Better care **together**

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

THE BETTER CARE TOGETHER PROGRAMME

PROGRAMME INITIATION DOCUMENT

December 2014

CONTENTS

Executive Summary

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

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

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

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

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

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

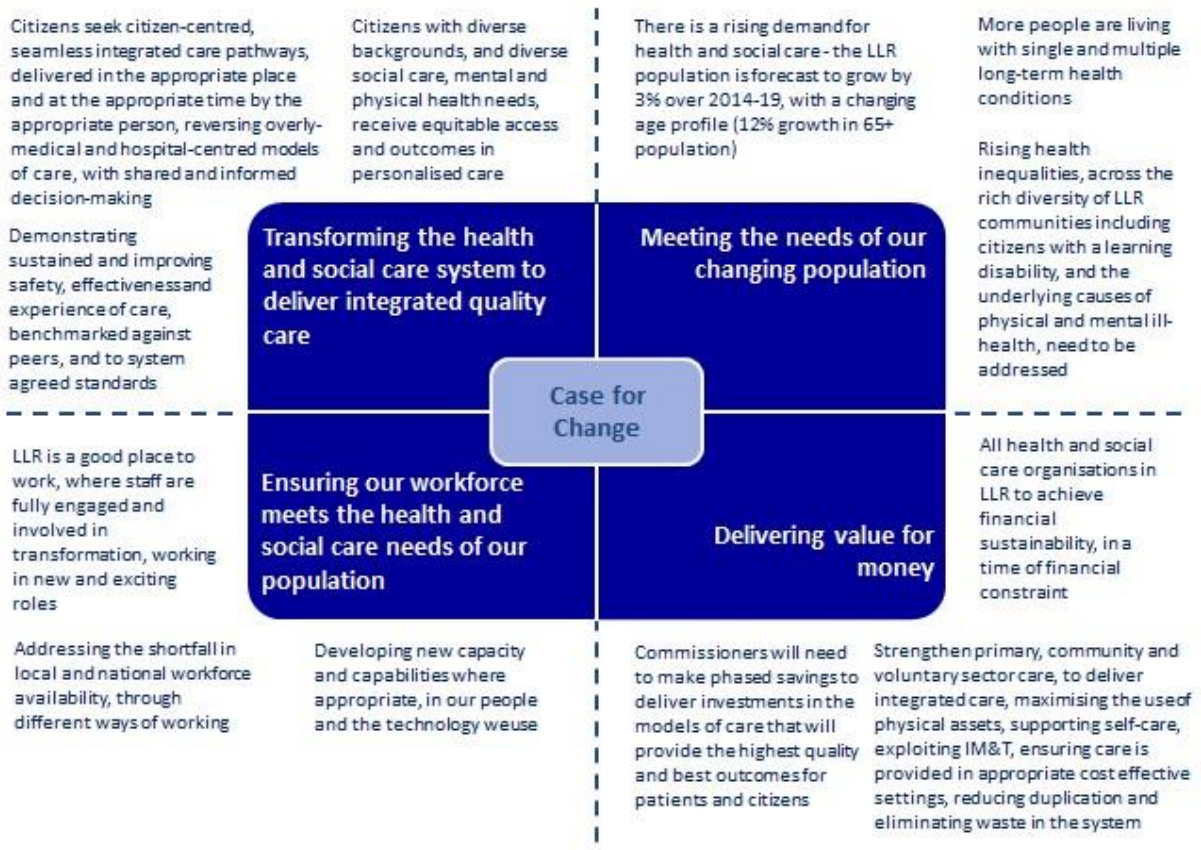
Introduction	
1.1	**Aim of the document** The aim of the Programme Initiation Document (PID) is to provide the authoritative definition of the BCT Programme that sets out the basis on which the Programme is to be initiated, governed and delivered. In doing so, the PID sets out the policy of the Partnership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

Top Level Requirements

2.1 **Case for Change and Background**

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

The case for change is summarised in the diagram below.



