BOURNEMOUTH, CHRISTCHURCH AND POOLE

CARE TECHNOLOGY OPTIONS APPRAISAL

July 2022

Hampshire County Council

PA

BCP Council

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Executive Summary

Bournemouth, Christchurch and Poole (BCP) Council have, in the ASC Strategy 2021 – 2025, set out to improve the quality of life, health and wellbeing of residents in the Council area. The overarching priorities of the ASC Strategy are:

- Engage with individuals and communities to promote well-being
- Support people to live safe and independent lives
- Value and support carers
- Enable people to live well through quality social care
- Deliver services that are modern and accessible

Like all Councils, BCP is facing increasing service demand. Currently, residents aged 75 and over account for 75% of requests made to ASC services each year. The pressures are clear given that the current population of 395,600 is expected to rise to 420,900 by 2028. With this growing population size, the number of residents aged 65 and over is expected to grow by more than 30% between 2021 and 2040; from 86,900 to 115,000. This leaves Commissioners across the health and social care landscape in BCP are facing the combined challenges of increasing populations, people with more complex needs and reducing budgets. The current CT service, whilst successful in delivering a well-regarded basic service for citizens, has not yet realised its full potential.

BCP recognises that the CT offer is limited and that there is untapped potential to achieve outcomes for residents and the wider ASC system. The creation of the unitary council in 2019 has, however, introduced operational challenges in relation to Care Technology (CT) services; there are two legacy systems and processes, from Poole and Bournemouth, which are both in play. The reorganisation has, however, also presented an opportunity to define ambitious strategies and shape future ways of working. There is a clear ambition within BCP to use technology to enhance services and quality of life for residents, along with a recognition that technology has a part to play in all forms of care.

The Corporate Strategy Delivery Plan, under the Fulfilled Lives priority, specifically references extending the use of assistive and digital technology to enable independence and enhance people's quality of life, which is echoed in BCP's ASC Strategy. Furthermore, the Market Position Statement for Adults outlines an ambition to strengthen the offer of assistive technology across Bournemouth, Christchurch and Poole, and ensure it is included from the time people first engage with adult social care at the front door.

This options appraisal builds on the outcome of the CT Diagnostic and recommends a strategy and preferred option for future delivery of the CT service in BCP, in order to meet the Council's vision. The vision is the overall ambition for the CT service. This is supported by design principles, which are required to deliver the vision. 'Critical success factors' describe 'what good looks like', against which each option in this options appraisal is appraised.

Figure 1: Vision for the future CT service

The Council's ambition is to **transform the CT offer so that:**

Our Care Technology service is flexible, sustainable and trusted by all. It is embraced at the first opportunity to enable independence and enhance the quality of life for people across BCP. Care Technology is a cornerstone of our digitally enabled care approach that is embedded in practice and easy to access.

Figure 2: Design principles for the future CT service

Design Principles – these are the overall principles required to deliver the vision and should underpin the design of the future service so that CT will:

- Be equitable and accessible across BCP, including via self-service
- Be a personalised service that supports strengths-based approaches
- Support improved outcomes and reduce reliance on support for both care receivers and care givers
- Be a sustainable and scalable offer that delivers financial benefits for the Council
- Develop and deploy skills and capabilities in the most effective way
- Be accessible to a broad workforce, including external partners

