Analysis
- Case for Change

2.3.2. Stage 2 – Information Gathering

The Information Gathering stage took place over a two-month period. During this stage, 4OC worked closely with key stakeholders to get a clear understanding of the existing services delivered across Health and ASC customer service centres within LLR. The team completed site visits to the Points of Access and partner organisations to understand and map the following:

- Current services delivered across Points of Access, including Pathways
- Service delivery models and high-level business processes
- IT systems and infrastructure across Points of Access
- Partner relationships
- Demand for service
- Access Channels

In addition to the above, 4OC facilitated two co-design workshops with representatives from the identified stakeholder groups to discuss and agree options for a rationalised service delivery model across the existing Points of Access and capture individual/group ideas for an integrated operating model. The workshops were well attended by representatives at all levels across the stakeholder groups, including service users, and the programme team received very positive feedback from those who attended (see Appendix 3 for a summary of workshops).

Key Outputs

- High-level Customer Journey Maps for current service across multiple Points of Access
- Value Chain analysis detailing key activities and outcomes that informed the high-level options appraisal (see Appendix 4)
- Technology Maps for multiple Points of Access
- Service Demand Analysis across all services
- Target Operating Model Options
- Updated Risk, Assumptions, Issues and Dependencies (RAID)

2.3.3. Stage 3 - Analysis and Recommendation

The Analysis and Recommendation stage took place over a one-month period. This stage of the programme focused on detailed analysis of the information gathering stage, predominantly the value chain and strategic options appraisal, together with

recommendations for the Points of Access Target Operating Model (TOM) aligned to the overarching LLR vision for integrated services.

Key Outputs

- TOM Strategic Options Appraisal (see Appendix 5)
- Preferred list of ICT products to support the TOM
- Draft Business Case with recommended approach
- Draft implementation Roadmap

2.3.4. Stage 4 - Review

The review stage of the project presented the SRO and project board with an opportunity to review the outline business case and implementation roadmap as recommended by the project team. The business case and implementation plan were refined and updated as part of this process based on the feedback received.

Key Outputs

- Refined Business Case
- Implementation Plan and Roadmap

2.3.5. Stage 5 – Close Out

A workshop will take place with the Project Board to handover the final version of the business case and implementation plan.

Key Outputs

- Close Out Report

3. LLR Health and ASC - Target Operating Model

Leicestershire County, Leicester City and Rutland County Councils (LLR) have a range of Points of Access that provide help and support to the Health and ASC service provision including, assessment of need, signposting and responding to service requests. These Points of Access include disparate customer service/contact centres for each of the Local Authorities and a number of general and specialist customer service/contact centres within the Health settings.

Although the 'customer journey' and high-level business processes are relatively generic across these Points of Access, all of the existing services operate separately and in different ways, with little information sharing across services and visibility of service user outcomes.

3.1. Issues with the existing TOM

There are a number of operational issues with the existing services, which are discussed further below. These issues have been grouped in to three categories: People, Business Process and Technology.

3.1.1. People

- Staff, in some cases, do not have the necessary internal support materials to enable them to deliver a responsive and effective service. (For example, standard operating procedures (SOPs), up-to-date business processes, policies and procedures)
- Ambiguity exists amongst staff as to the service offer across points of access. For example, SLA and KPI management as opposed to service user focused contact. In this case, some staff prefer to ignore call handling times/targets and provide the service user with a positive and quality engagement to determine the most appropriate action to take based on their needs which increases the overall process time
- Staff feel that they don't have access to the relevant knowledge and information to effectively manage contacts into the services and therefore assess users' needs effectively and sign-post to relevant services
- In some instances, staff circumvent the agreed business process and approach it in the way that 'they see fit'. For example, the detailed ASC assessment process is inconsistently completed introducing duplication of effort and elongating the overall business process time

3.1.2. Process

- All services operate differently and to different business process and standards, which may not have been documented either in business process format or SOPs. In

some cases, these are not up-to-date or reflective of the current service offer

- There is evidence of manual workarounds to support business processes where there is no supporting system, for example schedules of work for mobile staff and rostering systems for internal service staff
- There is variability as to how the services capture data and undertake resolution

3.1.3. Technology

- The services are telephony centric and have various telephony solutions deployed that provide varying levels of MI that may be used to manage the service effectively in terms of demand management
- There are five different systems used to capture customer contact, manage referrals and capture sign-posting information which are not currently integrated. This results in duplicate service user records and lack of end-to-end visibility of the customer journey and outcomes
- Services rely on outdated technology to receive referrals into the service, for example, faxes
- Operations do not have the capability to schedule work according to team capacity either within an organisation or into multidisciplinary teams
- Lack of systems functionality, sophistication and integration means that performance management and all aspects of quality, including measuring effectiveness of pathways and outcomes, cannot be achieved nor services improved

3.2. Service Specific Findings

Table 1 below summarises some key findings from the site visits to the Points of Access as part of the information gathering stage of the project. These are presented as 'what works well' and 'what doesn't work so well'.

It is important to note that initiatives are underway within individual organisations to address some of the issues presented below (what doesn't work so well).

Table 1 - Summary of Key Findings per Point of Access

Ref	Point of Access	What works well	What doesn't work so well
1	Leicester City – Single Point of Contact	▪ Excellent, experienced team with a 'can do' attitude ▪ Initial triage completed by team Support Worker to identify the reason for the call and either sign-post as the caller isn't eligible or transfer	▪ Focus on service user experience means that SLAs and KPIs and service demand may not be managed effectively ▪ Lack of SOPs and supporting information that supports

Ref	Point of Access	What works well	What doesn't work so well
		to a duty worker for further assessment to a social worker if they already have a case ▪ Focus on service user experience ▪ Home visits, pre-screening and assessment to ensure best use of staff time and minimise wasted visits ▪ Pending implementation of an on-line portal that may enable channel shift (to be rolled out across County and Rutland)	service delivery ▪ Manual spreadsheets and workarounds to manage staff capacity and work allocation ▪ Assessment forms are completed manually on the site visit and then re-keyed to the Liquid Logic system meaning duplication of effort and increased process time ▪ Lack of multi-skilled staff
2	Leicester County – Customer Service Centre	▪ Good contact centre infrastructure including accommodation and lay out, telephony and Liquid logic system ▪ Teams are well structured with health care professionals co-located in the call handling teams to support initial assessment and sign-posting ▪ Multi-channel contact centre with telephony, email, and web contacts ▪ Broad and deep service offering ▪ Good management of SLAs and KPIs ▪ Staff get good experience and build in-depth knowledge of Adult Social Care services ▪ Strong Management team in place	▪ Limited multi-skilling and assessment ▪ Staff over-assess callers because of the above ▪ The website and external collateral is not fit for purpose and therefore channel shift is difficult to achieve, increasing the level of phone contact and ultimately the cost of service delivery ▪ There is a high volume of calls from professionals in terms of progress updates ▪ Although SOPs are in place they tend to be out of date and aren't always followed correctly ▪ The service is seen as a recruiting ground for ASC and staff turnover may be a little high
3	Public Health Leicestershire County Council – First Contact Plus	▪ Strong and focussed management team ▪ Well skilled and experienced operation team with a 'can do' attitude ▪ Good location on the Leicestershire County campus ▪ Currently managing the requirements gathering and design of an on-line portal for providers and service users ▪ Process in place to measure	▪ Disparate systems to manage information ▪ Manual process for receiving referrals (pdf) recording the information manually and then entering in the system, duplication of effort

Ref	Point of Access	What works well	What doesn't work so well
		outcomes (although not automated)	
4	Rutland - Customer Service Team	▪ Small knowledgeable customer service team managing all contacts to the Council ▪ F2F offering for service users ▪ Good local knowledge of services for sign-posting ▪ Good website to promote self-care and sign-posting ▪ First Contact Bus for outreach	▪ The number of repeat calls made to the centre ▪ Currently in the process of configuring and implementing Liquid Logic, which will be a different instance of the system currently deployed at County CSC and Leicester SPOC
5	LPT CHS – Community Health SPA	▪ Good Contact Centre principles in place ▪ Strong management team ▪ Focused and knowledgeable staff ▪ Good management information available to resource the centre appropriately and manage SLAs and KPIs effectively	▪ No capacity planning and scheduling tool to effectively allocate work to remote locality teams which results in failure demand i.e. repeat calls ▪ Layout of current centre, separate rooms, not a standard call centre layout ▪ Receive a large number of faxes from GPs ▪ Noisy operating environment ▪ System navigation issues in terms of the number of clicks to process/access information
6	LPT AMH – Adult Mental Health SPA	▪ Operations is co-located with clinical professionals allowing case consultation to be undertaken ▪ The RIO case management system and telephony solution provides significant amounts of management information	▪ Small operation with on average 2 operators in place. ▪ Call lengths are long and convoluted as RIO often does not have patient information which keeps HCPs on the phone fro significant periods of time
7	LLR Wide – Bed Bureau	▪ Small, focused and knowledgeable team ▪ Co-location in the hospital means that they can contact professionals for advice and guidance ▪ Good controls in the system to minimise risk particularly around ambulance bookings	▪ Small, cramped office located on the hospital site ▪ No telephony system producing meaningful MI ▪ MI collated manually ▪ Disparate systems to manage referrals and booking to appropriate hospital for in-chair triage ▪ Rely on manual systems to get

Ref	Point of Access	What works well	What doesn't work so well
			up-to-date information as to bed availability ▪ GPs tend to send faxes ▪ SOPs are out of date and require updating
8	Leicester City - ICRS	▪ Co-location of the ICRS service in the Neville centre with partners from Mental Health, Community, Therapy ▪ Services are co-located and leads from each service are in constant dialogue to manage the service effectively ▪ Joint assessment visits (holistic assessments) to assess user needs and ensure that they get the right care ▪ ICRS has a service delivery success rate of 75% i.e. 75% of service users do not require any further intervention or hospital admission ▪ The team use a robust capacity planning tool Staff Plan (Advance Health Care) which pushes the itinerary to operational staff	▪ As with other services, the service manages disparate systems causing duplication of effort ▪ Lack of SOPs and supporting process material although this is work in progress

3.3. Proposed Target Operating Model (TOM)

The proposed TOM for Health and ASC Points of Access aligns to the original vision for a co-located and integrated Health and ASC service delivery model. The proposed model has been co-designed with key stakeholder groups across the Health and ASC setting including:

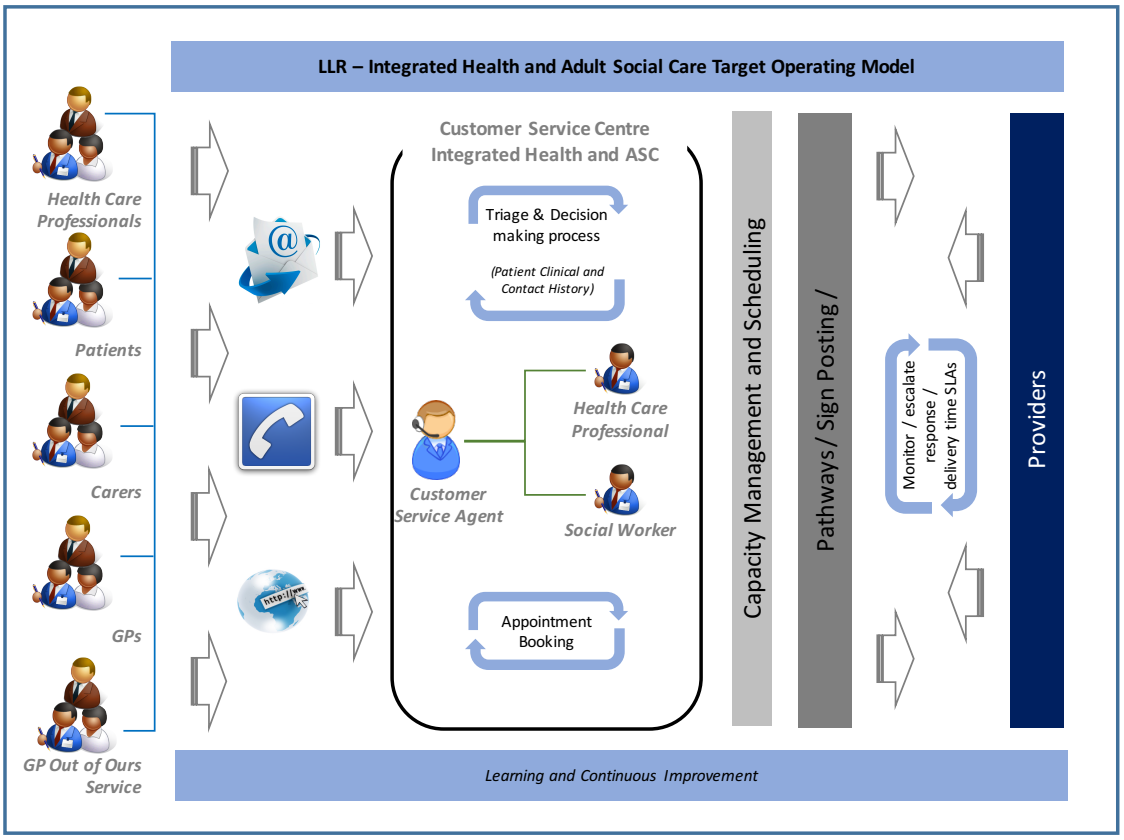
- Heads of Service
- GPs
- Vanguard representatives
- Contact Centre Managers
- Members of CCGs
- Frontline staff including call handlers
- Service Users
- Representatives from 111

Iterations of the proposed TOM have been presented to the Project Board and subsequently

approved. **Figure 2** below illustrates the proposed TOM and this section will elaborate on the following:

- The shared vision for integrated service delivery across Health and ASC services
- TOM Features
- Implications
- Rationale

Figure 2 - Future Target Operating Model for LLR Integrated Health and ASC



There is a clear vision for the service in the longer term that is based on:

- Either one or a significantly reduced number of co-located facilities that provide a single or reduced number of points of access to Health and Social Care services across LLR
- A high-performing operation that provides timely response and feedback on a wide variety of access to services
- A single repository for interactions from across LLR generating quality management information that can be used to inform continuous improvement and support decision making regarding the evolution of services
- Generating granular data that can be used to identify and flag early indications of critical care requirement
- A shift towards community defined services
- A community of professionals creating appropriate pathways for individuals

- A digital self-service offering for professionals and service users alike
- Improving outcomes for service users and patients

3.4. Proposed TOM Features

- A primary focus on providing a single point of access for professionals into the resources that execute a defined set of services in the LLR system
- The principles and capability will be extended to support patient facing activities
- Where possible, the process of service request and notification of service progress and completion will be automated
- Non-value adding work will be removed and transactional activities will be automated
- Validation and pre-population of information in the assessment process
- E-referral processes
- Operators will have access to a shared record, initially based on information from SystmOne and Liquid Logic
- Workflow updates will notify progress of activities
- There will be standard ways of working and managing performance
- Operating agreements will be in place at transition points
- There will be a single number to access multiple services
- Where possible resolution will be at the first point of contact
- There will be shorter call times driven by business process and system automation
- A method of capturing data to drive improvements and support system and potentially clinical decision making or interventions

3.5. Implications

- There should be a single management structure in each site, operating to the same standards
- Processes should be co-designed and shared between the sites
- Consistent operating processes and performance measures should be in place, as well as clearly defined transition points and service levels
- There should be a single service governance for each site with membership from each of the service provider groups and from the CCGs
- SystmOne would be used as the single source of interactions, but where a transaction involves social care, the details would be replicated within Liquid Logic
- Technology solutions would be integrated to reduce the level of double keying
- SystmOne would be configured to generate outputs that would allow the generation of Management Information and Business Intelligence
- The introduction of a capacity planning and scheduling tool will improve the interface between the contact centres and operation delivery, therefore complimenting existing mobile working solutions/technology and ultimately

reducing failure demand

- Staff should be seconded into the service to reduce complexity, maintaining Terms and Conditions

4. Alignment to Vanguard

4.1. Background

There are a number of programmes that are underway across LLR that have or could have an impact on the shape of the eventual solution being proposed. The most significant of these in terms of dependencies is the Vanguard programme and, in particular, the Urgent Care workstream, Workstream 1 as well as the LLR IM&T programme.

Vanguard, Workstream 1 are developing a new model of primary and intermediate care for the LLR system to align with the re-procurement of the 111 service. Following a period of engagement with key stakeholders, the Vanguard team have arrived at a draft operating model that contains aspects of the service being proposed through the Integration of LLR Points of Access.

To co-ordinate the design of these services, it was agreed that the Vanguard team would be included in the governance structures for this programme and have attended all programme boards. There have also been a set of design workshops to generate an holistic picture of the two proposed operating models to ensure consistency of vision and approach.

The design workshops for the Integration of LLR Points of Access programme have consistently promoted the need for increased levels of clinical support to the triage processes involved. The Clinical Triage Hub model being proposed by the Vanguard team provides a strong match to this requirement. To this end, we have jointly recognised the interdependencies between the programmes of work.

Work is ongoing to ensure a strong alignment of the Design Principles for the programmes and to capture and define in a formal manner the interdependencies that will need to be managed through implementation as the programmes are agreed. As an example of requirements for co-ordination the need for a consistent and co-ordinated IM&T strategy to support the implementation of these programmes has been identified and further engagement planned.

4.2. Options for Alignment

Although engagement has been positive and the programmes could continue to progress through the current governance structures, it is likely that as each programme progresses there will be increasing levels of interdependency and mutual risk that will need to be managed.

Another option is for the two programmes of work to develop a more formal joint

governance model to provide a single focus for management of activities, risk and dependencies.

5. Programme Implementation Approach

This section details the approach to implementation of the integrated Health and ASC model across LLR.

5.1. Phased Approach

The business case advocates a phased approach that takes into account the constraints within the LLR system and the practical realities of integrating at this scale. This phased approach allows some benefits to be realised early in the implementation and begins to build quality data and relevant information that can be used to inform decision making for the integration and co-location phases of the programme.

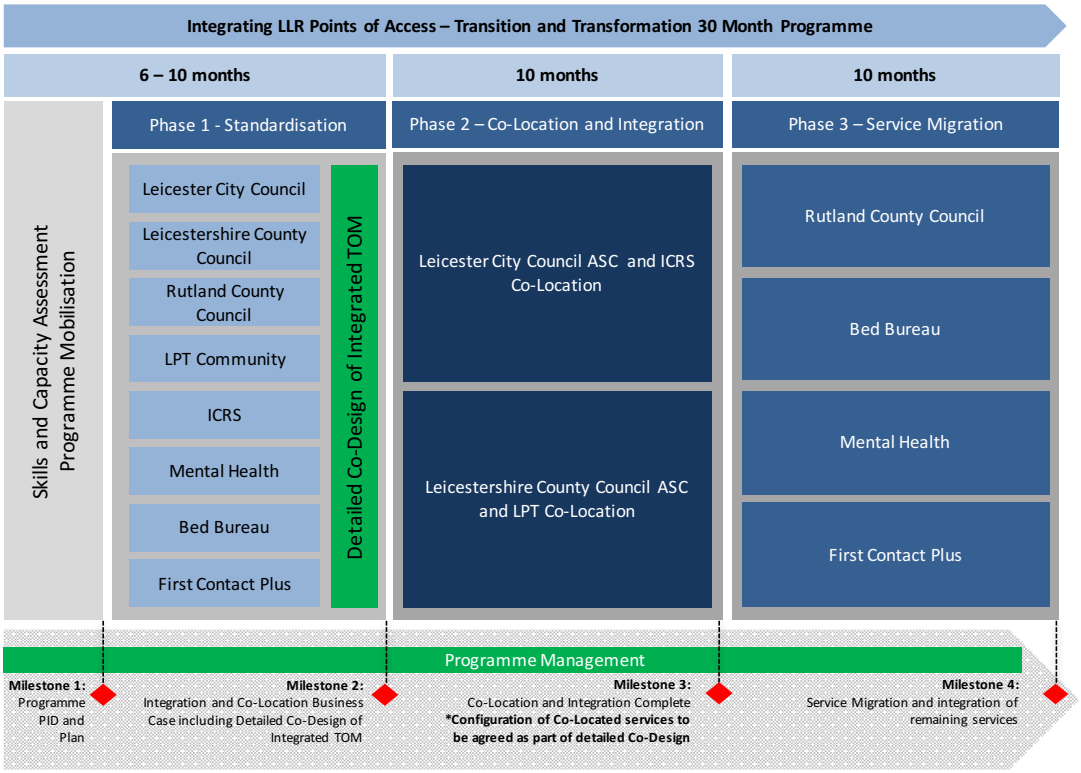
The approach has a number of staged phases as illustrated in **Figure 3** below. The implementations should be managed through a dedicated Programme Team to provide consistency and to ensure that the specialist resources undertaking the activity are used effectively. In addition, it will be important that the detailed design is co-designed with the service delivery teams, patients and service users as part of Phase 1 – Standardisation, to ensure that the solutions are workable and to cement commitment to the change.

The Roadmap in **Figure 3** is for illustrative purposes and outlines what can reasonably be achieved given the constraints, the risks that need to be managed and deliver the anticipated outcome and financial benefits. It highlights the potential phasing of the programme over the anticipated timescale of 30 months and the potential timescales per phase as well as key milestones and outputs.

The Roadmap will undoubtedly be reconfigured as the standardisation and co-design work commences and the detailed planning starts to take place. This will have an impact on the shape and timing of the integration and co-location activities and final shape of the Target Operating Model.

It should however be noted, that any changes to the assumptions contained within this business case will have an impact (positive or negative) on the costs, benefits and timelines. As outlined in this document, there will need to be an actively managed impact assessment process as part of the programme management of the implementation to allow the system to make informed decisions about any material changes to the assumptions in this business case.

Figure 3 - LLR Integration Roadmap



5.1.1. Programme Mobilisation

There will need to be a series of mobilisation activities prior to the commencement of the implementation phases these are as follows:

5.1.1.1. Setting up the Programme

- The drafting of the Project Initiation Document (PID), the programme plan and cost model in order to baseline all programme activities that will need to be measured
- The further development of the roles and responsibilities required
- The further development of the risks, issues, assumptions and dependencies (RAID) log
- The setting up of the programme board to manage the implementation phases
- The approval of these documents by the Programme Board

5.1.1.2. Skills and Capacity Assessment

A capacity assessment should be completed to establish what availability there is within the teams to participate in the programme of work and how this then can be managed on a day-to-day basis. This assessment will allow decisions on what additional resources may be required and how these can be sourced. It should be noted that if external resource is

required, time will need to be added to the programme plan for the procurement process.

There will be a requirement to undertake this assessment prior to detailed mobilisation activities. In addition, a decision will also need to be made from where the programme team is managed and which organisation hosts it and who has the bandwidth to manage the resources.

5.1.1.3. Set up of Programme Management Office (PMO)

There will be a requirement to have experienced and skilled resources to plan and manage the implementation activities, through the agreed governance in the programme. As part of this programme of work the key resources are defined as, Programme Manager, Programme Support and Change Manager (see *Section 5.7.1* – key programme roles).

Consideration should be given to seconding operational personnel into the team to develop capability for the later stages of the programme to reduce reliance on external resource. Consideration should also be given to utilising the existing skills within the PMO functions of the three councils and LPT.

The programme team should manage the following:

- The agreed governance controls, including programme boards and reporting
- The stakeholder engagement strategy and plan
- The relationship with the Vanguard programme of work (Workstream 1)
- Benefit identification, measurement and tracking including any associated risks that may hinder benefits realisation including an action plan to mitigate these
- The change strategy and plan including the communication approach and plan
- An impact assessment process to determine the impact to programme timelines, costs and deliverables that may result on the back of any requests for change
- Risks, Assumptions, Issues, Dependencies (RAID) and Mitigating strategies and actions
- Interdependencies between this programme and other programmes in the LLR system including Vanguard and IM&T
- The design of the Target Operating Model (TOM) and underpinning operating procedures based on the original agreed Design Principles, including business user requirements
- The undertaking of an assessment of organisational or digital readiness to assess the maturity of each of the organisations' change capability

5.1.1.4. The Set up of a Perfromance and Change Function

This will ensure that there are the skills within the system that can effectively plan and manage the change activities throughout the implementation phases. This function will also be responsible for identifying, prioritising and implementing additional change initiatives in the Business as Usual (BAU) operational environment.

5.1.2. Phase 1 – Standardisation

This phase of the programme will focus on system and process improvement across all in-scope areas. The aim is, before integration starts, to have a common and consistent method of operating, in line with the agreed Design Principles, which will make integration easier and potentially less costly as there should be a reduced requirement for bespoke IT configuration. The activities in this phase include:

Business Process Re-design (BPR): This will ensure that the business processes and standards that underpin the services, where possible, only undertake value adding work (non-value adding activities will be removed). It will also ensure that the operational processes are documented and Standard Operating Procedures (SOPs) and performance metrics are put in place to support the staff in their roles.

Requirements Definition: This activity will feed the technology workstream in the programme to ensure that any systems reconfiguration accurately reflects the redesigned business processes, business rules and policy and procedures. This activity and associated outputs (business user requirements) are critical to the successful design and implementation of the optimum TOM.

Benefits Identification and Management: The programme should develop an agreed process for benefit tracking and management for the entirety of the programme. A baseline exercise should be undertaken at the start of the implementation phase and a measurement method agreed. It should be noted that through this programme there will be achievable financial and non-financial benefits across the system, not only in the 'front door' of service provision. It is envisaged that users of the service will also be able to measure the benefits of the changes proposed under this implementation.

The development of the Estates Strategy: The estates strategy and plan will feed into the benefits realisation strategy. This activity will quantify the financial benefits associated with a rationalised call centre estate across the LLR system. In addition, the strategy should recommend an approach to estates management for these functions in the future.

Detailed Co-Design: In parallel to the standardisation phase a detailed co-design workstream should run to develop the optimal approach for integration and co-location.