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

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

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

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

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

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

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

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

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

3.2.2 **Organisation**

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

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

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

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

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

3.3 **Programme Processes and Stages**

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

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

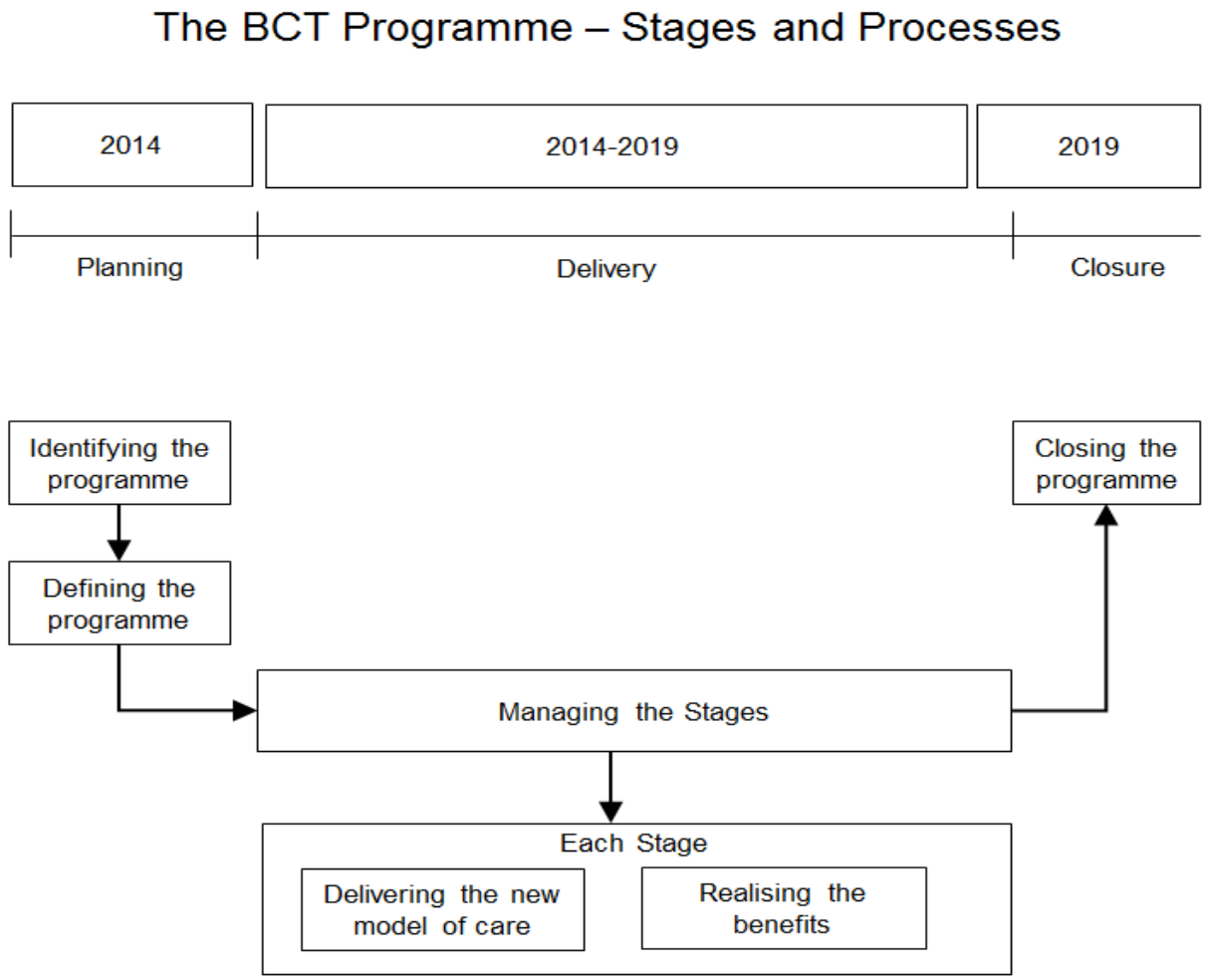
Stages. Delivery of the BCT Programme will be split into Stages. The end of each Stage will be a major review point for the Partnership Board. The start of a new Stage will be a step change in the transition to the new LLR model of health and social care. The Programme Director will present their End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

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

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

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

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



3.4 **Planning and Control**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Use of Business Cases for Workstreams and Projects in the BCT Programme

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

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

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

Consistent, rigorous and appropriate use of business cases by the Delivery Board will:

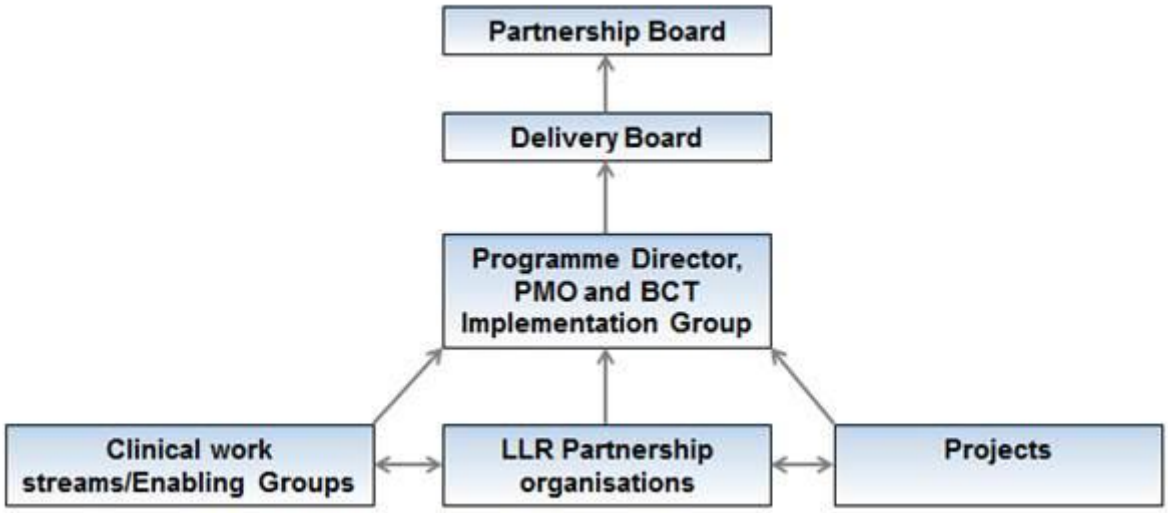
- guard against the BCT Programme starting and resourcing workstreams or projects that do not make a net contribution to achieving the Programme's objectives;
- provide an objective scrutiny of a workstream or project that may be a personal enthusiasm;
- put the workstream or project on a defined basis and will promote a shared understanding of what it is for, what is in and out of its scope, what it will cost and when it will end;
- produce the optimum balance of benefits, costs, timescale and risks;
- guard against scope-creep of the workstream or project, once it has been approved; and will
- facilitate the objective assessment of the work's value to the BCT Programme relative to other workstreams or projects, thus helping to optimise use of the Programme's resources.

Throughout the life of the project, workstream or BCT Programme, the business case for it will need to be continually maintained and updated. If the business case becomes no longer valid, the Delivery Board or workstream SRO must stop the work, close the workstream or project and release the resource.

3.5 **The Core Escalation Mechanism**

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

The escalation mechanism will be as follows.