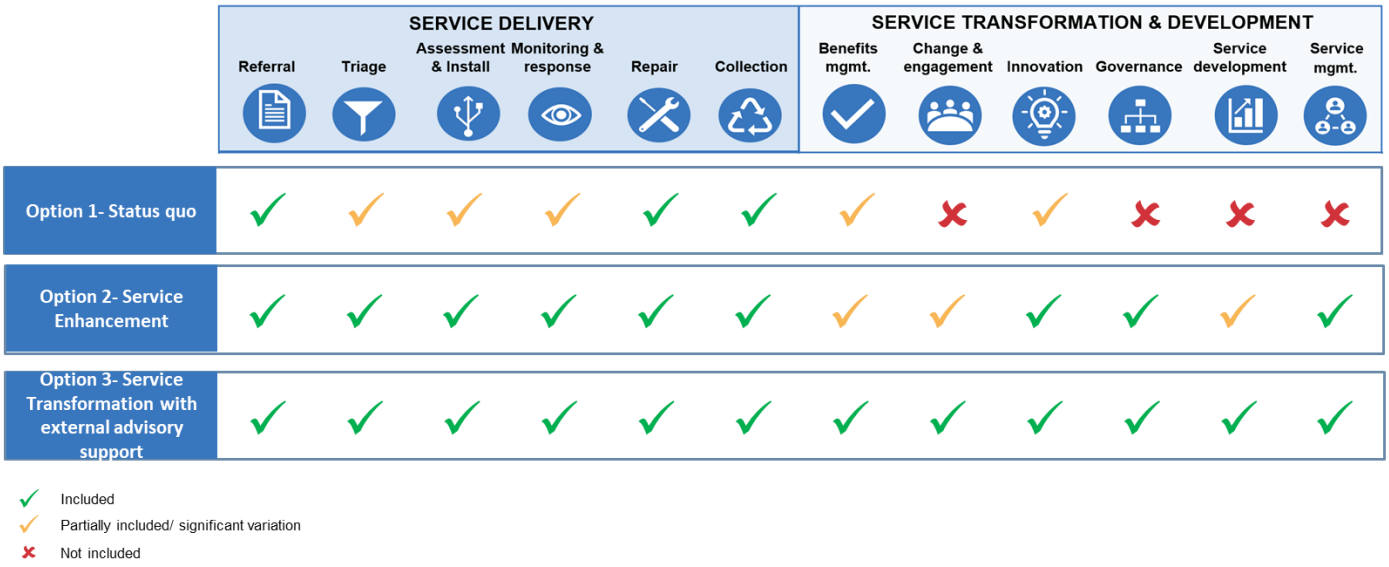
Figure 3: Critical success factors for the future CT service

	Theme	CT Project Critical Success Factors
1	Improved outcomes and experience	• People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible • Discharge from hospital is supported appropriately with CT • People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT
2	Improved efficiency	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
3	Service capacity and capability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
4	Value for money and financial sustainability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
5	Deliverability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake

Future options for the service

There are three options for appraisal, Option 1 - Status quo (the do-nothing baseline) represents the current position, Option 2 – Service Enhancement builds on the current service developing the CT service specification, whilst Option 3 – Service Transformation provides additional transformation benefits. These are set out at a high level in the figure below.

Figure 4: High level overview of options appraisal options



Option 1 - *Status quo* represents the current position. The status quo CT service assumes there will no change to the current offer, with the exception of those already underway. This means the status quo would continue to primarily offer services to older people and CT is offered to ASC eligible users in addition to a care package in most cases.

Option 2 – Service *Enhancement* builds on the current service with an enhanced specification. The service would expand to reach a larger number of users and consists of all of Option 1 plus more support for younger adults with LD needs, for example in Supported Living.

Option 3 - *Transform* builds on the cohorts in Option 1 and Option 2 by including a specific technology offer to OA (which could include pathways such as dementia) and younger adults (<65s) across all service areas. The transformed service will reach a greater number of people receiving CT, through a sustained programme of culture change, enabling teams across the Council to signpost to CT services, including a self-service option. It is assumed that transformation is driven by externally commissioned support, however this could be delivered internally if BCP determine that the capacity and capability exist.

Approach to appraisal

The qualitative appraisal has been completed by assessing the extent to which each option meets the agreed Critical Success Factors (CSFs) agreed by the Project Board. Board members completed a survey to score each of the options against each CSF out of 5, with the average of these responses providing the score. Adding the score for each of the 15 CSFs provides an overall qualitative score out of 75 for each option.

Analysis of financial benefits has been completed for several cohorts. These cohorts were scoped, defined and agreed in consultation with the BCP CT Project Board. The cohorts appraised financially are as follows, although this varies by option:

- Homecare Older Adult (OA) citizens (existing and new)
- Residential / nursing citizens (new)

- Supported Living Learning Disabilities (LD) citizens (existing and new)
- Citizens with CT (existing)
- Homecare LD citizens (existing and new)

Summary of qualitative and quantitative analysis

Option 1 - Status quo

The service would continue to reach the same core user base, predominantly focused on OA. Without additional investment, the service would also not have the skills and capacity to access new user groups and new forms of technology on a consistent and formal basis. As there is no major change taking place under this option, there are limited delivery risks.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 28/75. The detailed rationale for scoring given is provided in 6.2.1.

