NHS

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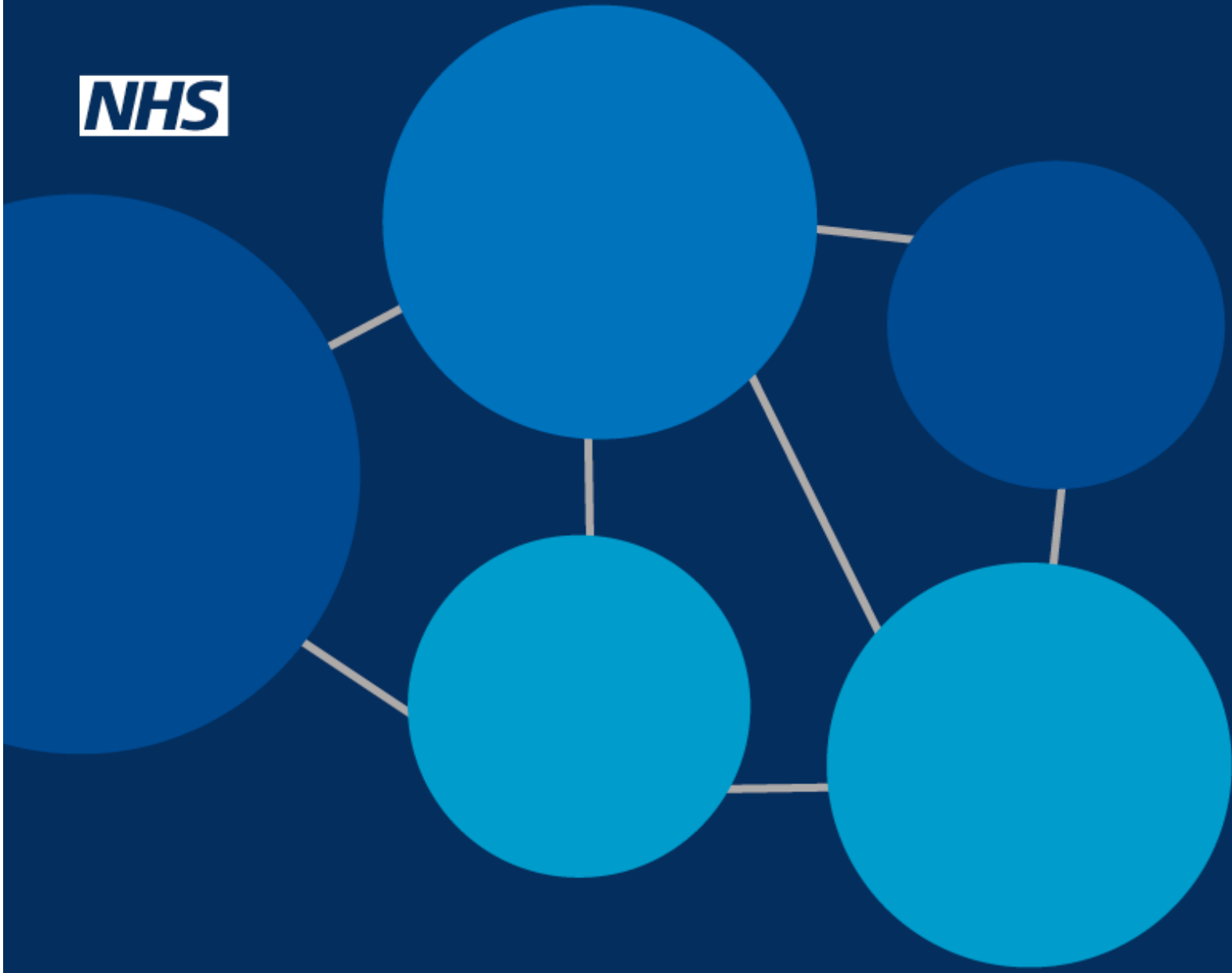

Draft Benefits Realisation Plan V0.9

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 Work streams, patient focus groups and the Clinical Reference Group. It was then further revised by Programme Team taking account of:

- The key benefits sought from the Programme
- The expected impact of the specific proposals under consideration
- 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 Outline Business Case.

The Programme Board approved the original draft in April 2015 for further detailed development of measures and timescales. The Programme team in 2018 has now amended the draft to incorporate recent changes in the clinical model. This BRP will now need further refinement post decision making and prior to finalizing in the OBC in July 2019.

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REF	OUTCOME AMBITION	INDICATOR	MONITORING METHOD
1.1	Patients will be cared for by the right clinician, first time	• % EC patients seen by an ED consultant 24/7 • ED staffing meets CEM guidance • % emergency surgery patients seen by a consultant surgeon 24/7 • 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 • Mortality rates for patients admitted at weekends/out of hours	• Service specifications • Trust(s) activity data
2.1	Improvement in patient reported experience of care	• *[relevant questions in existing surveys to be identified]*	• National Inpatient survey • Friends and Family • 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 • Local Healthwatch/CHC reports
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]* • BREEAM/DQI scores	• Family and Friends Test • Staff Survey • Local Healthwatch/ CHC reports • BREEAM/DQI assessments

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REF	OUTCOME AMBITION	INDICATOR	MONITORING METHOD
2.5	Patients will experience improved privacy and dignity	• % facilities meeting current standards • % single rooms	• Local Healthwatch/ CHC reports • Design specification • BREEAM/DQI
3.1	Eliminating avoidable deaths in our hospitals caused by problems in care	• SUIs	• Trust data
3.2	Separation of EC from planned care will reduce risk of hospital acquired infections	• HCAIs	• Trust data
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 planned care.	• modelling assumptions delivered	• Trust data
5.1	Significant reduction in excess emergency occupied bed days	• Zero day LOS • 27+ days LOS	• Trust(s) activity data
6.1	Step change in the productivity of elective care	• Day case rates • No. cancellations • 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: • Acute hospital episodes • Community hospital episodes • Integrated community teams • Mental Health	• Commissioner financial reports
6.4	Shift in community activity	• Admission avoidance	• Trust data

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REF	OUTCOME AMBITION	INDICATOR	MONITORING METHOD
6.5	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 • Guidance on consultant staffing levels met	• Trust(s) data
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 • Ambulance turnaround times • ED Family & Friends Test	• Trust data
7.2	Patients will wait less long for planned operations or procedures	• Median waiting time for elective admissions	• Trust(s) activity data
7.3	Some specialist services will be able to be repatriated from out of county hospitals as a result of workforce consolidation	Market share %	• Activity commissioned locally
7.4	A large proportion of current A&E attendances will be treated closer to home	• No. EC attendances • No. UCC attendances	• Trust(s) activity data
8.1	The clinical workforce will be more stable as a result of improved working conditions (rotas, specialisation, environment, etc.)	• Sickness absence rate • Turnover • 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: • Medical staff • Nursing staff • 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)* • External accreditation	• Staff Survey data • Staff Family & Friends Test • GMC student experience survey • Deanery accreditation

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