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

Supporting Functions	
4.1	**Information and Performance Management** Performance management will depend upon information management and much of the value of good information will be in enabling performance management. The Delivery Board will use performance management in a proactive way to make it easy for the programme's workstreams to deliver the desired outcomes and deliver their outputs to time, cost and quality. **Information Management.** The BCT Programme will follow three principles for successful information management. It will: • create and maintain a 'single version of the truth' to engage the BCT Programme's large number of stakeholders and to coordinate and manage its wide range of activity; • obtain enough relevant information, and make it available, to manage progress, realise benefits, control risk and make optimum use of our resources – this is the heart of programme management; and • regulate the volume and flow of information so that it is adequate to control the Programme and to manage quality without the Programme 'drowning in data'. Those principles will be applied through the PMO in partnership with the other key stakeholders of information management, notably information from BCT partner organisations. Through this coordinated approach, the PMO will be the information hub of the Programme. On behalf of the Programme Director, the PMO will be responsible for meeting the information requirement to direct, plan and control the Programme. In certain circumstances this may also involve the PMO stating what information is required. **Performance Management.** The role of performance management will be to turn information into business intelligence in order to inform decisions by the Programme Director and Delivery Board. Performance management is the function that turns: • information into business intelligence; • business intelligence into informed decisions; • informed decisions into effective action; • effective action into learning from experience and increased capability. Performance management will look at the past, present and future. One of its key functions is to forecast future performance and give warning if performance is forecast to fall below that required for the Programme. The Delivery Board will direct the Programme Director to develop a performance management capability that: • measures, manages and communicates past, present and future performance; • progressively improves the accuracy of forecast performance; • promotes a common sense of purpose and working together across the partnership;

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

4.3	**Benefits Realisation** The BCT Programme will apply the following principles: • LLR system-wide change and BCT Programme-wide change will be benefits-driven; • benefits will be clearly linked to the six strategic objectives (Section 2.5.2); • benefits will be measured, tracked and recorded through appropriate performance management arrangements; and • oversight of benefits delivery is discharged through the BCT Delivery Board. The BCT Programme will realise benefits through a sequence of: • planning benefits and resourcing their realisation; • delivering change (elements of transitioning to the new model of integrated health and social care); • realising the benefits from those changes and embedding the new configuration of infrastructure, organisation, workforce, working practices and relationships; and • further developing or exploiting those benefits to the advantage of the partnership and its capability to serve its stakeholders. The Delivery Board will oversee benefits realisation through: • a benefits plan that maps out the system-wide impact and identifies key dependencies; • a benefits profile that describes how benefits will be attributed to partner organisations; • a description of how benefits will be measured, tracked and realised including the name of the responsible owner for delivery; and • the PMO monitoring the actual realisation of benefits against those planned.
4.4	**Risk Management and Issue Resolution** **Risk Management.** There will be a close relationship between effective risk management and sound governance of the BCT Programme in that risk management will be a subset of the Programme's internal controls. The BCT Programme will adopt a risk management strategy that embraces the principles, approach, and processes of risk management. This strategy will be underpinned by communication and embedding and reviewing the management of risk. Communication will be carried out throughout the whole risk management process. Embedding and reviewing embraces all the steps in the risk management process and reviews the overall effectiveness of the whole process. This strategy will have two main benefits: first, effective management of Programme risks, and second, the Delivery and Partnership Boards being able to assure themselves of the effectiveness of the Programme's risk management. The PMO will link Programme risk management and assurance for the Boards. The PMO will ensure appropriate risk reporting and risk management processes are in place across the BCT Programme.

In outline, the BCT Programme will apply the following principles when managing risk.

- The risk management process will feed back to LLR partner organisations.
- The BCT Partnership and Delivery Boards will use a Board Assurance Framework (BAF). The BAF will allow those Boards to assess for themselves the adequacy with which Programme risks are being managed. This assurance of risk management will inform the view of those Boards on the overall deliverability of the Programme.
- Risks in well-defined areas will be owned by the relevant or appropriate body in the Programme governance structure, such as clinical risks being owned by the Clinical Reference Group.
- Risk will be managed at the lowest possible level of the organisational structure. An escalation and de-escalation mechanism will link the levels of projects, workstreams and the BCT Programme. The Programme's reporting of risk will be compatible with the reporting mechanism used by LLR partner organisations.

The risk management process will be a sequence of four steps.

- Identify the context of the risk and the risk. The risk may be a threat or an opportunity. The objectives or benefits determine the relevance of a threat or opportunity.
- Assess the risk. This step may be divided into estimating the likelihood and impact (together the severity) of the threat or opportunity and evaluating the net effect of the aggregated threats and opportunities on an activity. The proximity of the risk may be added to the estimating step.
- Plan the response to the risk. Responses to a threat can be categorised as: Remove; Reduce; Transfer; Retain or Share. A combination of responses may be possible to reduce the risk to a level at which it can be tolerated. Responses to an opportunity can be categorised as: Realise; Enhance; and Exploit. 'Realise' seizes an identified opportunity. 'Enhance' improves on realising the opportunity by achieving additional gains. 'Exploit' seizes multiple benefits.
- Implement the response to the risk. This step ensures that the planned response(s) is implemented and monitors its effectiveness. If a response to a risk does not achieve the expected result, corrective action will be taken as part of this step.

The Programme will manage risk in a consistent way at three levels: workstream, BCT Programme and Delivery Board. Clinical workstreams and enabling groups will identify risks through their workbooks. Those risks of concern beyond the workstream will be escalated to the Programme risk register. In the Programme risk register, risks of concern to the Delivery Board will be escalated in the Delivery Board BAF. Any risks of concern to the Partnership Board will be escalated in the Partnership Board BAF. The core escalation mechanism for risk management is that shown in Section 3.5.

Clinical workstreams, enabling groups and the BCT Programme will all operate a risk register as the basic tool for managing risk. The PMO will be the custodian of the Programme risk register. The format for the Programme risk register is shown at Appendix 7.