The projected cost of the existing CT service for ASC eligible users over the next 5 years is £1.9m.

Option 2 - Enhance

Option 2 – The Service Enhancement option meets the CSFs to a greater extent than Option 1 - Status quo, increasing user volumes and developing a clearer referral pathway. This option presents a greater risk to BCP than Option 1 as there is a requirement for change. Delivery risks could include the failure to meet time, cost and quality requirements. The breadth of the service will be relatively limited and is unlikely to grow significantly over the longer term without additional investment.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 47/75. The detailed rationale for scoring given is provided in 6.2.2.

Across five years this option results in a total incremental gross benefit of £4.54m and a total incremental cost of -£1.6m. Therefore, this results in an incremental net benefit of £2.95m.

Figure 5: CT service growth across 5 years

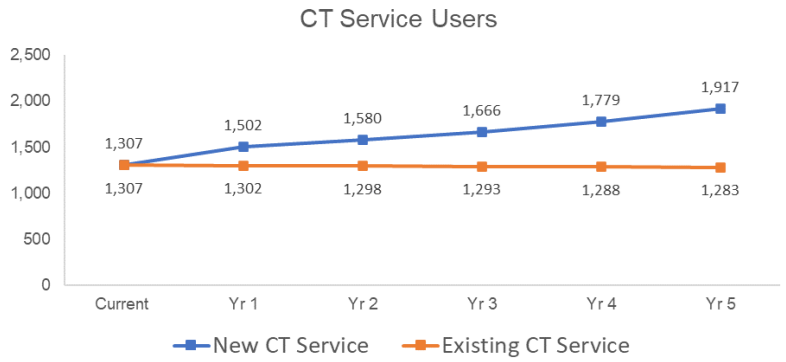


Table 1: Option 2 quantitative appraisal

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.15MM	£0.22MM	£0.17MM	£0.15MM	£0.13MM	£0.82MM
Gross benefits from new ASC citizens	£0.35MM	£0.59MM	£0.76MM	£0.94MM	£1.09MM	£3.72MM
Total Incremental Gross Benefit	**£0.50MM**	**£0.81MM**	**£0.93MM**	**£1.08MM**	**£1.22MM**	**£4.54MM**
On-going incremental CT service cost[1]	-£0.21MM	-£0.20MM	-£0.24MM	-£0.30MM	-£0.36MM	-£1.30MM
One-off transformation cost[2]	-£0.20MM	-£0.10MM				-£0.30MM
Total Incremental Costs	**-£0.41MM**	**-£0.30MM**	**-£0.24MM**	**-£0.30MM**	**-£0.36MM**	**-£1.60MM**
Incremental Net Benefit	**£0.09MM**	**£0.51MM**	**£0.69MM**	**£0.79MM**	**£0.86MM**	**£2.95MM**

Option 3 - Transform

Option 3 – Service Transformation meets the CSFs to a much greater extent than Option 2 – Service Enhancement. This approach increases volumes by reaching a broader range of users including those with complex needs. The change will be more likely to generate and sustain momentum as there will be a managed change and engagement programme. However, change of this scale carries higher delivery

risks and the project will need to be carefully managed in order to meet time, cost and quality requirements. To provide the capacity and capability to deliver transformation of this scale and to mitigate against the aforementioned risks, ongoing external advisory support has been assumed for this option[1].

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 66/75. The detailed rationale for scoring given is provided in 6.2.3.

Across five years this option results in total gross benefit of £7.44m and a total incremental cost of -£2.44m. Therefore, this results in an incremental net benefit of £5m.

