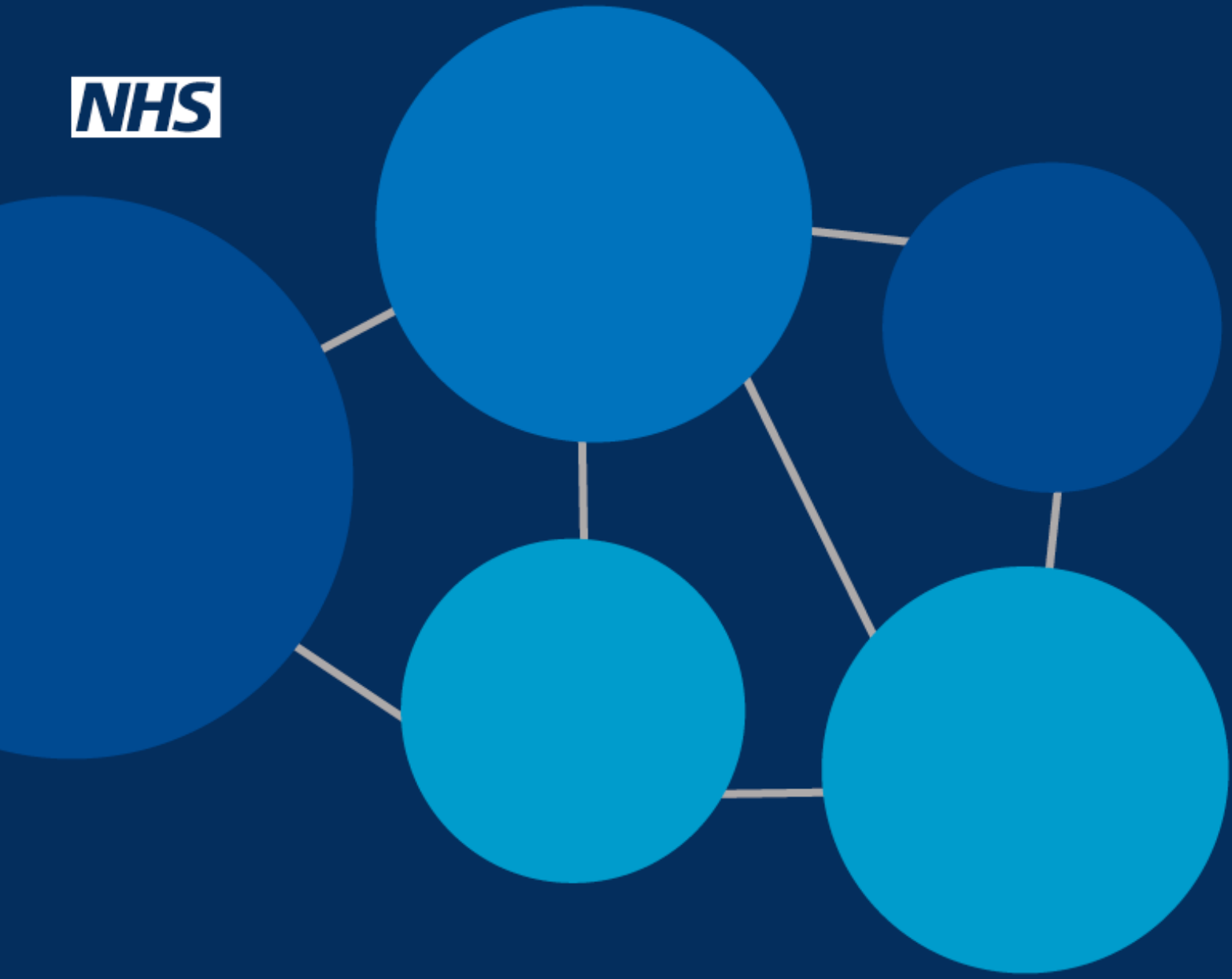
# APPENDIX 7C – BENEFITS REALISATION PLAN



# Draft Benefits Realisation Plan V0.9

# Benefits Realisation Plan

The purpose of this plan is to set out the nature, degree and timing of benefits that the Programme expects to deliver. As such it is a key tool of post project evaluation.