There will be a coherent risk review cycle. Although the Chair of the Partnership Board and joint SROs can initiate a risk review whenever they see fit, this routine cycle will link the BCT Implementation Group, the BCT Delivery Board, special interest groups such as the CRG and PPI Reference Group, and the LLR Partnership Board. The cycle will be a logical progression that matches the rhythm of meetings. Subject to trial and adjustment in the light of experience, this cycle will be:

Board/Group	Frequency of Reviewing Risk
LLR Partnership Board	Quarterly
Special interest Groups (eg CFOs, CRG, PPI)	Quarterly
BCT Delivery Board	Quarterly
BCT Implementation Group	Monthly
BCT PMO	Continual

The Programme risk register will inform the BAF for the Delivery Board. The distinction between the Programme risk register and the Delivery Board BAF is that whereas the Programme risk register is a tool to manage an individual risk in the Programme, the BAF is a tool used for the Board to assure itself, or not, that risk management across the Programme is adequate.

Issue Resolution. The Programme Director will develop an issue resolution process for projects, workstreams and the BCT Programme to capture, assess and resolve issues in a coherent, prompt and effective way. The PMO will maintain a Programme Issue Log to help assess the effectiveness of our risk management. In the event of any dispute in the Programme, the Programme Director will be the arbiter unless the dispute requires escalation to the joint SROs or, in an extreme case, to the Partnership Board.

4.5 **Quality**

Quality is defined in Appendix 1. There are variations in applying quality between the programme management and the clinical domains. The Programme's management of quality will be based on continuous quality improvement.

The Programme will make and implement a Quality Improvement Strategy that embraces the approach, standards, processes and responsibilities for planning and delivering quality across the Programme. This Strategy will link quality in the areas of programme management and clinical quality. As an introduction to the Quality Improvement Strategy, quality in the programme management domain is covered in Section 4.5.1 and quality in the clinical domain in Section 4.5.2.

The effectiveness of quality management will be reviewed and assured by the Partnership and Delivery Boards, together with any external assurance those bodies may commission such as the OGC and the Clinical Senate, and throughout the BCT Programme governance structure.

Responsibilities for quality management in the BCT Programme will be as follows.

Role	Responsibility
Partnership Board	Accountable for all aspects of quality improvement in the Programme.
Joint SROs	Responsible for all aspects of quality improvement in the Programme.
BCT Delivery Board	Supporting the joint SROs.
Programme Director	Responsible for developing and implementing the Programme's Quality Improvement Strategy.
Partner Organisations	Building quality improvement in to every aspect of the Programme, especially though workstream and project workbooks.
The Clinical Senate	Providing clinical assurance external to the LLR Partnership.
The CRG	Providing clinical assurance internal to the LLR Partnership.
The PMO	Facilitating effective management of quality across the Programme. Drafting the Quality Improvement Strategy. Ensuring the Programme complies with relevant regulation and standards. Promoting best practice and setting standards for quality improvement. Arranging the review process, as directed by the Programme Director. Obtaining appropriate assurance, as directed by the Programme Director.

4.5.1	**Programme Management Quality** Programme management quality in the BCT Programme will be the standards, processes and responsibilities that control the Programme's delivery of its changes and benefits. The Programme will apply quality management at the project, workstream and programme levels. It will make quality management integral to its daily activities, supported by information management and version control. Programme management quality will ensure that the BCT Programme's stakeholders are satisfied that the benefits they expect will be realised. Quality management in the BCT Programme will: • support LLR policy and strategy and meet agreed standards; • meet the expectations of the Programme's stakeholders; • optimise the use of resources across LLR partner organisations; and • make consistent use of best practice processes, tools and techniques. Quality will be managed differently at the programme and workstream/project levels. At the BCT Programme level, quality management will focus on achieving the six strategic objectives (Section 2.5.2). During the Programme, these objectives may change in response to LLR circumstances and priorities. In contrast, quality management at the workstream/project level will focus on ensuring that the changes to services meet the business case or the quality criteria defined in the workbooks. The BCT Programme will: • define the expectations of stakeholders, especially those of patients, their carers, clinicians, Commissioners and the public; • define quality or acceptance criteria for the main products of workstreams and projects, such as a redesigned pathway, and will develop service changes against these criteria; • review the proposed service change against the quality or acceptance criteria, and test it through independent internal assurance, such as the CRG, or external assurance, such as the Clinical Senate; • plan flexibly so the plan can be adjusted, if necessary, during delivery of the service change; and • test its delivery of the benefits of change on stakeholders such as patients and the public.
4.5.2	**Clinical Quality** There are several definitions of clinical quality and they have much in common. The Programme will recognise the following definitions. Lord Darzi defined the three domains of clinical quality as patient safety, clinical effectiveness and patient experience. The Institute of Healthcare Improvement has adopted the 'triple aim' of: • improving the experience of care for the individual; • contributing to population health; and • reducing the per capita cost of care.

The six dimensions of clinical quality are that care and treatment is:

- safe;
- clinically effective;
- timely;
- patient-centred;
- efficient; and
- equitable.

These dimensions are supplemented by the five domains of the NHS Outcomes Framework.

NHS Outcomes Framework	
Domain	**Illustration**
Preventing people from dying prematurely	How the proposal helps people to live longer; how it reduces premature mortality.
Enhancing quality of life for people with long-term conditions	How the proposal directly impacts on people living with long-term conditions.
Recovery from episodes of ill health or injury	How the proposal helps people to recover following ill health (including mental illness) or injury.
Ensuring a positive patient experience	How the proposal results in: personalised and compassionate care; meets patient needs; and positive survey results from patients.
A safe environment free from avoidable harm	How the proposal reduces risk to patient safety and wellbeing, including through reduced 'hand-offs'. How having staff trained and systems in place to safeguard patients prevents harm.

Clinical quality will drive the BCT Programme's redesign and reconfiguration of its health and social care services. Two of the system objectives of the BCT Programme are to deliver high quality, citizen-centred, integrated care pathways and to increase the number of citizens reporting a positive experience of care across all health and social care settings. Clinical quality will be embedded in all work streams and contractual arrangements. The Programme's service reconfiguration plans will demonstrate an improving quality of health and social care, benchmarked against agreed standards.