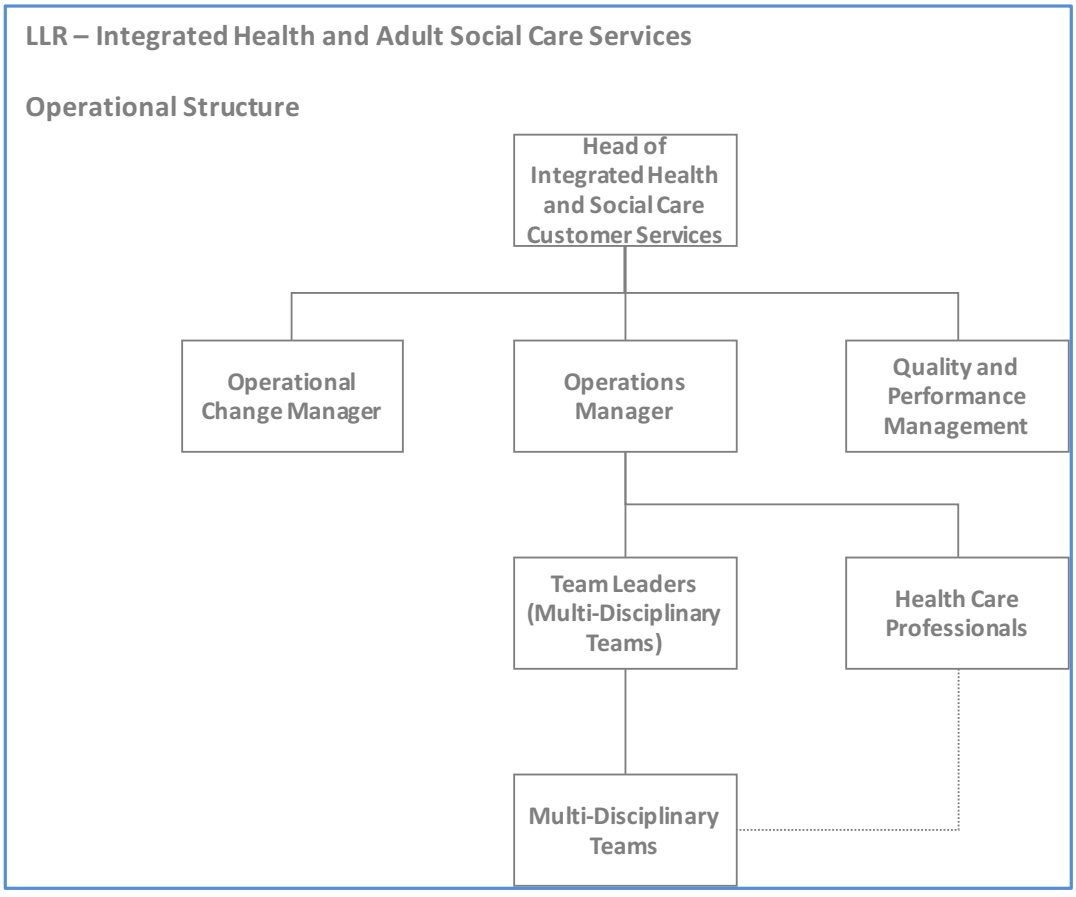
This phase should result in the production of a more detailed business case to allow the programme board to make decisions of the configuration and phasing of the integration and co-location activities, based more robust assumptions on costs, benefits, risks and mitigations.

5.1.3. Phase 2 – Integration

Following approval of the detailed business case and development of the implementation plan the co-location and integration activity can commence. The business case outlines the areas that at this stage of analysis would appear to be more straightforward to integrate at this early stage. This recommendation is also based on the knowledge that there are already existing working arrangements in the system.

One Governance Structure: A uniform management structure should be designed in the detailed design phase and agreed as part of the detailed business case approval. Once the services are co-located, this structure should be refined and improved to ensure that the aims and objectives of the service integration are met. The structure will reflect the roles and responsibilities of all staff in the services. An example structure is illustrated below:

Figure 4 – Integrated Health and Social Care Structure



Management Events: This activity relates to the design and implementation of management events that provide the management team with the necessary controls to monitor and measure the performance of services and teams. These controls include the reporting mechanisms required to highlight service performance. It also includes the management governance meetings to discuss underlying business issues and plan for corrective and preventative action, the outcomes of which will feed into the quality and performance management framework.

Multi-skilling: Once the above has been implemented and embedded, the management team can start the process of light touch multi-skilling of teams. This may initially take the form of job shadowing and joint assessments so that resources in the services get an understanding of the business processes and outcomes. This approach is currently deployed by the Leicester City, ICRS team and the co-located Health and Community services at the Neville Centre.

ICT Configuration and Integration: Reconfiguration and integration of ICT as well as procurement of any additional ICT (i.e. a capacity management system) will run in parallel with the above activities. This will be based on the business user requirements documented in Phase 1 of the programme as well as the agreed Design Principles (see Appendix 1 for the agreed Design Principles).

5.1.4. Phase 3 – Service Migration

Phase 3 addresses the phased migration of the remaining, now standardised Health and ASC customer services across the LLR system to the locations that have been agreed in the detailed business case. By this stage of the programme those services that have already been co-located will have benefited from the implementation of standardised and best practice business processes and new ways of working.

Financial and non-financial savings will have been realised and the new entities will have achieved proof of concept, which in turn will improve confidence in the new integrated ways of working. This in turn will make the migration of the remaining services less contentious and significantly easier to incorporate into the new TOM.

The migration will be planned and take into account the operating priorities of each of the remaining services at the time of service migration.

5.2. Timelines

Based on 4OC's experience of similar sized Transition and Transformation programmes, we anticipate a 30-month programme of work to achieve the agreed aims and objectives

aligned to the shared integration vision across stakeholder groups. This delivery would be split as follows:

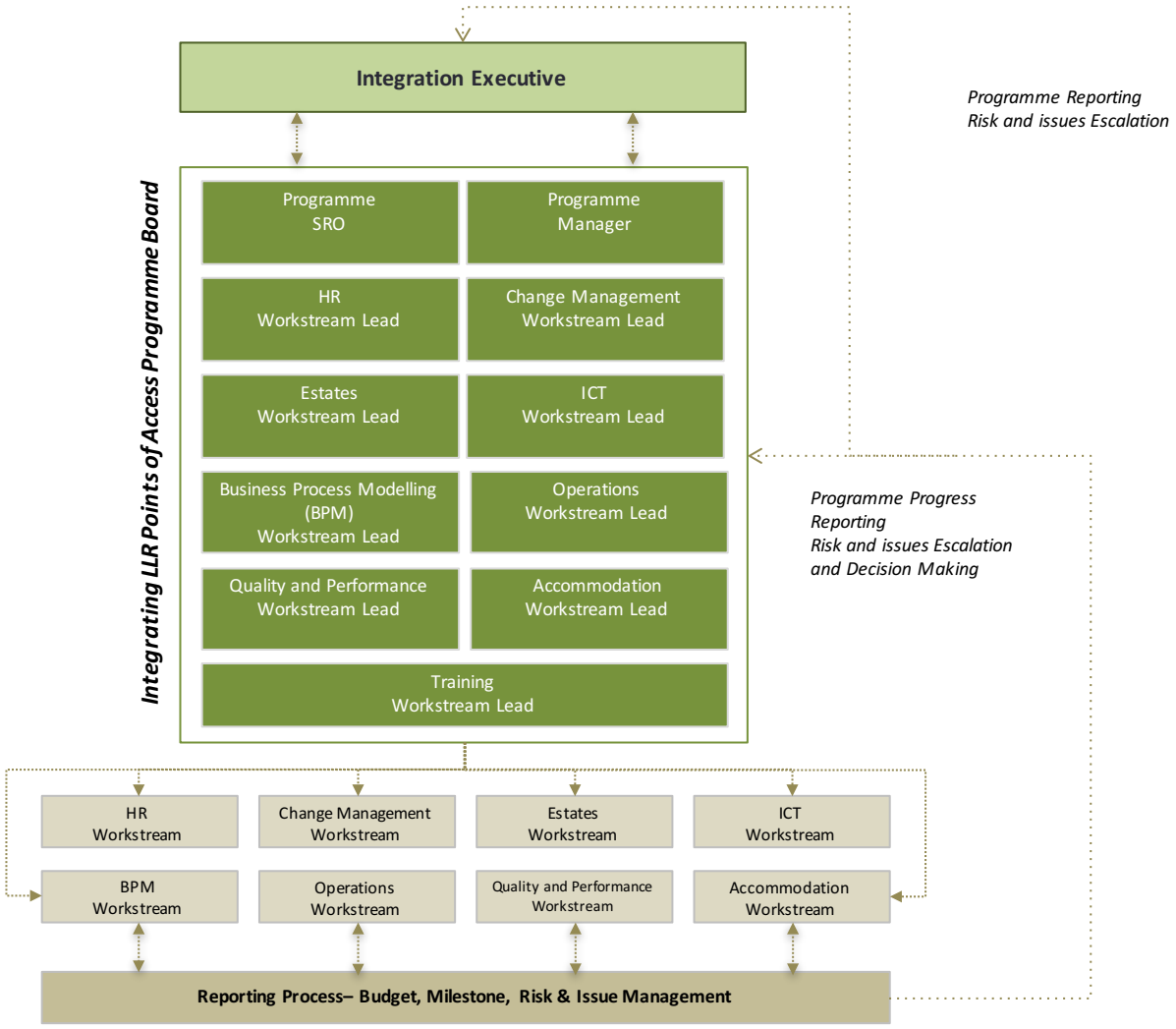
- Operational Readiness – 6-10 months
- Integration Phases – 10 months
- Service Migration – 10 months

It is likely that, during detailed planning for the later stages of the implementation, the programme timings may move as new information is produced.

5.3. Programme Governance

Figure 5 below illustrates the programme governance structure, detailing key roles and alignment to the Integration Executive.

Figure 5 - Programme Governance Structure



5.4. Change Approach

The challenge in this programme will be to drive the change while ensuring that there is no increased risk and minimum disruption to current service delivery. The following section outlines the key elements of a successful change approach that will ensure there are sustainable changes in behaviour, systems, processes, organisations and job roles, that are designed around the needs of the community that is being served.

5.5. Decision Making

The change and programme approach should allow managers throughout the programme to make decisions based on good information. As the detailed design of the solution emerges, it should provide them with the flexibility needed if new information or issues arise. The programme governance should provide a clear mandate to the programme to achieved the aims and objectives.

The programme manager should set up the programme to ensure that this happens. The time spent planning, engaging with stakeholders and engaging in detailed co-design with staff and users should not be underestimated. It will be essential that a programme manager who has experience of delivering this level of change across multiple organisations is sourced to drive the programme.

It will be vital that the senior stakeholders be clear about the relative priorities and that they support staff and professionals with the decisions they will face as to whether to engage and execute the change. Those involved in the programme must be given head-room and support so that they can properly engage in managing the change and that their managers in turn must be properly informed and equipped to allow them to do that. The programme manager must support the senior stakeholders by providing them with quality and timely information to make those decisions.

5.6. Co-Design

The Design Principles agreed at the outset of this programme and documented in this business case should provide the framework for the detailed co-design phases throughout the implementation. It is essential that during the design, planning and implementation of the programme these principles should be constantly referenced to check that the programme is not designing out the intent articulated by the principles. The process of co-design of the case for change provides senior managers and staff with a level of comfort that they are making controlled decisions.

Co-design with those who operate the services and with service users and patients is essential. The associated effort and costs involved are often overlooked in programmes and

are a contributing factor as to why programmes fail. The detailed co-design must engage staff in meaningful and cost effective activities that contribute to the overall aims of the programme so that they can recognise their contribution. It also provides a solid foundation on which to build communication and engagement plans.

Co-design provides a vehicle for gaining a common understanding of the aims of the programme, the definitions used and what they really mean along with absolute clarity on what people are required to do. This gives individuals and teams the time to work through and process the words being used into the associated actions and, most importantly, it allows them to recognise what it means to them and the people they interact with. It also ensures that best use is made of all available expertise and experience in the development of robust and sustainable solutions. It makes staff, professionals and patients feel that they are making a contribution to the change and not having change done to them.

This phase should also take into account any previous work or engagement with patients and service users to reduce the amount of rework.

5.7. Experienced Programme Management

This programme will need to be led by an experienced programme manager who has a successful track record of delivering change programmes that have produced measurable results. They should have specific experience of delivering change across departmental/budgetary/organisational boundaries, and be able to demonstrate how their approach has supported the decision making in the programme.

The programme manager should establish the programme in such a way that the programme team is made up of a combination of experienced programme skills and resources seconded from the operational areas so that capability and capacity can be developed to manage subsequent programmes in LLR system, reducing reliance on external agencies. The methodology used should ensure that those engaged in delivering the programme have their skills increased as a direct result of being involved. The ability to plan, manage interdependencies, work with stakeholders and communicate effectively are key skills in any job and involvement in this programme should measurably improve these skills.

5.7.1. Key Programme Roles

The key roles for the overall programme have been identified and are listed in **Table 2** below together with responsibilities, skills and experience.

The key PMO resources that have been identified for this programme are:

- Programme Manager
- PMO Support
- Change Manager

The above roles equate to c. 27% of the total programme spend of £1.8m and reflect the level of leadership required to deliver a programme of this scale and complexity.