Figure 6: CT service growth across 5 years

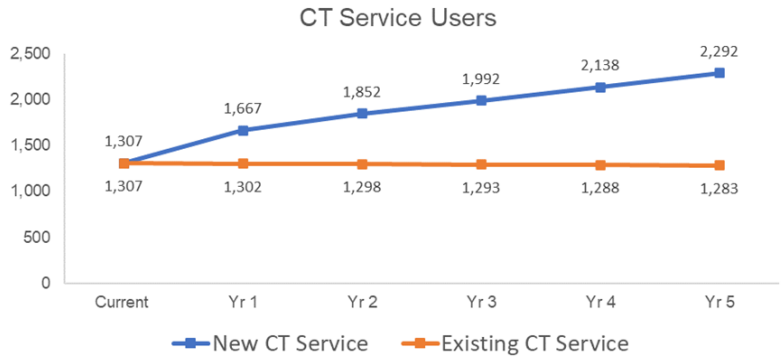


Table 2: Option 3 quantitative appraisal

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Gross benefits from new ASC citizens	£0.62MM	£0.97MM	£1.16MM	£1.39MM	£1.57MM	£5.70MM
Total Incremental Gross Benefit	**£0.97MM**	**£1.44MM**	**£1.51MM**	**£1.69MM**	**£1.84MM**	**£7.44MM**
On-going incremental CT service cost[1]	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off transformation cost[2]	-£0.35MM	-£0.15MM				-£0.50MM
Total Incremental Costs	**-£0.68MM**	**-£0.47MM**	**-£0.37MM**	**-£0.43MM**	**-£0.49MM**	**-£2.44MM**
Incremental Net Benefit	**£0.29MM**	**£0.97MM**	**£1.14MM**	**£1.26MM**	**£1.35MM**	**£5.00MM**

In assessing both the qualitative and quantitative factors for the three options, the CT Project Board has concluded the following:

1.1.1 Option 1 – Status quo

Maintaining Option 1 - Status quo will see the volume of citizens accessing the CT remain static in line with current trends. The type of referrals will continue to focus on basic support for older people with moderate needs, thus losing the opportunity to support a greater number of people to live independently. It does not represent a tangible change versus the current situation and therefore does not meet many of the CSFs. However, as there is no significant change the delivery risks are low.

1.1.2 Option 2 – Service Enhancement

Option 2 – Service Enhancement improves the current service by growing users and expanding support to more younger adults (<65) with LD needs and increasing the number of older adult users. There is a moderate growth in the CT service and moderate benefits. The anticipated growth in the service is such that by the end of the 5th year there is anticipated to be 1,917 citizens accessing the service compared to 1,283 expected under Option 1.

This option therefore partially meets the critical success factors with moderate risk and reward.

[1] The external party would work closely with BCP colleagues to deliver the transformation. However, this could be delivered internally should BCP identify sufficient resource and be confident in the available capability.

1.1.3 Option 3 – Service Transformation

Option 3 – Service Transformation builds significantly upon Option 2; it mainstreams CT effectively across social care encouraging practitioners to consider it as part of the 'first offer' for a wider range of citizen needs. It therefore requires sustained focus, resource and effort on cultural and behaviour change of practitioners. It transforms the CT service by supporting a larger number of younger adults (transitions/LD/Mental Health/PD etc) and expands the offer for older people with complex needs, including via the introduction of a self-service access route, leading to a higher growth in the CT service and higher benefits.

This option fully meets the CSFs and delivers significant reward, but with correspondingly higher level of risk and transformation costs, although it is anticipated these will be offset to deliver a significant overall net benefit. The scale of transformation required under Option 3 is assumed to require external transformation and ongoing advisory support, but this may not be required should BCP determine the required capability exists internally and capacity can be created accordingly.

1.1.4 The preferred option

The preferred option, as agreed and recommended by the CT Project Board on 20 July 2022 is Option 3 – Service Transformation. Option 3 aligns with the BCP's ambition to significantly improve the CT service and integrate it into part of the 'first offer' of support, including via self-service access routes. It has the biggest potential to improve user outcomes and is also forecast to achieve the largest net financial benefit to the system, although it is the highest risk option.

Costs of delivery and how the service will be funded

The 5-year total funding requirements are of £4.38m. This is an additional funding requirement of £2.44m compared to the Status quo – Option 1 (existing CT service costs), representing the one-off transformation costs and ongoing incremental costs. It is anticipated that the service will be funded through existing budgets in line with funding for the current service, and costs are expected to be offset by gross benefits of £7.44m. This investment therefore results in a net benefit of £3.06m over 5 years.