The Programme will follow current best practice for clinical quality. It will adopt these principles.

- Clinical quality is the degree of excellence in health and social care. Clinical quality has to be measured, using shared indicators. The indicators will be one or more of: patient-reported outcome indicators; clinical outcome indicators; and process outcome indicators.
- Quality improvement gives a better patient experience and better clinical outcomes.
- The Programme will approach quality through quality improvement and not through the previous approach of quality control and quality assurance.
- Clinical quality will be delivered using a patient-centred approach. Usually, it will be implemented by working collaboratively in multi-disciplinary teams of health and social care professionals and staff, both clinical and non-clinical.
- Clinical quality does not 'fall out' of systems. It is produced by individuals behaving well, working systematically and basing their clinical work on scientific knowledge and evidence.

	• The keys to improving clinical quality are adaptive leadership and the behaviour of individuals. Adaptive leadership shows the ability to live with unpredictability and to exploit opportunity. The BCT Programme's clinical workstreams will build upon the integrated approach to service planning and delivery already established locally. This will underpin the changes in culture and approach we need. Each workstream lead will ensure that a proposed service change will result in a positive impact for patients and staff. They will test proposed clinical changes on the internal assurance of the Clinical Reference Group and, if appropriate, on the external assurance of the Clinical Senate. Each clinical workstream workbook will address the six dimensions of clinical quality. Workbooks will be assessed against the 'Duty of Quality' outlined in the five domains of the NHS Outcomes Framework.
4.6	**Equality and Diversity** The BCT Partnership Board requires the Delivery Board to ensure that the undertakings for Equality, Inclusion and Human Rights (EIHR) set out in the Five-Year Strategic Plan are met and that LLR Equality and Diversity policy is implemented in the BCT Programme. The Delivery Board will oversee effective execution of all Equality and Diversity responsibilities. The Delivery Board, supported by the PMO, will be the focus for the Programme's implementation of LLR Equality and Diversity policy. Consideration will be given to the needs of the whole LLR community, including those communities whose interests are specifically protected under law. Consideration will be given to assessing and, where required, mitigating the impact of the BCT Programme on the workforce as well as on patients, service users and carers. The Partnership Board's undertakings include: agreeing an Equality Statement; using the evidence base of the three Joint Strategic Needs Assessments; engaging with special interest and 'seldom heard' groups; overseeing the production of Equality Impact Assessments (EIA) as appropriate; ensuring that EIA findings are reflected in the operational plans for clinical changes; and ensuring that those operational plans are updated on an appropriate basis. The Equality Statement for the BCT Programme is shown at Appendix 8. The Delivery Board will be the authority for approving EIAs and mitigation plans. Clinical Workstream and Enabling Group SROs are accountable for addressing Equality and Diversity early on in their workstream. A forum of Equality leads will assure the Delivery Board on workstream EIAs, the aggregated impact of clinical changes in the BCT Programme, and suitable mitigation.
4.7	**Change Control** Change control is a supporting function closely related to Programme Control and the Use of Business Cases (Section 3.4.2) and Version Control (Section 4.8). Change control will provide the Programme a single means of capturing and considering change requests, suggestions, ideas or concerns, and ensuring appropriate action is taken and the decision communicated back to the originator. Throughout the life of the Programme anyone with an interest in the Programme, or its outcomes, may wish to request a change, raise a concern or express a dissatisfaction with work already done. Collectively, these 'programme issues' will be most efficiently addressed though change control. The PMO will be the focus for change control in the BCT Programme. The PMO will capture change requests, assess them and communicate decisions on them to the source that raised them. The authority for deciding what action is to be taken will be, depending upon the scale and significance of the change request, either the Delivery Board, the Programme Director or the workstream SRO. Whatever level of authority takes the decision, they will follow the process of:

	• capturing and logging the change request; • analysing the change request and assessing the implications of implementing it; • proposing the action to be taken; • deciding the action to be taken (approve, reject or defer); and • implementing the action to be taken. In step 2 of the process above, assessing the implications of implementing the change request will consider the overall balance of advantage of: • the benefits from the change against the time, cost, added complexity, and risk of obtaining them; • the relative priority of this change against the priority of work already in the Programme – is the new work a higher priority than any work we are already conducting? The overall assessment will be a product of the impact of the change on the: • whole Programme; • business case for the workstream; • benefits to be derived from the workstream; • risks to the Programme and the workstream, including the possible creation of new risk(s) and the impact on existing risk(s); and • allocation of Programme resource, including the possible dissipation of effort and multiplication of priorities. In deciding the action to be taken, the change request can be approved, rejected or deferred, perhaps to be modified and resubmitted.
4.8	**Version Control** Version control is the activity that controls critical documentation in the BCT Programme. This will be the responsibility of the PMO. It will ensure that version control links closely with the Programme's processes for information and performance management, planning and control, quality management, communications and engagement and change control.

Resources	
5.1	**Resource Allocation** Resource for the BCT Programme concerns funding, staff, skills, time and space. The Partnership Board recognises that this resource is owned by partner organisations, under Chief Officers. Following completion of the SOC, and on an ongoing basis, the Partnership Board will review the existing resource allocation in order to satisfy itself that: • resource is adequate to deliver the Programme's changes and benefits and thereby to achieve the six strategic objectives (Section 2.5.2); • the Programme's allocation of resource is aligned with Programme-wide priorities; and • the use of resources is optimised across the Programme. The Partnership Board will regularly review the Programme's benefits, risks and allocation of resources, including the relation between them, as outlined in Section 4.4.