Table 2 - LLR Integration Programme - Key Roles

Phase	Total Programme Costs by Phase	Costs
Standardisation	Programme Resource Costs	*£621,000*
	Transition Technology Costs	*£82,600*
Integration	Programme Costs	*£871,200*
	Technology Costs	*£300,000*
Service Migration	Service Migration Programme Costs	*£323,300*
	Service Migration Technology Costs	*£75,000*
Total Costs		**£2,273,100**

Ref:	Role	Responsibilities	Skills and Experience
1	Programme Manager	- Manage the Transition and Transformation Programme of Work - Governance arrangements including programme controls - Creating and managing the programme plan on a day-to-day basis - Budget Management - Reporting to the Programme Boards - RAID Management	- A Minimum of 8 years experience of managing complex programmes of work - Certification in one or more project / programme management methodologies, for example Prince II, Agile or Managing Successful Projects (MSP) - Ability to work well under pressure and to tight deadlines - Able to manage / priorities complex and multiple programme activities - People management
2	PMO Support	- Planning - Bookings - Reporting - Document configuration and management	- A minimum of 3 years of experience of managing PMO activities on complex programmes of work - Ability to work under pressure and to tight deadlines to achieve overall programme objectives and deliverables - Knowledge of one or more project / programme management methodologies, for example Prince II, Agile or Managing Successful Projects (MSP)
3	Change Manager	- Change Strategy - Change Plan - Communications - Stakeholder Engagement	- Extensive experience of managing change workstream on complex programmes of work - Knowledge of Change Management Methodologies, for example Kotter - Ability to communicate effectively at all levels within the programme governance framework - Experience of benefits realisation methodologies / management
4	Estates Workstream Lead	- Develop estates strategy in-line with the programme aims and objectives - Estates rationalisation - Lease negotiation	- Experience of estates rationalisation activities as part of a complex programme of work - Excellent communication and negotiation skills - Excellent business and financial acumen
5	Business process Design Workstream Lead	- Business process Modelling Strategy - Business Process Modelling - Implementation of Integrated TOM - Business User Requirements gathering aligned to the agreed Design principles and redesigned business processes	- Experience of Business Process modelling as part of a large programme of work - Knowledge of one or more BPM methodologies such as Business process Re-engineering and lean - Excellent workshop facilitation and tools and techniques
6	Operations Workstream Lead (inc. SOPs)	- Develop the Service offer - Standard Operating Procedures - Alignment to Quality and Performance	- Strong Operational experience in terms of managing operational resources, including budgets, people business process - Strong understanding of business process improvement and how this translates in to the day-to-day operating environment to realise efficiencies - Ability to own and manage the operational outputs of a complex programme of work
7	Quality and Performance Workstream Lead	- Develop the Quality and Performance Management Framework - Develop the continuous improvement approach including outcome measures - Develop the approach to the maintenance of the Directory of Services	- Experience of managing the design of quality and performance frameworks to achieve operational effectiveness as well as drive best practice activities and behaviours - Knowledge of best practice quality and performance management frameworks and methodologies
8	Accommodation Workstream Lead	- Work with the Estates workstream lead to determine the configuration of co-located sites - Ensure that the integrated sites have adequate equipment and facilities that support integrated working	- Experience of relocating services to alternative facilities as part of a complex change programme of work - Experience of managing all aspects of accommodation reconfiguration including the transfer of all necessary hardware and work station assembly - Technical infrastructure design and configuration

5.8. Training

The programme will need to have a workstream responsible for training. A training needs analysis will be required to identify the most effective means of ensuring staff have the

capabilities to apply the new operating model to their roles. The approach to staff training will be identified through this activity, ensuring staff are engaged in a way that best meets their needs. The training material should be developed to provide a resource that staff can use on an ongoing basis, and which can be redeveloped alongside any future changes.

5.9. Performance Measures

A key part of the design phase of new ways of working will be the development of a series of indicators demonstrating how those new ways of working are contributing, directly or indirectly, to the aims of this programme. It is vital that these indicators do not contradict or work against what is being measured or managed in people's day jobs.

In addition, it will be important to ensure that the measures are supported by policies in HR, training, patient safety, etc. There should be a 'golden thread' of metrics running from the aims of the programme, through the outcomes frameworks in each organisation to the new ways of working. There should also be metrics which measure the service user and patient experience.

5.10. Impact Assessment

Throughout the design phases of the programme, each proposed change will inevitably have an impact on the activities of the current operation. These impacts must be understood and made visible so that the programme, sponsors and politicians can make informed decisions on whether to proceed with the changes. These impacts should be articulated in terms of risks, accompanied by a set of proposed mitigations, costs and benefits and timescales. This process should be completed under the programme disciplines brought by the programme manager.

Part of this process should be a review of other change initiatives running concurrently to identify the most appropriate interfacing/resource usage. The programme should be aware that organisations have a finite capacity for change and that the same key resources will often be engaged in other change projects across the LLR system. Change fatigue is a real phenomenon that exhausts and confuses people and organisations. This will firstly need to be understood and then managed so the timescales for delivery are planned properly.

5.11. The Development of Change Strategies

The approaches to change, communication, engagement, testing and training should be developed by the programme team, who must ensure that they reflect the existing policies (and/or have a process to vary policy if required) across the system. HR, communications

and IT teams should be involved in the detailed design phases to prevent delay or rework in the latter stages of the programme.

5.12. Change Planning

Below are detailed the key components of a good change strategy and plan:

Communications: A communication strategy and plan should be drafted as part of the detailed planning phase of the programme. The strategy should consider the following:

- Each organisations' communication strategy, if applicable, in terms of what types of communication is deemed to be effective
- The media available and accessible to the programme to communicate effectively across individual organisations
- Language and tone used to communicate consistently across the individual organisations in-scope of the programme
- A detailed communication plan with assigned owners, aligned to key programme milestones and deliverables including scheduled events to communicate progress (e.g. roadshows)
- Alignment to the agreed stakeholder engagement strategy

Stakeholder Engagement: The level of stakeholder engagement in the implementation phase should not be underestimated. This is a complex delivery in a complex Health and ASC system. In order to develop this business case, there has been up to 30 days of effort in stakeholder engagement alone, from the programme board members and the 4OC team. It was also estimated that the time spent on stakeholder engagement in the development of the Better Care Fund plans exceeded this.

It is critical that this time is planned properly and the extent to which stakeholders are expected to be involved is communicated early and as clearly as possible. This is key in ensuring that key stakeholders are comfortable with the decisions that the programme will ask them to make.

6. IM&T Requirements and Approach

There has been a significant amount of activity to understand the current issues and plans the surround the ICT architecture across services. The following sections examine these issues, which have informed the implementation approach outlined in this Roadmap.

6.1. Current Landscape

6.1.1. Lack of Interoperability

There is a lack of interoperability with the business systems currently deployed by the services across Health and Adult Social Care (ASC). The services are therefore unable to exchange or share information that would improve service delivery for service users and health care professionals alike. For example, a single view of the service user history across a range of Health and ASC services may improve decision making and future signposting to relevant services.

6.1.2. Inability to produce Meaningful Management Information

There is currently no consistent or structured approach to capturing service user information at the point of care. This results in multiple care records in multiple systems across services as well as variations of management information that requires further manipulation to be meaningful. This issue is compounded by the maintenance of manual records to support service delivery.

6.1.3. Lack of Business Intelligence

Overall, the services lack the ability to produce business intelligence from the systems in terms of recording patient outcomes post care intervention. This in turn means that the services are not able to identify and continue the commissioning of effective pathways, execute a continuous improvement approach to service delivery and maintain an up-to-date directory of services.

6.1.4. Asset and Resource Optimisation

Asset and resource optimisation is not achieved within the current structure. There is a reliance on manual workarounds to assign work items and appointments as well as work schedules across teams and across localities, for example, in community nursing. This in turn means that there is a lack of visibility of teams' activities and potentially increased resources and therefore increased cost to support this.

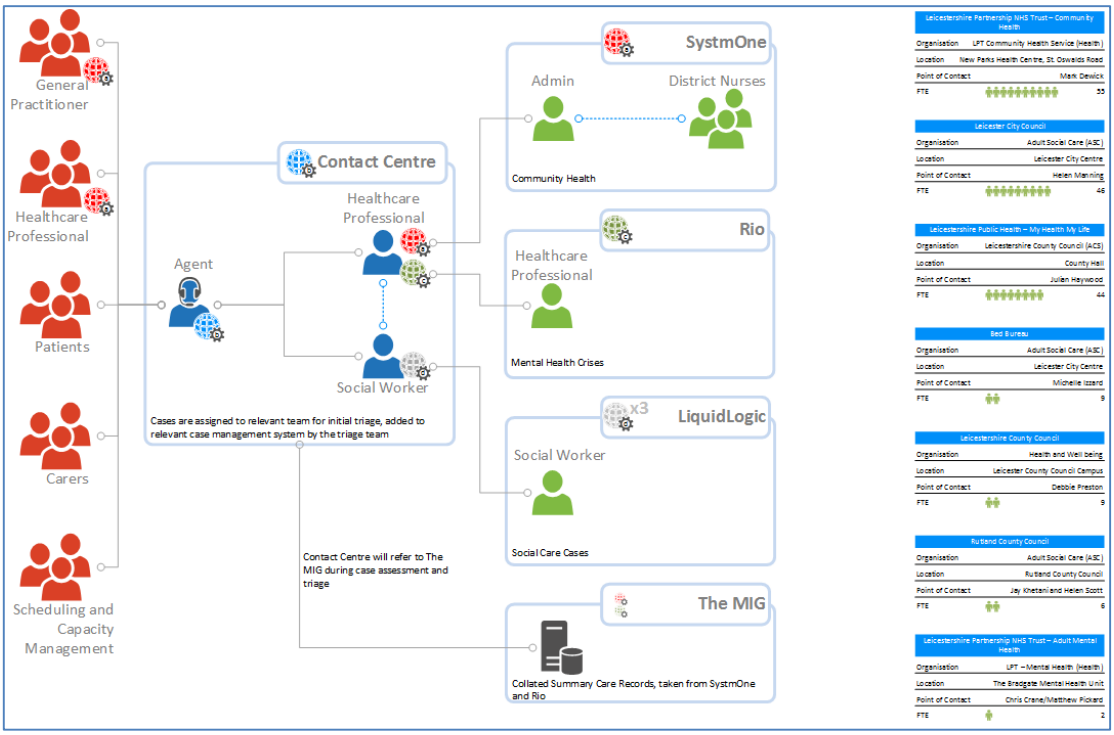
6.1.5. Progress of Assessment and Care Provision

Although there are plans to introduce online portals for health care professionals and the public, including within Leicester ASC and First Contact plus, there is no mechanism for professionals and service users to receive notifications as to the status of progression through the process. This results in increased contact to the services for progress updates and high levels of failure demand management.

6.2. Proposed architecture

The proposed architecture for the integrated Health and ASC Point of Access is illustrated in **Figure 6** below:

Figure 6 – Proposed Architecture for Integrated Health and ASC Point of Access



The architecture required will have the following features:

- Telephony solution that interoperates with the solutions used within EMAS, 111 providers and the other providers in the LLR health and social care system
- The ability to support warm handovers of end users between the relevant subject matter experts within the system
- Provision of web-based and app-based front end to service requests supporting single sign on and a security model
- Case management solution that allows the capture of information, the sharing of case notes, the development of care plans and the provision of notes back to primary care

- The ability to trigger service requests and track status of requests across the case management solutions across the system, particularly Liquid Logic in social care
- Capacity management planning and resource scheduling tool to support the most appropriate allocation of work within the provider base and remotely to reduce failure demand and improve service delivery
- The generation of management information to support the efficient and effective delivery of services

6.3. Solution Requirements

Solution Requirements for the architecture to be put in place for an integrated point of access will include:

- Consolidated record for service users and referrers
- Feedback on requests to the shared summary record for service users and to primary care records
- The provision of status for each service request
- Contact centre functionality and reporting
- Ability to transfer records from one operator to another in near real time
- Call scripting and knowledge management to support more efficient processing
- Highlight patient history including previous referral patterns
- Record, time stamp, track and manage requests for Unscheduled and planned Care services
- Highlight potential breaches of service levels
- The provision of Management Information and Analytics that support:
- A set of reporting metrics and analysis tools that will allow the business to manage its performance, meeting and surpassing the organisation and patient expectation as well as to engage with partners to drive channel shift and support internal transformation initiatives
- The development of data from the service that will allow the development of internal continuous improvement and to support organisational decision making
- The development of a Self-Management capability via the implementation of an on-line portal

6.4. Information Governance

There will be a significant challenge around data and information security for the integration programme particularly the challenge of sharing data between the in-scope organisations across Health and ASC.

The principles of information security require that all reasonable care is taken to prevent

inappropriate access, modification or manipulation of data affecting service user records.

The Information Governance frameworks for both Health and ASC services will be identified early in the Standardisation phase of the programme. The co-design activities will therefore consider these frameworks and requirements when developing the detailed design of the integrated Health and ASC TOM.

6.5. Areas of Risk and Potential Mitigations

Technology and integrations are likely to generate a high level of risk to the delivery of the programme. The programme has been structured in a way that reduces dependency on integration and to drive savings out of operational best practice. However, in order to achieve the operating model described, significant changes will need to be made to the systems landscape across LLR.

The risks identified during the analysis phases include:

- Data inconsistency across systems. The way data is captured and the varying standards applied to data capture, make it difficult to share information across service resulting in a risk that operational efficiencies will be hard to achieve
- The mitigation to this risk is included within the activities in Phase 1 with a focus for staff on the design of consistent master data across services. This will require a degree of data cleansing and configuration within the existing case management solutions, and completion of a universal data dictionary, which is allowed for within the timescales and costs
- Solution resilience
- Each of the services provides an important component of the overall functioning of the Health and Social Care system for LLR. Consolidating technology solutions, while delivering many benefits, also increases the risk that a systems outage will impact the system on scale, generating concern about the approach and progress of the programme
- The mitigation to this risk involves a clear focus within the programme requirements, Design Principles and solution design on ensuring resilience and fault tolerance is built in to all proposals and that stakeholders are briefed on these aspects of the eventual solution
- Information Governance is always a challenge in multi-agency environments and there is therefore a risk that a solution design does not adequately allay concerns across the organisations involved. This could impact the implementation timescales for the technology solution in Phase 2 increasing the cost of the programme and potentially negatively impacting the benefits through efficiencies
- The mitigation to this risk involves building upon the work achieved through the LLR IM&T BCT Enablement Group and the in place Data Sharing Agreement. The

development of any solution designs that relate to information and sharing of data will be impact assessed with the relevant IG representatives across the LLR provider base

6.6. Capability and Capacity

The following highlights the capabilities required in developing a new architecture including:

- The solution providers and their ability to deliver requirements
- The bodies of expertise in each of the organisations associated with the systems used
- The requirements for significant levels of change over the coming years
- The development of this capability to support functions such as ILPoA

7. Financial Assessment

7.1. Introduction

The analysis team, on behalf of the programme board, have reviewed each of the services through staff and management interviews, staff shadowing, data collection and follow up meetings as well as financial analysis, to form a view of the operational structures, operating model and efficiency and effectiveness in order to generate an informed view of a future operating model and a level of potential savings.