It was initially developed through the involvement of many stakeholders via Programme Workstreams, patient focus groups and the Clinical Reference Group. Recently, it has been further revised by Programme Team taking account of:

- The key benefits sought from the Programme (these are stated in the Programme Execution Plan and form the section headings below);
- The expected impact of the specific proposals under consideration (the way in which the acute options/local urgent care offer could deliver the clinical model);
- Examples from comparable business cases in other reconfiguration; and
- Further input from Clinical Design, Finance and Workforce workstreams.

For the current stage of the Programme, detailed measures and timings are not required but the draft plan will form part of any Strategic Outline Case.

In addition, the Outcome Ambitions that it contains will form part of both the Pre Consultation Business Case and the key messages to the public during Consultation. These ambitions should be linkable to detailed evidence in support of the case for change (e.g. the current disbenefits arising from workforce shortages).

The Programme Board approved the current draft in April 2015 for further detailed development of measures and timescales.

# Benefits Realisation Plan

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| REF | OUTCOME AMBITION | INDICATOR | PERFORMANCE | | MONITORING METHOD | REVIEW DATE | LEAD RESPONSIBILITY |
|---|---|---|---|---|---|---|---|
| | | | Baseline | Target | | | |
| **1. IMPROVED CLINICAL EFFECTIVENESS (OUTCOMES)** | | | | | | | |
| 1.1 | Patients will be cared for by the right clinician, first time | • % EC patients seen by an ED consultant 24/7<br>• ED staffing meets CEM guidance<br>• % emergency surgery patients seen by a consultant surgeon 24/7<br>• Medical consultant rotas will be fully staffed with permanent appointments | | | • Trust data | | |
| 1.2 | Clinical outcomes will improve for acute hospital patients through bringing specialists together and enabling 7 day working | • Range of services operational 7/7<br>• Mortality rates for patients admitted at weekends/out of hours | | | • Service specifications<br>• Trust(s) activity data | | |
| **2. IMPROVED EXPERIENCE OF CARE (INCLUDING ENVIRONMENT)** | | | | | | | |
| 2.1 | Improvement in patient reported experience of care | • *[relevant questions in existing surveys to be identified]* | | | • National Inpatient survey<br>• Friends and Family<br>• Local Healthwatch/ CHC reports | | |
| 2.2 | Reduction in complaints about acute and community hospital care | • The number of complaints relating to specific issues *(to be defined)* | | | • Trust(s) data<br>• Local Healthwatch/CHC reports | | |

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| 2.3 | The local health economy will be more resilient to emergency demand surges as a result of workforce consolidation and lower bed occupancy assumptions | • The number cancellations of planned operations, treatments and tests will be reduced as a result of the separation of EC from DTC and planned occupancy rates of 85% | | | • Trust data | | |
| 2.4 | Patients, visitors and staff will experience improved caring/working environments through an increased % facilities meeting current standards and site(s) being configured to provide better clinical adjacencies | • *[identify relevant questions in existing surveys and/or add to local surveys]*<br>• BREEAM/DQI scores | | | • Family and Friends Test<br>• Staff Survey<br>• Local Healthwatch/ CHC reports<br>• BREEAM/DQI assessments | | |
| 2.5 | Patients will experience improved privacy and dignity | • % facilities meeting current standards<br>• % single rooms | | | • Local Healthwatch/ CHC reports<br>• Design specification<br>• BREEAM/DQI | | |
| **3. REDUCED HARM** | | | | | | | |
| 3.1 | Eliminating avoidable deaths in our hospitals caused by problems in care | • SUIs | | | • Trust data | | |
| 3.2 | Separation of EC from DTC will reduce risk of hospital acquired infections | • HCAIs | | | • Trust data | | |