APPENDIX 1 – GLOSSARY OF TERMS

Term	Meaning
Assurance	All the systematic actions to provide confidence that the object of the assurance is appropriate. Assurance has a level of independence from that being assured.
Benefit	The measurable improvement from a change perceived as an advantage by one or more stakeholders.
Blueprint	A model of the inside of the future organisation, showing its working practices, processes, information flow or contractual arrangements necessary to realise the vision. The blueprint is a design document derived from the vision.
Business as Usual	The way the organisation normally achieves its objectives. Portfolio management seeks to find the optimum balance of business as usual and organisational change.
Coordinate	Bring the different elements of a complex activity or organisation into an efficient relationship. Move the different parts of the body smoothly and at the same time.
Governance	The functions, responsibilities, processes that define how the Programme is set up, managed and controlled.
Issue	An event or development that has happened, that is affecting the Programme and needs to be actively dealt with and resolved.
Portfolio	All the programmes, workstreams and projects being undertaken by the organisation or group of organisations. The totality of the organisation's investment in change.
Programme	A management structure created to coordinate, direct and oversee the implementation of a set of related workstreams, projects and activities in order to deliver outcomes and benefits of strategic importance to the organisation.
Programme Management Office	A central office that coordinates the Programme on behalf of senior management. The information hub and standards custodian for the whole Programme. Across the Programme, it plans and controls work, tracks and communicates progress, facilitates benefits realisation and risk management, and optimises use of resource.
Project	A temporary organisation created to deliver one or more new or changed products or services according to a specified business case.
Quality	All the features and factors that affect the ability of a product, process or service to meet expectations or stated needs, requirements or specification.
Risk	An uncertain event or set of events which, should they occur, will have an effect on the achievement of objectives. A risk can be either a threat or opportunity.
Senior Responsible Owner	The individual with overall responsibility for ensuring that the Programme achieves its objectives and delivers the projected benefits. The owner of the overall business change.
Stage	A section of the Programme's life which produces a step change in the impact of benefits delivered or in the organisation's capability. The end of a stage is a major control point for the Board and milestone for the Programme.
Stakeholder	Any individual, group or organisation that can affect, be affected by, or perceive itself to be affected by, the Programme.
Stakeholder group	A group of stakeholders who share broadly similar interests, influence and disposition towards the Programme.
Transformation	A distinct change to the way in which the organisation conducts its business. The change may affect its 'look and feel', its organisation, its character or its output.
Vision	A picture of the better future, from outside the organisation. The end-goal of the Programme.
Workstream	The level of work beneath the BCT Programme and above the project level. A workstream incorporates a number of projects.

APPENDIX 2 – THE LEFT SHIFT: A BLUEPRINT OF THE LLR 2019 SYSTEM - INTEGRATED HEALTH AND SOCIAL CARE

A financially sustainable LLR system of integrated health and social care that meets the future needs of patients and maximises value for money through safe, high quality services in the most efficient and effective settings

<table>
<tr><td colspan="6">The Clinical Settings of Care</td></tr>
<tr><td colspan="6">The ‘Left Shift’ completed</td></tr>
<tr><td rowspan="2">Self-Care, Education and Prevention</td><td rowspan="2">Primary Care</td><td rowspan="2">Community and Social Care services</td><td rowspan="2">Urgent Care</td><td colspan="2">Acute Care hospital-based services</td></tr>
<tr><td>Secondary Care</td><td>Tertiary Care</td></tr>
<tr><td colspan="3">Primary, Community and Social Care expanded and reshaped to support care at home. The Voluntary Sector well engaged and supportive</td><td>Crisis response, reablement and discharge</td><td colspan="2">Acute Care reduced and reshaped into two hospitals, with fewer beds, that focus more on specialist care, teaching and research</td></tr>
<tr><td colspan="6">Physical and mental health integrated</td></tr>
<tr><td colspan="6">Health and Social Care integrated</td></tr>
</table>

Commissioning that emphasises prevention rather than treatment

The health and social care estate reconfigured and used more effectively

Improved utilisation of our workforce and new capacities and capabilities developed where appropriate