They have also undertaken a number of workshops with practitioners, frontline staff, local management and executives in order to ascertain the shape and approach to develop an integrated point of access for the LLR Health and Adult Social Care system. From these activities we have identified an incremental approach to the development of an integrated service that the services involved and the programme board feel is an appropriate and deliverable means of generating the objectives for this business case.

A key deliverable of the business case approach was to to identify areas of potential savings and to identify the cost of development of the agreed solution. Our findings indicate that there is scope for financial and cashable savings that can be delivered in a structured way through the three distinct phases identified in Section 5, which are the:

- Standardisation Phase
- Integration Phase
- Service Migration Phase

We believe, supported by the findings of the workshops, that an 'in-place' process improvement exercise, undertaken at the outset would best prepare the services for integration. This activity would in itself yield significant savings against our benchmarks for public service delivery functions. We have identified the high-level costs and expected benefits for this first phase, as outlined later in this section.

The second phase of activities, Integration, will focus on the larger areas of service delivery across the system. This in turn lays the groundwork for a wider integrated point of access for Health and Adult Social Care services. The savings delivered through this integration are based on a set of reasonable assumptions relating to a level of achievable technology integration and increased levels of self-service and automation.

We have provided an estimate of expected costs and benefits/savings for this phase, as outlined below. We recommend that additional analysis be carried out through the first phase, as detailed requirements should be developed to support the validation and refinement of the assumptions made within this document.

The third phase of activities, Service Migration, involves the integration of the remaining services across the system into the the integrated hub or hubs created in the Integration phase. We envisage additional services being introduced over the following months as the technological prerequisites for integration are met.

This programme provides the foundation for a broader integration and we have estimated the potential costs and savings for the current in-scope services. It should be noted that there remains an opportunity to deliver additional savings and to provide a more rounded service for health and social care, including young people, for professionals in other organisations and areas of service delivery within the system.

Finally, we have developed a proposed financial governance approach to ensure that both the constituent organisations and the overarching Better Care Together programme can exercise managed control over investment decisions.

7.2. Expected savings and sources

There are five primary sources of financial savings that have been profiled within the business case, which are described within this section. Savings have been modelled based on assumed efficiencies that could be achieved through reported transaction volumes, staffing numbers, hours of service and recommended management structures. The savings have been identified against each phase of the programme for the services that are in-scope.

We have assumed savings arising from the reduction in staff and management numbers, but we have not factored in redundancy costs. We have assumed that the reduction in numbers can be achieved through natural attrition given the reported levels of staff turnover in the current services.

7.2.1. Process Efficiencies

Our analysis has shown that the in-scope services are run on a professional basis and there are pockets of best practice. Consolidating these approaches and applying best of breed management techniques across all the services will yield efficiencies. In particular, our analysis has identified resource planning, performance management, continuous improvement techniques and the standardisation of processing as contributory factors in the delivery of savings.

7.2.2. Channel Shift

There are some examples of good practice in the use of on-line approaches to facilitating

service requests that could further reduce the level of manual processing and intervention required across the services if applied consistently throughout the service.

Although good progress is being made in the reduction in use of paper and fax, there are still relatively high levels of service requests being triggered by paper based forms.

7.2.3. Reduction in failure demand

Across all services there was evidence of activity being generated and undertaken that yielded few positive outcomes. Examples include chase calls for non-appearance of staff or for status updates. There were a number of instances where there were high levels of service requests that resulted in no further activity being generated, particularly around adult social care.

There was evidence of considerable chase activity to other delivery areas within the system being undertaken by the services in scope. The root causes for this chase activity included communications breakdowns in process and unidentified implications of roster changes.

7.2.4. Management efficiencies

We have assumed a management span of control metric based upon extensive experience across a range of public sector contact centre and administrative services. Through the delivery of Process Improvements and later through the integration of services, we have identified savings amongst the management and team leader cohorts as the metrics associated with this span of control are achieved.

Some of the existing services suffer from a lack of scale and variety of spans of control which has lead to the entire system having more management roles than in best practice operations. As the approach moves towards co-location and consolidation, we have identified savings relating to the reduction of management roles.

By contrast, for this type of service delivery, there are some roles that are notably absent. When the operations are consolidated, we recommend that these should be put in place as they support best practice working in a service that is a front door. These roles include Quality and Information Management, Change Management and Training. We have factored these roles in to the future organisation shape and have included the associated costs as additional cost against the overall savings. We believe that these roles are essential in supporting an agile service at this scale.

7.2.5. Property Rationalisation

During the Integration and Service Migration phases, there will be the opportunity to reduce

deskspace demands across a number of buildings for the constituent organisations. We envisage that the future operating model would best be supported by at most two locations, a reduction from the eight currently in operation.

We have identified a saving through migration to existing properties within the combined estate and the reduction in demand for floorspace. The degree to which these savings are could be claimed as cashable is currently being reviewed.

7.3. Other notes

It is important to note that any reduction in demand that we have allowed for are relevant only to the services in scope. We have made no assumption for the impact (in terms of effort reduction) for the 'back office' services that underpin the points of access. We would recommend a parallel process be undertaken to review delivery processes in light of the recommended changes by the transformation teams within each organisation.

The team have assumed conservative estimates for savings. In reality we would expect the delivery of greater efficiencies than those described.

7.4. Savings Assumptions and justification

The smaller services included within the scope of the business case tend to have less associated overhead. The efficiencies identified above therefore have a more marginal impact at this scale and as a result we have not included any potential savings in these cases. These services include Rutland County Council and the ICRS service provided out of City Adult Social Care.

For the remaining services we have made the following assumptions:

7.4.1. Leicestershire County Council - CSC

We have assumed a reduction in failure demand across the service through an effective community and professional engagement campaign to ensure a higher level of appropriate referral. We have assumed a resulting 10% reduction in contact demand.

We have assumed a 5% reduction in effort through a review of the processes in place within the service. Average effort per case is over 35[1] minutes currently providing scope for implementation of standard procedures to free up time. For this service we have assumed no channel shift savings.

[1] It should be noted that this includes contact and administrative time

7.4.2. Leicester City SPOC

We have assumed a reduction in failure demand across the service through effective community and professional engagement campaign to ensure a higher level of appropriate referral. We have assumed a resulting 10% reduction in contact demand.

We have assumed a 5% reduction in effort through a review of the processes in place within the service. Average effort per case is over 70[2] minutes currently providing scope for implementation of standard procedures to free up time.

For this service we have assumed no channel shift savings.

7.4.3. First Contact Plus

Analysis of the contact data provided by the service reflected a greater cross-community age profile for this service than the other services. It also indicated a lower level of repeat calls, whether to chase progress or to raise subsequent service requests. To this end we have made a very low estimate for improvement in failure demand and have assumed a 1% reduction.

Based on a review of the contact data provided, we believe that the service could benefit from a review of process and the identification and definition of standard operating procedures. The training and application of these processes would lead to an estimated 5% reduction in effort across the service.

7.4.4. Leicestershire Partnership Trust - SPA

The review of this service with management and staff and the analysis of the data provided from SystmOne allowed the team to develop a profile of activity undertaken within this service. The structure of the service is split between contact centre staffing and administrative staff that are co-located with front-line staff. The scope of this review has included contact centre functions only.

The identified savings are associated with call handling and processing of both e-referrals and paper-based referrals. It should be noted that there is a large degree of interdependence between these functions and the change programme would need to manage these interdependencies from a process design and organisational change perspective.

[2] Based on the data provided to the team from the case management solution

Reported high levels of repeat calls per service request (e.g. Where's my Nurse) and the level of outbound calls would indicate high levels of failure demand. The root causes are likely to be working practice issues that will require significant change programme effort to resolve and an investment in solutions to better support a peripatetic workforce. We have estimated a 10% reduction in processing demand for the Point of Access. We have also costed for solutions in this space to facilitate new working styles.

Review of the data extracted from SystmOne indicates that there are improvements in data collection that could drive process revision and reduction in effort for the Points of Access. We have assumed a 5% reduction in effort through the development and implementation of revised standard operating procedures and a revised quality and performance framework.

We have also assumed additional improvement in the migration towards increased e-referral, which will require professional engagement and training. We have estimated a conservative 5% reduction in handling activities through this approach.

7.5. Phasing of the savings

Tables 3 and 4 below, identify the savings associated with each phase of delivery. For the Operational Readiness phase this is identified by constituent organisation. For the subsequent phases, the savings have been identified for the integrated service.

Table 3 - Phasing of Savings

Phase	Saving
Benefits by phase	
Phase 1	2,647,050
Phase 2	913,528
Phase 3	794,566
Total	4,355,144

Table 4 - Phasing of Savings over time

Phase	16/17	17/18	18/19	19/20	20/21	21/22	Total
1	-	487,323	664,531	664,531	664,531	166,133	2,647,050
2	-	86,902	254,347	254,347	254,347	63,587	913,528
3	-	17,901	234,691	240,877	240,877	60,219	794,566

7.6. Cost of Implementation

7.6.1. Phasing of delivery

We have developed a model that captures the costs associated with the three phases of

activity defined within the implementation section of this document as illustrated in **Table 5** below. Following feedback from the wider team we developed a best case and worst case scenario in order to model these costs. The variables used included:

- The duration of the phases - in particular the length of time associated with phase 1
- The level of backfill required for operational roles in order to mitigate the effect of secondments of key staff into the programme team
- The level of change management resource applied to the costs in order to support the move to new ways of working

For the purposes of costings for this business case it was agreed that a mid-point would be used between the best case and worst case scenarios.

Table 5 - Programme Costs by Phase

Phase	Total Programme Costs by Phase	Costs
Standardisation	Programme Resource Costs	*£621,000*
	Transition Technology Costs	*£82,600*
Integration	Programme Costs	*£871,200*
	Technology Costs	*£300,000*
Service Migration	Service Migration Programme Costs	*£323,300*
	Service Migration Technology Costs	*£75,000*
Total Costs		**£2,273,100**

7.6.1.1. Standardisation Phase

This phase is intended to allow individual services to prepare for the joint working across LLR, to identify and implement common approaches to service improvement, to identify larger programmes of change as part of consolidation and to mitigate the risks associated with a move to an integrated service.

The teams will be supported through the provision of subject matter experts in the areas of business process redesign, organisational change, training and communications. The programme team will also focus on defining the next phase of activities to the next level of detail.

The scope of the operating model design improvements will include:

- Development of standard operating procedures that are co-designed and shared across services
- The development of common customer contact standards with similar service levels across service
- The identification of common working practices and engagement with staff to agree these practices across LLR

- The introduction of revised working practices that allow improved performance including:
  - A revised structure with standardised spans of control
  - A performance management framework that supports staff to achieve team targets
  - The introduction of "management events" to allow team leaders, managers and staff to review ongoing performance, recommend future changes and discuss the pending implementation of small and large changes. This phase accounts for close to 25% of the overall spend planned for the programme. The bulk of the activity will occur in the financial year 2016/2017, with savings delivered in the following financial year.

The plan purposefully avoids including technology development through this phase, reducing costs and shortening the timescales for implementation and benefit delivery. **Table 6** below summarises the spend by quarter profile.

Table 6 - Spend by Quarter

Phase	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	Total	%'age
1	245,200	287,275	119,375	55,750	-	-	-	-	707,600	26%

7.6.1.2. Integration Phase

The second phase of change will focus primarily on the development of large centres of best practice for the delivery of an integrated point of access for services. This will be based on a twin track approach of multi-disciplinary case activity and the development of the required technology underpinnings. The following will be in scope for this phase:

- The development of two sites within the geographical area, which will host state of the art contact centre functions providing site resilience
- The development of common pathways in association with the planned Clinical Triage Hub and other clinical services within the system to support the right-shift of care away from emergency and unplanned admissions
- The development of shared care and case records that enhance the visibility of patient centred activity across the system
- Improvements in the the visibility of the status of planned patient activities (in order to reduce the levels of failure demand)
- Increased levels of e-referral and online self-service for health care professionals
- Improved capacity management, both for the contact centre services but also within the operational delivery realm, through better co-ordination, planning and underlying software tools

From an organisational perspective, the scope of this phase covers Leicestershire County and Leicester City Adult Social Care contact centres and LPT Community Services SPA.

This phase accounts for close to 60% of the profiled spend for the programme and involves the bulk of the spend on technology. The spend is spread over the 16/17 and 17/18 financial years on a 40/60 basis as illustrated in **Table 7** below.

Table 7 - Spend by Quarter

Phase	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	Total	%'age
2	-	54,300	155,250	285,250	316,550	226,650	107,550	32,850	1,178,400	55%

7.6.1.3. Service Migration Phase

This final phase is designed to build on the practices and infrastructure delivered through Phase 2, drawing in a wider range of services from across the system developing towards a more comprehensive point of access for services.

The scope of this phase is similar to phase 2 but includes the following services within the scope:

- Rutland County Council Adult Social Care
- Leicestershire County - First Contact
- LPT - Mental Health Crisis team
- UHL - Bed Bureau
- Leicester City – ICRS service

It should be noted that there are a number of other services that will be included within the scope of this phase but which have been excluded at this stage due to technology change requirements.

This phase accounts for 20% of the overall spend. This spend of approximately £400k is spread between the financial years 17/18 and 18/19, as illustrated in **Table 8** below.