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| **4. BETTER SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS** | | | | | | | |
| 4.1 | Average LOS for acute inpatients will reduce as earlier access to a consultant will lead to more appropriate care, first time; along with fewer internal transfers due to separation of EC and DTC. | • Phase 2 modelling assumptions delivered | | | • Trust data | | |
| **5. BETTER SUPPORT FOR PEOPLE TO LIVE INDEPENDENTLY** | | | | | | | |
| 5.1 | Significant reduction in excess emergency occupied bed days | • Zero day LOS<br>• 27+ days LOS | | | • Trust(s) activity data | | |
| **6. MOST EFFECTIVE USE OF RESOURCES** | | | | | | | |
| 6.1 | Step change in the productivity of elective care | • Day case rates<br>• No. cancellations<br>• Total activity | | | • Trust data | | |
| 6.2 | Ambulatory care sensitive conditions treated in appropriate settings | • Non-qualified admissions | | | • Trust data | | |
| 6.3 | Increase in proportion of commissioner spent on care closer to home | % spend on:<br>• Acute hospital episodes<br>• Community hospital episodes<br>• Integrated community teams<br>• Mental Health | | | • Commissioner financial reports | | |
| 6.4 | Hospital services will be clinically and financially sustainable through consolidating resources, improving teamwork and integration, providing economies of scale and high volumes of care to maximise expertise and improve outcomes | • Trusts achieve required surplus<br>• Guidance on consultant staffing levels met | | | • Trust(s) data | | |

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| **7. EQUITABLE ACCESS TO SERVICES (including treatment closer to home)** | | | | | | | |
| 7.1 | Waiting times in ED will reduce as an increased number of ED patients will be seen by a consultant as a result of rota consolidation, access to specialties7/7 and improved adjacencies | • 4 hour waiting time target<br>• Ambulance turnaround times<br>• ED Family & Friends Test | | | • Trust data | | |
| 7.2 | Overall patient travel times will reduce for planned care and urgent/emergency care | • Emergency care<br>• Urgent care<br>• Elective care | | | • CSU Modelling<br>• Audit | | |
| 7.3 | Patients will wait less long for planned operations or procedures | • Median waiting time for elective admissions | | | • Trust(s) activity data | | |
| 7.4 | Some specialist services will be able to be repatriated from out of county hospitals as a result of workforce consolidation | Successful repatriation of:<br>• Cardiology services including non-primary PCI<br>• Respiratory Cancer activity | | | • Activity commissioned locally | | |
| 7.5 | A large proportion of current A&E attendances will be treated closer to home through the creation of a local urgent and emergency care network | • No. EC attendances<br>• No. UCC attendances | | | • Trust(s) activity data | | |
| 7.6 | More planned care diagnostics will be provided closer to home enabled by economies of scope with UCCs | • Increase in volume of diagnostic activity at non-acute sites | | | • Trust(s) activity data | | |
| 7.7 | Local Urgent Care Centres will have extended opening hours | • Min. 16 hours per day, 7/7 | | | • Service specification<br>• Trust(s) activity data | | |

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| **8. IMPROVED STAFF RECRUITMENT, RETENTION & SATISFACTION** | | | | | | | |
| 8.1 | The clinical workforce will be more stable as a result of improved working conditions (rotas, specialisation, environment, etc.) | • Sickness absence rate<br>• Turnover<br>• Agency, bank and locum utilisation | | | • Trust data | | |
| 8.2 | Clinical posts will be easier to fill as a result of consolidated rotas, co-located departments and services; better site configuration; new facilities; new roles. | Vacancy rates for:<br>• Medical staff<br>• Nursing staff<br>• AHP staff | | | • Trust(s) data | | |
| 8.3 | Improved staff satisfaction as a result of improved rotas through fully staffed, co-located departments and services; better site configuration; new facilities; new roles. | • Staff feedback *(specify survey questions)*<br>• External accreditation | | | • Staff Survey data<br>• Staff Family & Friends Test<br>• GMC student experience survey<br>• Deanery accreditation | | |