Figure 7: Total 5-year funding requirement

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Option 1 estimate of current costs	-£0.39MM	-£0.39MM	-£0.39MM	-£0.39MM	-£0.38MM	-£1.94MM
On-going incremental Option 3 CT service cost	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off Option 3 transformation cost	-£0.35MM	-£0.15MM	-	-	-	-£0.50MM
Total Option 3 Costs	**-£1.07MM**	**-£0.86MM**	**-£0.76MM**	**-£0.81MM**	**-£0.87MM**	**-£4.38MM**
Funded through:						
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Total ASC funding and benefits for existing ASC citizens	**£0.35MM**	**£0.47MM**	**£0.35MM**	**£0.30MM**	**£0.27MM**	**£1.74MM**
Net funding requirement - assuming benefits from existing ASC citizens only	**-£0.73MM**	**-£0.39MM**	**-£0.41MM**	**-£0.51MM**	**-£0.61MM**	**-£2.64MM**
Gross benefits from new ASC citizens	*£0.62MM*	*£0.97MM*	*£1.16MM*	*£1.39MM*	*£1.57MM*	£5.70MM
Net funding requirement - assuming benefits from existing and new ASC citizens	***-£0.11MM***	***£0.58MM***	***£0.76MM***	***£0.87MM***	***£0.96MM***	**£3.06MM**

Delivering the change

It is expected to take 7 months to fully mobilise and implement Option 3 – Service Transformation once the service delivery model and any commercial implications are confirmed (if required); 1 month to plan implementation and mobilise the project team, 5 months to deliver implementation activity prior to go-live and 1-month post go-live activity. Implementation will involve work to refine governance structures, redesign priority pathways and processes, develop a robust benefits realisation framework and tracking approach, increase learning and development across a wide range of stakeholders and communicate and engage with residents, BCP staff, providers, and partners.

Achieving and sustaining successful change of this nature relies on a campaign to win hearts and minds. It will not be a one-off exercise but will need to be part of an ongoing approach, which will need to be adopted by staff, citizens, carers, providers, partners, and senior leadership.

2 Introduction and purpose

This section will describe the introduction, background and purpose of this options appraisal.

2.1 Background

A CT (care technology) diagnostic was commissioned in October 2021 by Bournemouth, Christchurch and Poole Council (BCP) to better understand existing provision and the future potential for CT across the council. This report found, much like other CT services around the country, that the service in BCP predominantly served Older Adults (OA) and CT was in most cases used in addition to, rather than instead of, other costlier support provided as part of a package of care, such as domiciliary and residential care.

The diagnostic identified a clear opportunity to enhance the offer available to Older Adults (OA) and broaden the offer to include younger adults with Learning Disabilities (LD) and people with mental health (MH) needs. This promotes independence and wellbeing, reduces reliance on other costlier services and hence provides a financial benefit to commissioners.

This diagnostic review of the current service found a clear case for investing in the CT service and to support the realisation of this opportunity, this options appraisal has been developed.

2.2 Purpose of this options appraisal

The options appraisal builds on the outcome of the CT diagnostic and recommends a strategy and preferred option for future delivery of the CT service in BCP. This options appraisal:

- Sets out the vision, design principles and critical success factors (CSFs) for the CT service in BCP;
- Defines the different possible alternative service models (the options) for CT in the future;
- Undertakes cost, benefit and risk analysis to enable a decision as to which option presents best public value for money (including outcomes for citizens);
- Outlines the commercial, financial and management / project implications of the preferred option;
- Defines the next steps, following agreement and confirmation of a preferred option, that will lead to the development of redesigned CT Pathways, a detailed implementation plan and a comprehensive workforce change programme.

2.3 Scope – what do we mean by Care Technology (CT)?

CT covers a broad spectrum of technology and equipment, including telecare, telehealth, telemedicine, telecoaching and self-care services, and sometimes referred to as Assistive Technology (AT) or Technology Enabled Care (TEC). All these services share the aim of putting people in control of their own health and wellbeing. It should be noted that the current BCP service does not deliver CT in its fullest definition as per the figure below. The current service mostly consists of basic telecare pendants and a limited range of peripherals to meet moderate needs and activity monitoring through the use of Just Checking.