Table 8 - Spend by Quarter

Phase	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	Total	%'age
3	-	-	-	-	-	25,975	94,175	104,750	366,750	20%

7.6.2. Split of costs between organisations

We have identified a split of costs between organisations in **Table 9** below on the basis of the potential financial benefits of undertaking the integration of points of access. However

for organisations with smaller points of access benefits may be close to zero or negative, therefore we have smoothed out the effect.

Table 9 – Cost by Organisation

Point of Access	% of benefits	Phase 1 Costs	Phase 2 Costs	Phase 3 Costs	Total Costs
CSC (County)	22%	£ 154,792.00	£ 334,628.57		£ 489,420.57
SPOC (City)	23%	£ 161,828.00	£ 349,838.96		£ 511,666.96
First Contact Plus (County)	8%	£ 56,288.00		£ 138,539.13	£ 194,827.13
SPA (LPT)	27%	£ 189,972.00	£ 410,680.52		£ 600,652.52
Bed Bureau	5%	£ 35,180.00		£ 86,586.96	£ 121,766.96
Rutland County	5%	£ 35,180.00		£ 86,586.96	£ 121,766.96
ICRS (City)	5%	£ 35,180.00	£ 76,051.95		£ 111,231.95
Mental Health Crisis (LPT)	5%	£ 35,180.00		£ 86,586.96	£ 121,766.96
Total		**£ 703,600.00**	**£ 1,171,200.00**	**£ 398,300.00**	**£ 2,273,100.00**

7.7. Financial Governance

This section will deal with the financial governance for the delivery of the integration programme. The team recommend the following principles underpin the management of finance during the delivery phases of the programme:

- That for the first phase of delivery, as defined in the implementation plan, and for those elements of subsequent phases that precede the development of an integrated service under one management structure, financial governance is undertaken by the constituent organisations for the in-scope services
- The funding for the implementation of the changes described, as well as a contribution to the overarching programme management, will be prorated across the organisations in scope. For the first phase and until there is a single entity in place to manage an integrated delivery of service, the associated benefits will accrue to these organisations
- The financial governance for each organisation will include the business case submission for capital and revenue funding for the programme and the management of subsequent MTFS, QIPP or similar business planning as a result of planned savings
- Subsequent funding to support technology integration and further integration of services will be sourced through constituent Better Care Funds and national technology funding initiatives.
- Efficiencies associated with these later phases will be used to re-invest in change initiatives for integrated services across the system

For subsequent phases of investment, where investment is being made for a single entity (the integrated service) a revised financial governance will be put in place that will reflect

the governance associated with the Better Care Together programme.

There are a number of initiatives, in place and planned, that require the creation of a single entity to manage back office/shared services across the system. This programme will ensure that the management structures services defined within this document will align with these other planned services (e.g. Help To Live At Home programme).

We recommend that there is a stage-based approach to approval of spend for the implementation programme to ensure that funding matches the achievement of goals (both in terms of deliverables and benefits/savings).

For phases of delivery subsequent to the first Process Improvement phase we have estimated the costs and benefits based on the scope as currently set out. We would recommend that these figures are reviewed and refined in advance of the commencement of the Integration and Service Migration phases.

7.7.1. Benefits Tracking

This programme of works is dependent upon, and is a dependency for, a number of programmes of work across the system (e.g. Mobile Working within LPT Community Health). We would recommend that the programme structures put in place to manage the tracking and reconciliation of benefits and savings across the system for all works impacting the cost of delivery for the integrated service. This would ensure:

- That the interdependencies between programmes of work that ensure the delivery of the financial and non-financial benefits are monitored and reported upon
- That there is reduced risk of multiple business cases claiming the same benefits
- That the the full picture of the impact of the planned changes on the system are mapped, commonly understood and reported upon

8. Risks, Issues and Constraints

This section details the immediate risks, issues and constraints associated with the proposed integrated TOM and approach to implementation as well as mitigating actions.

8.1. Programme Risks

Table 10 - Initial Risk Register

Ref.	Risk	Probability	Impact	Mitigation Strategies
1	A delay in the final sign-off of the business case and a subsequent delay in the decision making process to proceed to implementation, may result in loss of momentum and key programme resources (who have participated in the business case process) *and* who have been assigned to the implementation programme may move on to other projects or programmes. This will leave a programme skills gap and result in a subsequent delay to programme mobilisation and ultimately an impact to benefits realisation	H	H	(1) Discuss and agree a robust decision making and business case sign-off process across partnering organisations. (2) Undertake a capacity planning exercise to assess skills available across organisations' PMO functions and develop a resourcing plan to fill capacity and skills gaps (3) Develop and agree a recruitment plan and mobilise
2	Subject Matter Experts (SMEs) and Change Champions assigned to the Transition and Transformation Programme from the points of access in-scope are not back filled therefore they will have conflicting priorities between Programme and BAU activities that may hinder progress	M	H	Agree which resources are required to participate in the programme as part of the implementation approach (Inc. costs) and agree approach to backfilling as part of the sign-off stage and pre-mobilisation of the implementation phase
3	The organisations involved may not be able to reach agreement on progressing through the implementation phases delaying progress and impacting benefits realisation	M	H	Ensuring that there is a commonly understood and agreed set of aims, objectives and Design Principles that are aligned to the LLR overall vision. This has created a framework to guide the programme though the design and implementation phases

Ref.	Risk	Probability	Impact	Mitigation Strategies
4	The overall benefits may be diluted as the timelines for benefit realisation become extended and the economies of scale of running a concertinaed implementation phase are reduced	L	M	Developing a set of reasonable assumptions that will allow the programme to move through each of the phases with known, unknown and managed risk
5	The Transition and Transformation programme is not resourced appropriately with a mix of internal and external staff with the required experience and the project will fail to meet the aims and objectives in the business case including benefits realisation	M	H	Undertake a skills gap analysis against programme governance resources to determine which internal resources may be assigned to the programme and those resources and skill sets that need to be procured
6	Health and Local Government cultures and ways of working, together with differing priorities may mean that there is a challenge getting stakeholders together and make timely decisions, which have an adverse impact on programme timescales	H	L	On-going stakeholder engagement and communication as per the proposed approach detailed in the implementation plan Use the Governance framework and controls to identify and mitigate risk as soon as possible
7	Cost of systems integration and interoperability may impede transition to optimum Operating Model	M	M	Complete a detailed business requirements mapping exercise as part of the design phase of the project to determine costs of integration between existing systems and the procurement of any additional systems and assess the impact to the TOM and agree alternative solutions
8	A lack of clearly thought through internal communications regarding the Transition and Transformation programme could result in inaccurate messages filtering through to staff impacting morale and delivery progress	L	M	(1) Communications strategy to be put in place early in programme mobilisation (2) Pre-emptive messages to be disseminated (3) Ensure the process is open and as documented as possible
9	As this level of integration has not been achieved before, the LLR system may not have confidence to move at the	M	M	(1) Developing a set of reasonable assumptions that will allow the programme to move through each of the

Ref.	Risk	Probability	Impact	Mitigation Strategies
	pace required to deliver the benefits identified in the business case			phases with known, unknown and managed risk (2) A phased implementation approach to standardise and optimise the ways of working across all the organisations involved to drive out savings early in the programme to help build credibility and confidence
10	The timelines for the IT integration and the Vanguard projects may have a material impact on the progress on this project	M	M	Regular communication with IT and Vanguard stakeholders to asses progress, identify risks, issues and mitigating strategies and align change plans
11	The implementation phases cause business interruption	M	M	The planning of the implementation phases should be done in conjunction in the operational areas to minimise business interruption
12	The cost of the Transition and Transformation Programme is deemed too expensive and does not get the appropriate approval and therefore the programme is shelved	L	H	Present alternative costing options for review by the Sponsors and agree mitigating actions
13	Disagreement as to which body funds the service once it is in BAU as well as value of contribution which may adversely impact go-live and BAU	M	M	Explore the governance arrangements as part of the business case review and approach to securing funding from appropriate stakeholder groups
14	The proliferation of case management solutions and instances will prevent the transition to the optimum model and efficiencies may not be realised	L	M	(1) Complete a detailed business requirements mapping exercise as part of the design phase of the project to determine costs of integration between existing systems and the procurement of any additional systems and assess the impact to the TOM and agree alternative solutions (2) Align to the IM&T working group and strategy

Ref.	Risk	Probability	Impact	Mitigation Strategies
15	Senior management and operation staff do not know what is expected of them pre programme mobilisation and during during transition	L	M	(1) Agree governance of the programme early including roles, responsibilities and accountabilities (2) Ensure that a suitably skilled Change Manager is assigned to the programme to develop a Change strategy, communications and stakeholder engagement plan
16	As the phasing of the project is over a 30 month period the partners involved may drift away from the programme as their priorities change and this may have an impact on the overall benefits.	L	M	The partners are aligned to a strategic vision for the LLR system which should be reviewed and refreshed on a regular basis to ensure that this is still relevant to the system. In addition the project team must ensure that in the design and implementation phases that all organisations are actively engaged in the design and identification of benefits
17	There may be unforeseen policy or political changes that have an impact on both the benefits and the time line for the project	M	H	The project team should ensure that an impact assessment is completed on any changes that may impact the project. This impact assessment should allow the system leaders to make informed decisions about progress of the project.
18	Delay in the intervening period between the Business case Sign Off and the start of implementation, causing delay to benefits realisation and a loss of momentum and a potential lack of continuity of the personnel involved.	H	M	Activities are underway to start the process of finding a project manager to take the project forward. Retain, where possible the key personnel involved in the development of the Business case.

8.2. Constraints

Although there is a shared vision for the service and features of the operating model, there are a number of constraints associated with moving straight to the end solution for all services in scope, including:

- The maturity of each organisation's and the integrated system's change approach
- Different political priorities that may impair the ability to have an immediate unified service offering across Leicester City Council, Leicestershire County Council ASC and Rutland.
- The timescale for the Vanguard programme and its potential for overlap with this solution
- A phased approach may lead to organisations drifting away from the original vision as priorities move over time
- The costs associated with the integration of systems will be loaded against a single programme, when in reality progress is being made in this direction over a longer period of time
- Finding a location that could accommodate the service at its current size within the current estate
- The ability to realise cashable savings from vacating locations currently occupied by the existing points of access

9. Market Testing

In the original Request for Quotation (RFQ), the following was asked of the analysis team:

- Where available, explore what others have achieved in order to validate the integration options and identify any external best practice to consider as part of the integration programme
- Scope the requirement for a scheduling and capacity management system and identify and shortlist possible solutions

The primary focus for the capacity management system was for the planning and scheduling of work for staff in the field.

9.1. Approach

We undertook three methods of research to establish if and where, there had been integrations of Health and ASC services that were similar to the ambition in LLR. We specifically focused on finding exemplars that were at a certain level of depth and scale. These three methods were:

- Desktop research
- Engagement with Isle of Wight (IoW) Council
- Input from Health and ASC professionals

9.2. Conclusion

We were looking for the following characteristics so that we could use the research to support the development of this Roadmap:

i. The project was of the scale and ambition of the integrating LLR Points of Access project
ii. The project had similar aims and objectives to those of the LLR Points of Access project and those of the LLR Vanguard project
iii. The project had been fully implemented and its success measured so that the team to use the lessons learned from it

The team found that there was a myriad of Health and ASC integration initiatives under way across the country, however we were unable to identify an example where a comparable level of integration that is required in the LLR project had been achieved.

We were however, able to source the following material that has been summarised in the following narrative. This has been used to support the assumptions that underpin this business case and the recommended approach in this Roadmap.

9.3. Desktop Research

We reviewed a number of reports and publications on Integrated and the delivery of new models of care. We have selected and summarised those examples of integrated working that have helped in the production of this Roadmap. Many of the examples can be found in the Integrated Care and Support Pioneer Programme, released by NHS England. The full report can be found at the link below:

http://www.local.gov.uk/documents/10180/6927502/Integrated+Care+Pioneer+Programme+Annual+Report+2014/76d562c3-4f7d-4169-91bc-69f7a9be481c

9.4. Integrated Care and Support Pioneer Programme

A pioneer programme led by NHS England set out to test how integrated care could provide more support at home and earlier treatment in the community, how this could help people to be healthier for longer and how health and care services could work more closely. This process started in late 2013 when fourteen locations were chosen to develop innovative ways to coordinate people's care. The pioneering organisations include a broad range of health and care economies, ranging from large urban populations to rural counties across the country.

The pioneer sites are:

- Barnsley
- Cheshire
- Cornwall and Isles of Scilly
- Greenwich
- Islington
- Kent
- Leeds
- North West London
- South Devon and Torbay
- Southend on Sea
- South Tyneside
- Stoke and North Staffordshire
- WELC (Waltham Forest, East London and the City) West Norfolk
- Worcestershire

9.5. Worcestershire

One example of the pioneer projects is being delivered in Worcestershire, which is a large county in West England with a population of 567,000. It has an urban centre and a scattered urban population, similar to the demographics of LLR. Their integration programme is called

Well Connected and is a collaboration between three Clinical Commissioning Groups (CCGs), an acute NHS trust, a health and community NHS trust, Worcestershire County Council, NHS England, Local Healthwatch and representation from the voluntary and community sector.

Their vision for improved and integrated care covers all people in Worcestershire with a focus on older people, adults and children with multiple long-term conditions or complex problems. At the beginning of the programme, all partners worked to identify what transformations in care the population needed through a series of multi-organisational meetings and visioning events. This process culminated in the development of a comprehensive five-year strategy defining the direction of changes in health and care in Worcestershire. The three main workstreams of the programme were defined as:

Future Lives: The major change programme for adult social care, including new models of care for integrated health and social care working.

Out of hospital care: This project is in an early stage and will be developing new models for primary care at scale and care closer to home, including enhanced services for prevention and early intervention.