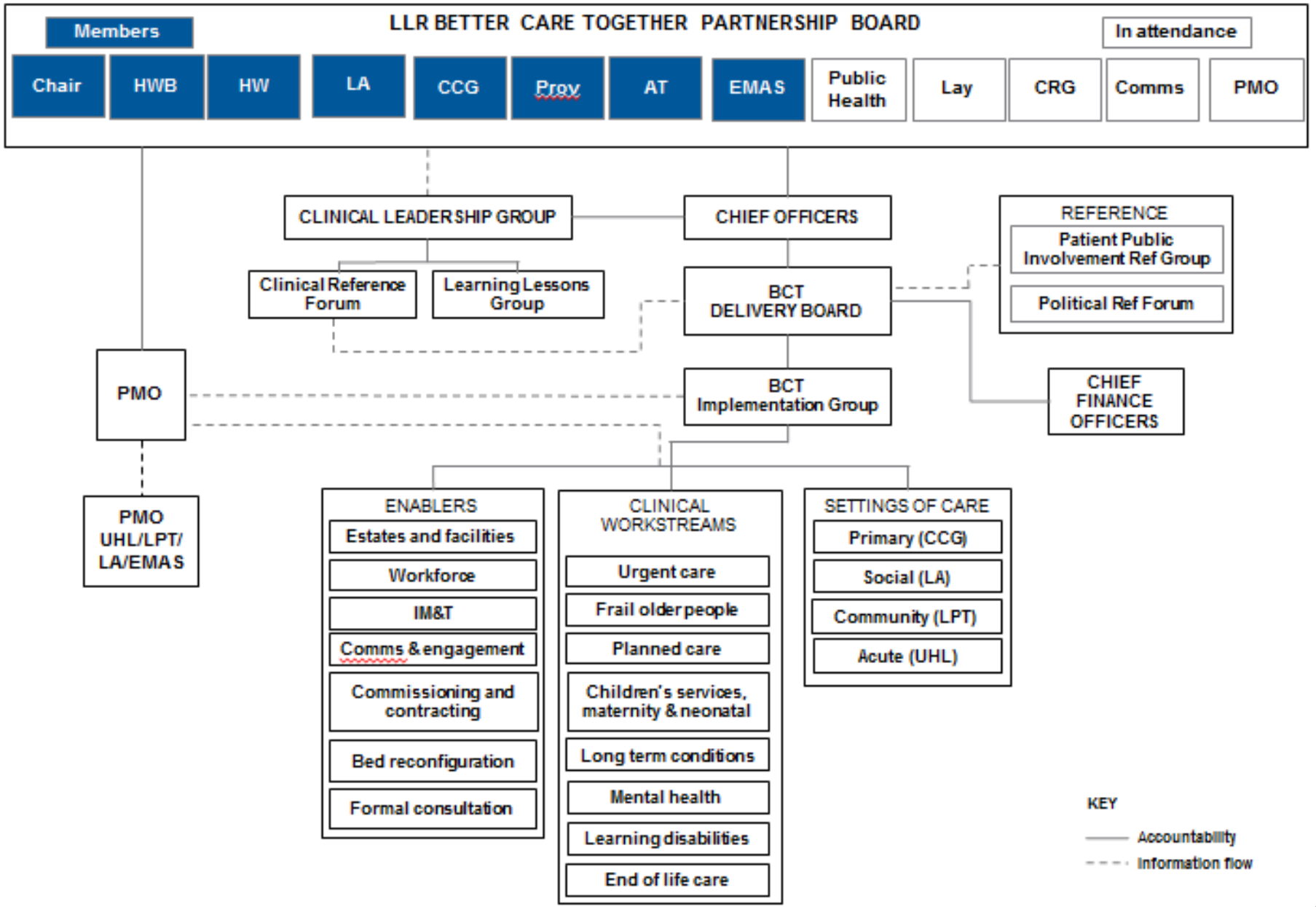
All LLR partner organisations financially sustainable

APPENDIX 3

RACI - ROLES AND RESPONSIBILITIES IN BCT PROGRAMME MANAGEMENT BY PROCESS

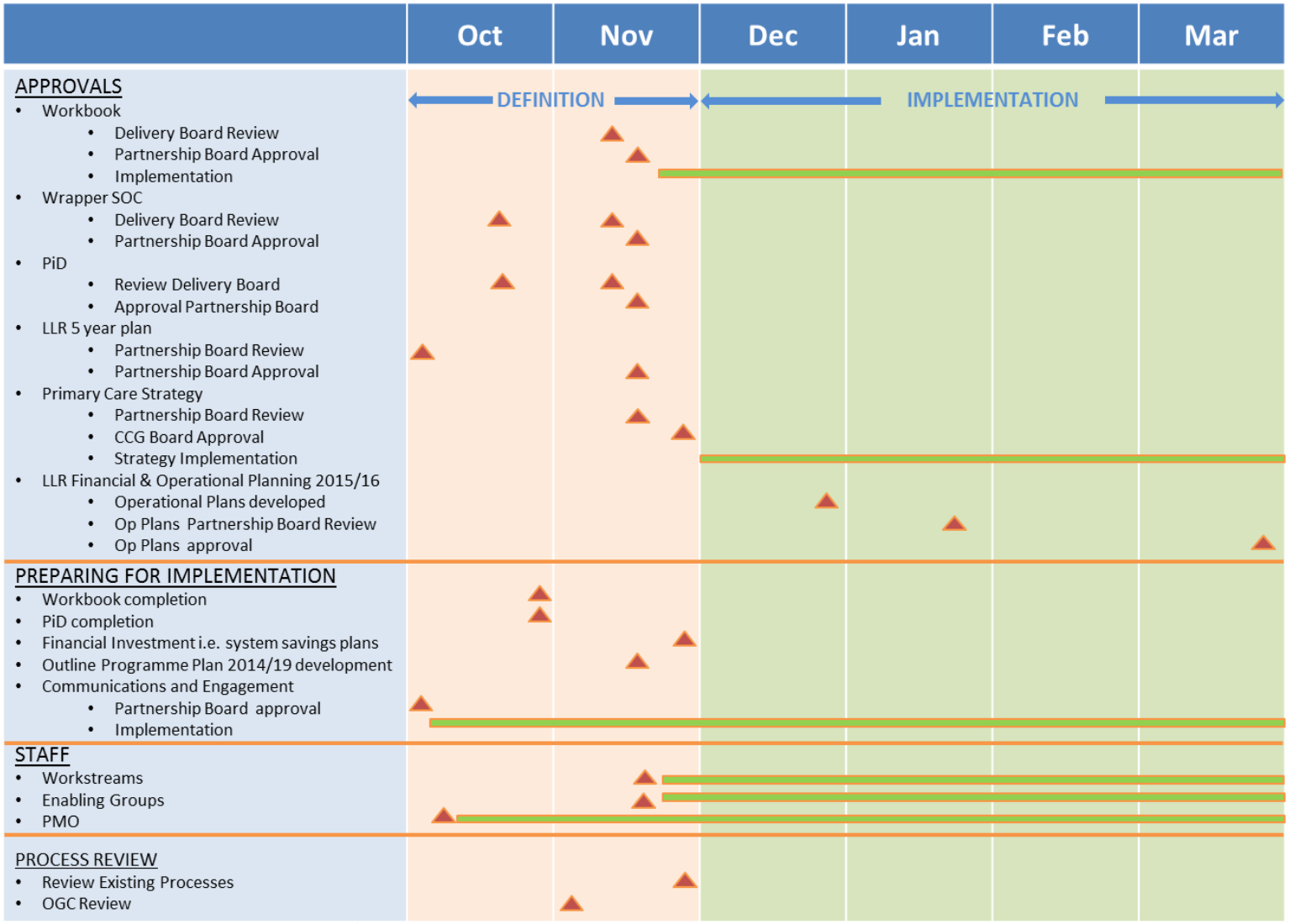
Programme Process	Partnership Board	Joint SROs	Delivery Board	Programme Director	PMO
Defining the Programme					
- establish the infrastructure		A		R	C
- establish the programme team		AR	C	I	C
- develop the Blueprint		A	C	R	C
- develop benefit profiles		A	C	R	C
- select the Stages		A	C	R	C
- design the Programme organisation		A	C	R	C
- develop governance arrangements		A	C	R	C
- make the Programme Plan		A	C	R	C
- prepare for the first Stage		A	C	R	C
- approval to proceed to the first Stage	A	R	C	I	I
Managing each Stage					
- direct work		A	C	R	C
- manage risks and issues		A	C	R	C
- control and deliver communications		A	C	R	C
- manage information		A	C	C	R
- manage people and other resources		A	C	R	C
- monitor, report and control		A	C	R	C
- prepare for the next Stage	C	A	C	R	C
- review at end of Stage and close the Stage	C	A	C	R	C
Delivering the new Operating Model					
- start workstreams and projects		A	C	R	C
- engage stakeholders		A	C	R	C
- align workstreams with Programme objectives		A	C	R	C
- align workstreams with Programme benefits		A	C	R	C
- control and manage delivery		A	C	R	C
- close workstreams and projects		A	C	R	I
Realising the Benefits					
- manage pre-transition		A	C	R	C
- manage transition		A	C	R	C
- manage post-transition		A	C	R	C
Closing the Programme					
- notify Programme about to close	I	A	C	R	I
- review Programme	C	AR	C	C	C
- finish Programme information		A	C	R	C
- confirm redeployment of all Programme resource		A	C	R	C
- approve Programme closure	A	R	C	I	C
- disband Programme organisation and team		A	C	R	