Urgent Care: This encompasses fourteen projects to improve urgent care and manage increasing demand.

The Well Connected programme outlined three highlights in the first year of delivery:

- Developing and clarifying the health economy vision for health and care and incorporating the Well Connected vision into the Worcestershire five-year health and care strategic plan
- Profiling the health and care needs of half of Worcestershire's population to enable them to divide the population into segments with the aim of designing new models of care to meet their different needs, delivered by a collaboration of providers through the mechanism of a capitated budget
- Setting up an integrated commissioning unit to build on previous joint commissioning for mental health and learning disabilities, strengthening its governance and incorporating the necessary capacity for integrated commissioning for older people and to deliver our Better Care Fund proposals.

Key to the programme delivery has been system leadership and commitment to the enabling activity. The programme had buy in from all partners and a clear governance structure was installed from the outset. The strategy was developed with contribution from all stakeholders including service users and their families. Stakeholders are committed to the principle that the needs of service users are more important than the individual organisations.

One of the most challenging aspects of creating an integrated health and social care model

is laying the foundations of partnership working and maintaining this during challenging periods for each individual organisation. Information Governance has also been a struggle for the programme and has put a block on progressing certain areas of the project until a national agreement can be reached.

A lack of resources for the large-scale change made the implementation of the integration difficult, for example the extra investment needed in community services before the scaling down of effort from the acute sector. Workforce planning has also been a challenge and new ways of working can have unintended consequences, for example recruiting high-quality staff to the care home project has left workforce gaps elsewhere in the system.

Enablers and Barriers

Across the fourteen pioneer programmes, common themes were identified relating to the enablers and barriers for integration.

Enablers:

- Strong leadership and inter-organisation relationships
- Structured governance arrangements
- Public consultation and co-design of service
- Effective information sharing
- Capturing and sharing learning and evaluation

Barriers:

- Conflicting priorities across organisations
- Understanding the local workforce profile
- Information Governance
- Funding of Services

Impact of Integrated Care

In the first year, improvements in the pioneer population's health and experience of care started to show. This included reducing the number of times people were admitted to hospital (including admissions from care homes), increase in quality of life, greater independence in the home and, of course, financial savings. These programmes have shown how effective integrated care can be and why others should initiate work leading towards this model.

9.6. Isle of Wight Council – My Life a Full Life Programme

The Isle of Wight (IoW) Council are working together with the NHS Trust and CCG to create an integrated health and social care model. This programme is known as 'My Life a Full Life'.

The ambition is to link the established NHS Hub with the council's contact centre, which currently delivers contact facilities for all council services. The contact centre currently has a high rate of first contact resolution so a lot of training will be required to align the two services. The NHS Hub currently encompasses: 111, 999, Crisis team, Community Nursing, Social Workers, Hospital Transport, Pharmacy advice and Age UK. Mental health has so far been out of scope of the integrated programme.

The council and NHS Trust have formed a strategic partnership which has been signed off and they are now discussing the formal merging of the partnership. At present, all staff are still on their original contracts with no current plans to TUPE any staff. They aim to create a Single Access approach for the service users and residents of IoW. Training staff to be multi-skilled and work across functions has begun, however, slowly and only for those identified as having the appropriate level of knowledge and skill.

The governance arrangements are in place for the strategic partnership, including an Integrated Care Programme Board and two Integrated Access Strategic Leads, one for each organisation. A weekly report is submitted to board members and weekly huddles are used to discuss issues or concerns. A formal engagement strategy was signed off by the Programme Board but this information was not being cascaded down through management. This became an issue as staff did not feel engaged and began to feel nervous about what the programme meant for them. Generic messaging was not always the best way to deliver information regarding the programme.

The case management systems are not integrated across functions but the underlying infrastructure is being brought together where possible. Once the new processes are fully aligned the requirements may drive the need for a new platform that supports both systems.

They are working on creating a summary care record so there is a single view of the patient across health and social care. Due to information governance issues, this will need to be kept at a high level and only the necessary information will be shared with other parties. The council already have a lot of transactions being completed online and will use this to make health and social care services easier to access. This will make it easier for users to see their information and take control of their care. The care pathways are being developed to load support at the front end to try and keep people out of the system as much as possible. Social workers are present to complete the assessment at the time of the call to ensure the appropriate care is given to the right people at the right time.

The programme is in its early stages so the decision is still being made on how to measure success and evaluate the outcomes. The emphasis will be on the effectiveness of the service and outcomes for service users. The aim is cost avoidance, stopping residents from getting

to an acute ward. The council contact centre and NHS Hub have already been through efficiency savings so the next stage is how to use the current resources more wisely.
The lessons learned from the programme so far include:

- Staff engagement, be honest and consistent, ensure information is cascaded effectively
- Conflicting priorities between organisations
- Budget constraints may impede project success
- Setting a clear vision for the service early on and documented the design principles
- Don't Underestimate the cost of investment in ICT which may impede transition to the optimum model
- Accessing patient information will be contentious and expectations will need to be set in terms of IG constraints

9.7. Capacity Management System Analysis

9.7.1. Approach

We completed the following three stage approach to identifying a potential capacity management system:

1. High-level user requirement assessment
2. Engagement with ICRS management to discuss functionality of their current scheduling and capacity management system
3. Desk top research

9.7.2. Conclusion

There are many systems available on the market that would satisfy the requirement for scheduling and capacity management. One particular product that is currently deployed by the ICRS service and receives good reviews by the management team is a product called Staff Plan from a company called Advanced Health Care.

Individual and team work schedules are input to the system by the support team in ICRS which then populates daily and weekly work schedules to the field staff's smart phones so that they know where they need to be and when. The information is refreshed frequently to account for any changes to the schedule of work, for example cancellations or in the event of a death.

A full analysis on this system together with research on alternative solutions (see appendix 6).

10. Appendices

Appendix 1 - Integrating LLR Points of Access - Design Principles

The following details the approved Design Principles used to determine the options for integration across Health and ASC Points of Access and proposed Target Operating Model (TOM):

1. The proposed operating model will provide a simplified and standardised method of access for a defined range of services and customer group
2. The proposed operating model will seek to shield customers from process complexity
3. The proposed operating model, (the technologies, locations and organisational structure) will be developed to ensure that additional services can be added over time at incremental cost
4. The model will utilise existing physical and technology assets, where appropriate, including Staff; Locations; Systems
5. The detailed delivery model will be co-designed with input from service users
6. The operating model will align with the NHS 111 service offering and Vanguard
7. Additional channels will be added to the proposed operating model where they deliver:
    - A safe more efficient and improved level of service
    - Improved access, awareness and connectivity to appropriate health and social care activities in LLR
    - Improved insight into the referral behaviours and activities in the LLR region
8. Where appropriate existing channels that are inefficient will be reviewed with a plan to remove them (e.g. Faxes, unstructured emails and white mail)
9. The processes associated with the operating model will be defined and prescriptive (in the form of Standard Operating Procedures) and will provide detailed performance analytics to provide the wider BCT functions with required Business Intelligence
10. Measures will be built into the operating model and will need to be developed further with operational teams, for example:
    - How people access the service
    - Numbers of people using the service
    - Quality of life impact
    - Quality Measures
        i. Citizens reporting a positive experience of care across all health and social care settings
        ii. Improved quality of life?

iii. Reduce inequalities
iv. Outcome framework measures

11. The Point of Access has visibility of progress of the service request wherever it is being delivered and regardless who it is being delivered by
12. Two way OLA's will be put in place between organisations and departments across the end to end service delivery
13. There will be a single number per service line for citizens to contact/access services
14. The Point of Access Operating Model will have a triage function in order to ensure the most appropriate use of resource
15. Care pathways which have a clinical aspect to them will be approved and quality assured

Appendix 2 – Why Programmes Fail

The NAO has frequently reported on difficult or failed implementations in the public sector. The following table summarises their reasons for failure and suggests mitigations. The business case's recommendations in the Implementation Approach in Section 5 align to these mitigations.

Reason for failure	Questions to mitigate the risk of failure
Lack of clear links between the programme and the organisation's key strategic priorities, including agreed measures of success	Do we know how the priority of this programme compares and aligns with our other delivery and operational activities? Have we defined the critical success factors (CSFs) for the programme? Have the CSFs been agreed with the key stakeholders? Is the programme founded on realistic timescales taking into account any statutory lead times, and showing critical dependencies such that any delays can be handled? Are the lessons learnt from relevant programmes being applied? Has an analysis been undertaken of the effects of any slippage in time, cost, scope or quality? In the event of a problem/conflict at least one must be sacrificed Have the CSF's been agreed with the Service Provider? Do we have a clear programme plan that covers the full period of the planned delivery and all business change required, and indicates the means of benefits realisation?
Lack of clear Senior Management and Ministerial ownership and leadership	Does the Programme Management Team have a clear view of the inter-dependencies between programmes, the benefits, and the criteria against which success will be judged? If the programme traverses organisational boundaries are there clear governance arrangements to ensure sustainable alignment with the business objectives of all organisations involved? Are all proposed commitments and announcements first checked for delivery implications? Does the Senior Responsible Owner (SRO) have a suitable track record of deliver? Where necessary, is it being optimised through development and

Reason for failure	Questions to mitigate the risk of failure
	training? Are decisions taken early on, decisively and adhered to, in order to facilitate successful delivery? Does the programme have the necessary approval to proceed from its nominated Minister either directly or through delegated authority to a designated SRO? Does the SRO have the ability, responsibility and authority to ensure that the business change and business benefits are delivered?
Lack of effective engagement	Have we identified the right stakeholders? Have we, as intelligent customers, identified the rationale for doing so (for example, the why, the what, the who, the where, the when and the how)? Have we secured a common understanding and agreement of stakeholders' requirements? Does the business case take account of the views of stakeholders, including customers/users? Do we understand how we will manage stakeholders (for example, ensure buy-in, overcome resistance to change, allocate risk to the party best able to manage it)? Has sufficient account been taken of the subsisting organisation culture? Whilst ensuring that there is clear accountability, how can we resolve any conflicting priorities?

Reason for failure	Questions to mitigate the risk of failure
Lack of Skills and proven approach to Programme Management and risk Management	Is there a skilled and experienced programme team with clearly defined roles and responsibilities? If not, is there access to expertise, which can benefit those fulfilling the requisite roles? Are the major risks identified, weighted and treated by the SRO, the director, and programme manager and/or the programme team? Has sufficient resource, financial and otherwise, been allocated to the programme, including an allowance for risk? Do we have adequate approaches for estimating, monitoring and controlling the total amount of expenditure on programmes? Are the governance arrangements robust enough to ensure that 'bad news' is not filtered out of progress reports to senior managers? If external consultants are used, are they accountable and committed to help ensure the successful and timely delivery? Do we have effective systems for measuring and tracking the realisation of benefits in the business case?
Too little attention to breaking development and implementation into manageable steps	Has the approach been tested to ensure that it is not 'big bang' (for example, IT enabled programmes)? Has sufficient time been built in to allow for planning applications in property and construction programmes etc.? Have we done our best to keep deliver timescales short so that change during development is avoided? Have enough review points been built in so that the programme can be stopped if changing circumstances mean that the business benefits are no longer achievable or no longer represent value for money (VFM)? Is there a business continuity plan in the event of the programme delivering late or failing to deliver at all?
Evaluation of proposals driven by initial price rather than long-term value for money (especially securing delivery of	Is the evaluation based on whole-life VFM, taking account of capital, maintenance and service costs? Do we have a proposed evaluation approach that allows us to balance financial factors against quality and security of deliver? Does the evaluation approach take account of business criticality and

Reason for failure	Questions to mitigate the risk of failure
business benefits)	affordability? Is the evaluation approach business driven?
Lack of understanding of, and contact with the supply industry at senior levels in the organisation	Have we tested that the supply industry understands our approach and agrees that it is achievable? Have we checked that the programme will attract sufficient competitive interest? Are Senior Management sufficiently engaged with the industry to be able to assess supply side risks? Do we have a clear strategy for engaging with the industry or are we making sourcing decisions on a piecemeal basis? Are there processes in place to ensure that all parties have a clear understanding of their roles and responsibilities, and a shared understanding of desired outcomes, key terms and deadlines? Do we understand the dynamics of the industry to determine whether our acquisition requirements can be met, given potentially competing pressures in other sectors of the economy? Have we asked suppliers to state any assumptions that they are making against their proposals?
Lack of effective programme team integration between clients, the supplier team and the supply chain	Has a market evaluation been undertaken to test market responsiveness to the requirements being sought? Are the procurement routes that allow integration of the programme team being used? Is there early supplier involvement to help determine and validate what outputs and outcomes are being sought for the programme? Has a shared risk register been established? Have arrangements for sharing efficiency gains throughout the supply team been established?

Appendix 3 - Co-Design Workshop Output and Feedback

The Co-Design Workshop Output summary is provided separately in pdf format as the file is too large to embed in this section of the Business Case.

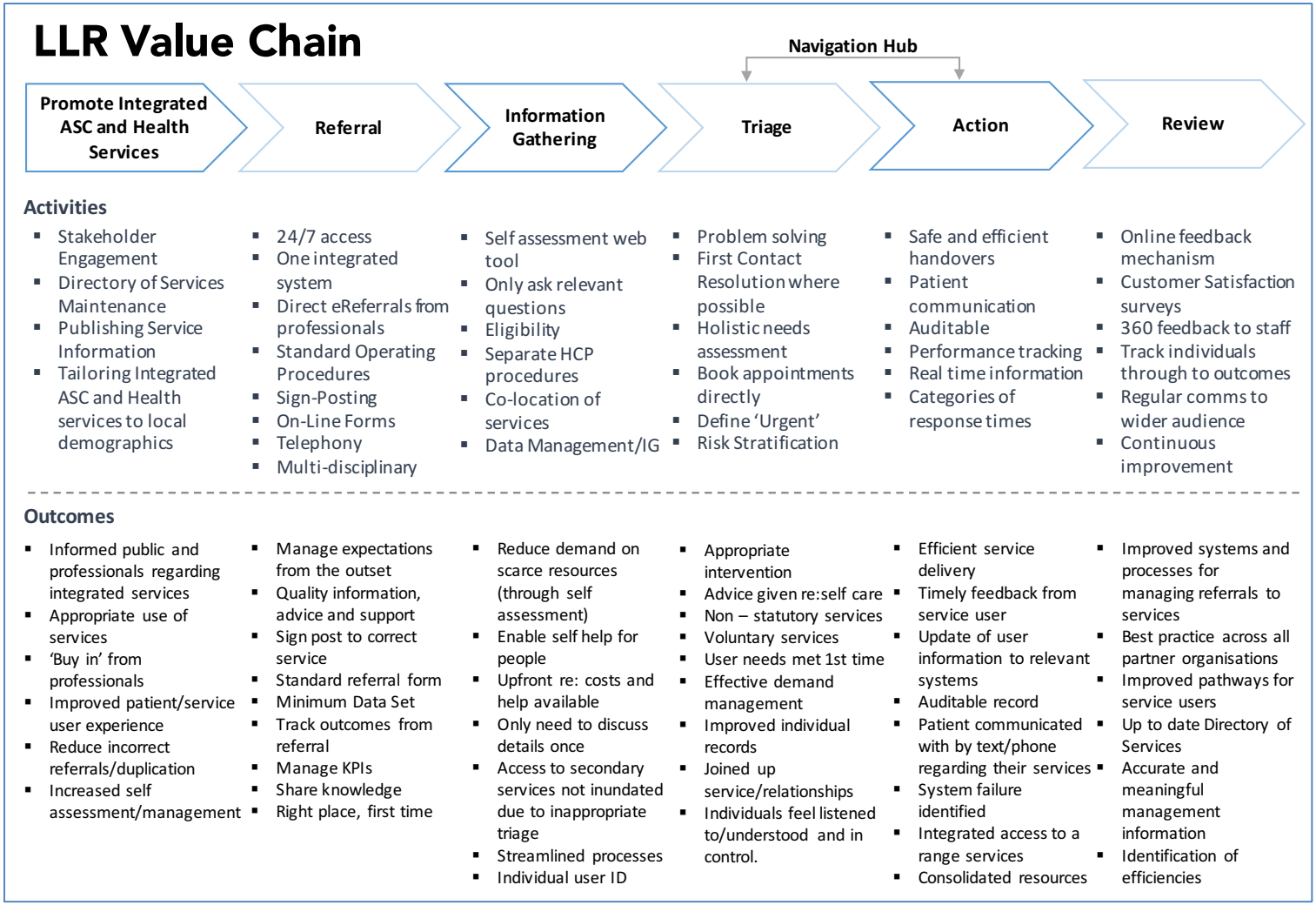
The pack provides a summary of the outputs from the two co-design workshops that were facilitated by LLR-Integrating Points of Access programme resources, as part of the information gathering stage of the programme

Contents

The pack provides the following:

- The purpose of each workshop
- A Summary of attendees/representatives present in each session
- An updated Value Chain - workshop 1
- Common Themes – workshop 1
- 'Sound bites' - workshop 2
- Common Themes – workshop 2
- Potential barriers and constraints to implementing an integrated health and social care delivery model

Appendix 4 - Value Chain Analysis



Appendix 5 – High Level Options Appraisal

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 1 Full Integration – three locations	Health and Social Care SPAs are fully integrated and operated from three geographical locations • Rutland • Leicester City • Leicestershire County	• Three discreet integrated ASC and Health SPAs servicing local populations • Multiskilled and professionalised workforce • Integrated ICT where possible • Case management system configured consistently across the three locations • On-line 'self serve' capability • Standardised and pathway driven business processes • Professional support available on-site to support first contact resolution and sign-posting • Up-to-date and maintained DOS to support effective sign-posting	**Cashable Benefit Areas** • Reduction in Management Structure • Estates rationalisation • Productivity and efficiency savings **BCT Benefit Enablers** • To optimise both the opportunities for integration and the use of physical assets across the health and social care economy • Ensure that services are easily accessible through appropriate access channels to as many people as possible within the community • To improve the utilisation of the in scope workforce and develop new capacity and capabilities where appropriate, in our people and the technology we use • To support the delivery of 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	• Retains localised knowledge around user groups and pathways • Financial Savings • Allows the testing of integrated working on a reduced scale and allow for the review of effectiveness • Financial savings could be delivered earlier than Option 2, albeit at reduced quantum • Can be used to spearhead efficient, effective and standard service delivery model across sites • Aligns to the BCT programme aims and objectives • Approach aligns to the Vanguard model	• Potentially more expensive to implement than Option 2 (maybe multiple transformation teams and locations across multiple sites) • Potentially longer timescale to implement (decision making by 100 cuts) • Fewer financial savings due to the above • Complex transition, merging existing operational activities with the new • Could create confusion with the user group • Potential confusion over accountabilities and responsibilities across partners • The opportunity to address underlying issues through pooled capability will be reduced resulting in an inability to deliver BCT objectives • The efficiencies of scale will not be realised and a larger level of management control will need to be maintained • More effort will be required to maintain and develop standard operating procedures across three sites

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 2 Full Integration Co-Located Services in One location	All Health and Social Care SPAs are fully integrated and operated from one location, operating to consistent operating procedures and with data integration to existing systems	• Co-located ASC and Health services • Multiskilled and professionalised workforce • Integrated ICT • On-line 'self serve' capability • Standardised and pathway driven business processes • Consistent service Delivery model for ASC and Health services • Demand management and scheduling capability • Managed under one management structure and/or one organisation's governance • Professional support available on-site to support first contact resolution and sign-posting • Up-to-date and maintained DOS to support effective sign-posting	**Cashable Benefit Areas** • Reduction in Management Structure • Estates rationalisation • Productivity and efficiency savings • Potential ICT support and maintenance costs **BCT Benefit Enablers** • To optimise both the opportunities for integration and the use of physical assets across the health and social care economy • Ensure that services are easily accessible through appropriate access channels to as many people as possible within the community • To improve the utilisation of the in scope workforce and develop new capacity and capabilities where appropriate, in our people and the technology we use • To support the delivery of 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	• Financial Savings including Estates, Management Resource and Operational delivery and Support Costs • Opportunity to achieve optimal integration across services and across ICT platforms • Opportunity to deliver an efficient and effective service delivery model staffed by an easier to flex professional and multi-skilled workforce • Easier to manage performance and drive standardised working practices under one management structure • Easier to drive change initiatives under one management structure • Allows the development of multi-disciplinary teams to develop interventions to reduce service demand • May help obviate some IG constraints • Step change will reduce the disruption caused by many and disparate programmes across the impacted organisation • The full benefits effect is realised on implementation • Aligns to and supports the delivery of the BCT programme aims and objectives • Approach does align to the Vanguard model [though more detailed co-design is required	• May create additional complexity of governance across statutory bodies and incur legal costs • Longer time frame for design and implementation • Potentially more expensive to implement (major programme resource injection will be needed) • Increased complexity in decision making throughout the design and implementation phases • Increased complexity leading to increased risk • Will require complex ICT infrastructure support the business process (increasing costs) • New ways of integrated working are only partially tested before they are changed for good • Early commitment to the model will be required from organisations who may have changing or uncertain futures • Loss of localised knowledge • Loss of well trained and productive staff

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 3 Part Integration of Health and ASC services (Reduced Scope)	Part integration of 'best fit' Health and ASC services: • ASC County • ASC City • LPT Community • First Contact Plus Specialist/smaller services continue to operate from discreet locations retaining individual governance but with revised and standardised operating procedures: • Bed Bureau • ASC Rutland • Adult Mental Health	• As Above in Option 2	• As Above in Option 2	• As Above with a nominal reduction in cashable benefits	• Less integration between mental and physical health excluding the mental health

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 4 Standardised Operating Model	All SPAs across Health and Social Care operate 'As Is' from discreet locations with a service improvement plan in place to address service delivery and operational issues	• Disparate services managed under one Governance • Shared MI and service improvement teams to manage change consistently across services • Information sharing across services	• **Potential process efficiencies**	• A level of consistent service delivery is achieved through the implementation of standard operating procedures • Improved quality and efficiency • Complex cases can be managed more efficiently • Improved customer experience	• Inefficient service delivery • No economies of scale • Service users access more expensive care (ED) • Increase in health and social care costs • Increased pressure on all health and social care resources • Cultural barriers to change • Political impact to services delivered

Appendix 6 - Capacity Management System – Research Findings

A number of staff rostering systems exist for use in the care industry. In this section we have outlined three that are specifically designed and in use in health and social care settings.

Staffplan Roster

The first of these is the product is Staffplan Roster by Advanced Health and Care which is currently being used successfully in the ICRS Point of Access. We have outlined the key features of this product and these can be used as a base upon which detailed requirements can be drawn at the later stages of the programme.

Staffplan Roster is a fully integrated software solution designed specifically for the homecare sector and is used by more than 1,000 homecare providers in the UK. It allows providers of all sizes to increase operational efficiency, improve care delivery and compliance.

Additionally, it serves all functions of a modern community care service from support worker recruitment and service user referrals, through to scheduling, training, timesheets, customisable invoicing, gross payroll, expenses and management reporting.

The features of Staffplan Roster are as follows:

- Service user record
- Care worker record
- Team management
- Allocation assistance
- Planning tools
- Communications
- Financial control modules
- Notes and journals
- Reporting and management information
- Design Your own reports

Service user record

- A comprehensive case file for each service user is stored in a compact and easy to navigate notebook tab format
- A full history of the referral and care plan is maintained, along with a complete record of all care planned and delivered

Care worker record

- A detailed personnel record is held for each care worker
- Contains extensive information relating to the care worker and their employment

history, training and qualifications, preferences, employment details, employment history and shift patterns

- Caters for management of care worker holiday
    - Automates care worker holiday management, whether care workers are on permanent, zero-hour or multiple contracts, making it easy to calculate care worker entitlement and their pay

Team management

- Care workers and service users can be allocated to teams which work both as rostering and reporting aid
- Care Managers can be set up to control a team or team group
- Only care workers and service users allocated to those teams will appear on their screen

Allocation assistance

- System includes a search feature that suggests care workers for a booking, taking into account such things as compatibility with service user, number of previous visits, skills, qualifications, languages, location and contracted hours

Planning tools

- Highly flexible toolset helps managers effectively plan care worker rosters, work patterns and visit cycles
- Planning tool takes into account cancelled, aborted, clashed and valid bookings
- A centralised management tool is available to help ensure care workers are kept fully informed of relevant changes made in their roster
- Wallcharts allow for easy visualisation and can be viewed from either a service user or care worker perspective

Communications

- System includes an integrated text message broadcasting feature, enabling efficient delivery of information to care workers without tying up office staff
- Messages can be sent to individuals, selected groups or even the entire workforce

Financial control modules

- All call charges and pay rates are automatically and accurately calculated as bookings are entered or updated
- A complete history of all invoices is maintained and every visit cross-referenced to its invoice, establishing a robust audit trail for query management
- All gross payroll calculations are automatically performed, saving time and ensuring accuracy

- Travel or any other type of expense can be entered against appropriate booking and automatically included in invoice and/or payroll runs

Notes and journals

- QuickNotes feature stores incoming messages against relevant service user / care worker and automatically bringing message to the attention of the coordinator
- A full log of all communications with both service users and care workers can be stored in 'Journal'
- Notes system allows targeted announcements and message passing within the organisation and provides an audit trail of activities

Reporting and management information

- All reports can be viewed on screen, printed or exported to a variety of standard formats
- Reports can accept user defined selection criteria, offering reporting flexibility

Design Your own reports

- System uses Microsoft SQL Server database and ODBC connectivity which allows users to design their own reports
- System also includes a built in banded report generator, ReportBuilder Enterprise.
- Following on from the features of Staffplan Roster, the associated benefits are:
- Intuitive and easy to learn
- Offers data security
- Offers flexibility to meet evolving demands of the care market
- Enables users to respond quickly and easily to ever-changing circumstances
- Enables users to make informed decisions quickly

QuikPlan Home Care Software

As previously mentioned there are a number of staff rostering systems for use in the care industry. Another example is QuikPlan Home Care Software. It is a cloud based staff rostering, care management and finance system that automates time consuming domiciliary care processes whilst reinforcing CQC compliance. This software has very similar features to Staffplan Roster, including:

- Care Staff Rostering
- Staff GPS Track and Trace
- ECM Visit Confirmation
- QuikPlan Mobile NFC App
- QuikCheck Care Monitoring

- Home Care Invoicing
- Domiciliary Staff Payroll
- Care Staff Details
- Service User Details
- Timesheets and Web Portals
- Mileage, Maps and Travel

Tagtronics

In addition to the above, Tagtronics also offers a home care management system. This system takes care of all carers training, application and recruitment process, supervision reviews, appraisals, DBS expiries and holidays and sickness. It therefore ensures the best match carer attends the home visit.

The benefits of Tagtronics' system are:

- Invoicing option allows user to produce invoices for both private clients and local authority with no limit to the number of invoice rates
- Payroll option calculates all pay rates by number of hours worked to produce gross wage totals of all staff
- Easy to use Windows based software
- Seamless integration with electronic monitoring system