Key
R – Responsible; gets the work done; **R reports to A**
A – Accountable; decides
C – Consulted; supports; has capability required
I - Informed; notified but not consulted


LLR BETTER CARE TOGETHER PARTNERSHIP BOARD
Members
Chair
HWB
HW
LA
CCG
Prov
AT
EMAS
In attendance
Public Health
Lay
CRG
Comms
PMO
CLINICAL LEADERSHIP GROUP
CHIEF OFFICERS
REFERENCE
Patient Public Involvement Ref Group
Political Ref Forum
Clinical Reference Forum
Learning Lessons Group
BCT DELIVERY BOARD
PMO
BCT Implementation Group
CHIEF FINANCE OFFICERS
PMO UHL/LPT/ LA/EMAS
ENABLERS
Estates and facilities
Workforce
IM&T
Comms & engagement
Commissioning and contracting
Bed reconfiguration
Formal consultation
CLINICAL WORKSTREAMS
Urgent care
Frail older people
Planned care
Children's services, maternity & neonatal
Long term conditions
Mental health
Learning disabilities
End of life care
SETTINGS OF CARE
Primary (CCG)
Social (LA)
Community (LPT)
Acute (UHL)
KEY
Accountability
Information flow

Appendix 4

APPENDIX 5 – BCT PROGRAMME PLAN FOR OCTOBER 2014 TO MARCH 2015



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

APPENDIX 6 – THE LINK BETWEEN BCT ACTIVITIES AND VISION

Line of Activity	The Five Year Strategic Plan's Six System Objectives	Blueprint for 2019	Vision
Primary, Community and Social Care	High quality integrated care pathways, delivered in more appropriate settings, reducing time spent avoidably in hospital	A healthcare operating model that emphasises integrated services delivered closer to home and community	Maximise value for the citizens of LLR by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring of safe, high quality services into the most efficient and effective settings.
Clinical Workstreams (x 8)	Reduce inequalities in physical and mental care across and within LLR resulting in additional years of life for those with treatable mental and physical health conditions Increase reporting of positive experience of care across all health and social care settings		
Enabling Groups (x 5)	Optimise opportunities for integration and use of physical assets across the health and social care economy, providing care in appropriate cost-effective settings, reducing duplication and eliminating waste Improve utilisation of our workforce and develop new capacity and capabilities where appropriate, in people and our technology		
Finance, including CIP, QIPP & Local Authority saving plans	All LLR partner organisations achieve financial sustainability		

APPENDIX 7 – FORMAT FOR BCT PROGRAMME RISK REGISTER

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

Risk Scoring Matrix

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

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

APPENDIX 8 – EQUALITY STATEMENT

The Better Care Together (BCT) Programme is committed to ensuring that equality considerations are embedded in all our actions as part of the Programme. We are committed to: addressing inequality in healthcare; avoiding discrimination against individuals, especially those in 'protected groups'; promoting equality in employment; and complying with Equality, Inclusion and Human Rights legislation.

We will meet our equality responsibilities by:

- assessing the impact of our decisions on different groups of people;
- being clear how we assess and meet individual need;
- not tolerating discrimination that affects our employees or our communities.

We recognise that equality and diversity is fundamental to delivering high quality health and social care that meets the needs of individuals across LLR. We also recognise that equality and diversity is essential in recruiting and retaining the best staff.

We will ensure that the BCT Programme treats LLR service users, patients, carers, visitors, volunteers and employees fairly and with respect. We will ensure that the Programme does not discriminate against individuals or groups on the basis of any of the 'protected characteristics' outlined in the Equality Act 2010. This includes the grounds of disability or by reason of a person's association with a disabled person, gender, marital or civil partnership status, race, colour, ethnic or national origin, age, sexual orientation, gender reassignment, pregnancy and maternity, religion or belief, or any other unjustifiable conditions or requirements.