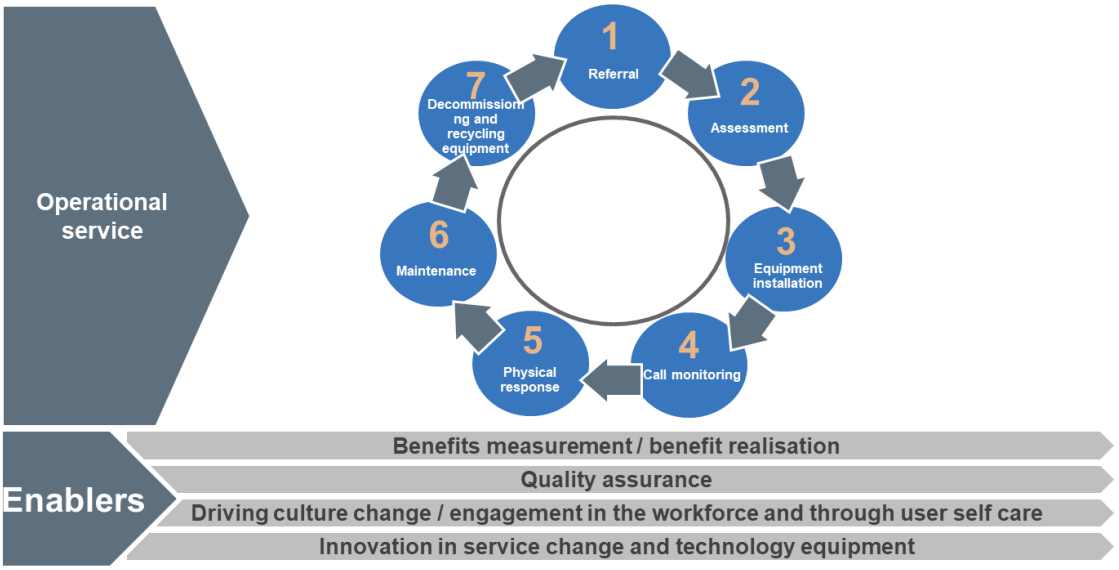
The figure below shows the scope of CT in this options appraisal, which analyses the potential for CT in the next 5 years in BCP. It should be noted that the longer-term vision for CT is broader than this, and over time may include incorporating telehealth, robotics, artificial intelligence, and other innovations.

Figure 8: Definition of CT for the scope of this options appraisal

CT – included in this options appraisal	Telecare	Typically, telecare services are provided through local authorities, housing associations, industry services and voluntary organisations. They include personal alarms, a wide range of 'passive' home sensors (e.g. fire and flood detectors) and activity monitoring. Alerts are monitored by control centres, which can be located anywhere, that can respond quickly to emergencies.
	Mobile care / health apps	Fitness and health/care apps (including mental health) are available for use on smartphones and tablets and are often referred to as mobile health or mHealth.
	Consumer devices	Consumer devices are Internet-capable personal devices (marketed at individuals) they can enable smart/remote environment control such as thermostat, lights and security. As well as smart speakers/voice activated assistants (e.g. Alexa), providing alerts/reminders, information and improving lifestyle (playing music/audiobooks etc.). Consumer devices also include standalone or smart-phone connected well-being trackers.
Not included in this options appraisal	Telehealth	Telehealth and telemedicine involve text, phone or video connections between patients and clinicians as well as active remote monitoring by clinicians of long term conditions (e.g. diabetes) using medical devices in the home (e.g. blood pressure and glucose monitors).
	Digital health	eHealth, Health IT and digital health are broader terms that can also include web-based home health support systems as well as electronic health and care records used by practitioners. Increasingly, they cover predictive data analytics, machine learning, care robotics, virtual reality, voice operable systems and artificial intelligence

The typical service model for a CT service involves an initial referral, assessment of the need and installing / providing training for the equipment or app, maintaining and reviewing, and then collecting or closing the service once it is no longer needed. This is shown in the diagram below, which shows the future potential CT model for BCP. Increasingly, councils are realising the benefits that CT services can deliver to people, carers and the local health and social care economy when used as an enabler to transform the way in which social care outcomes are achieved. If benefits can be robustly and effectively tracked, then data and information can be used to inform decision-making and evidence savings. In other councils, a focus on cultural change and engagement has also driven significantly increased take-up and supported people to integrate more digital technology into their lives. Service development integrates the CT services into wider social care and health services to ensure best outcomes.

Figure 9: Typical end-to-end CT service model[2]

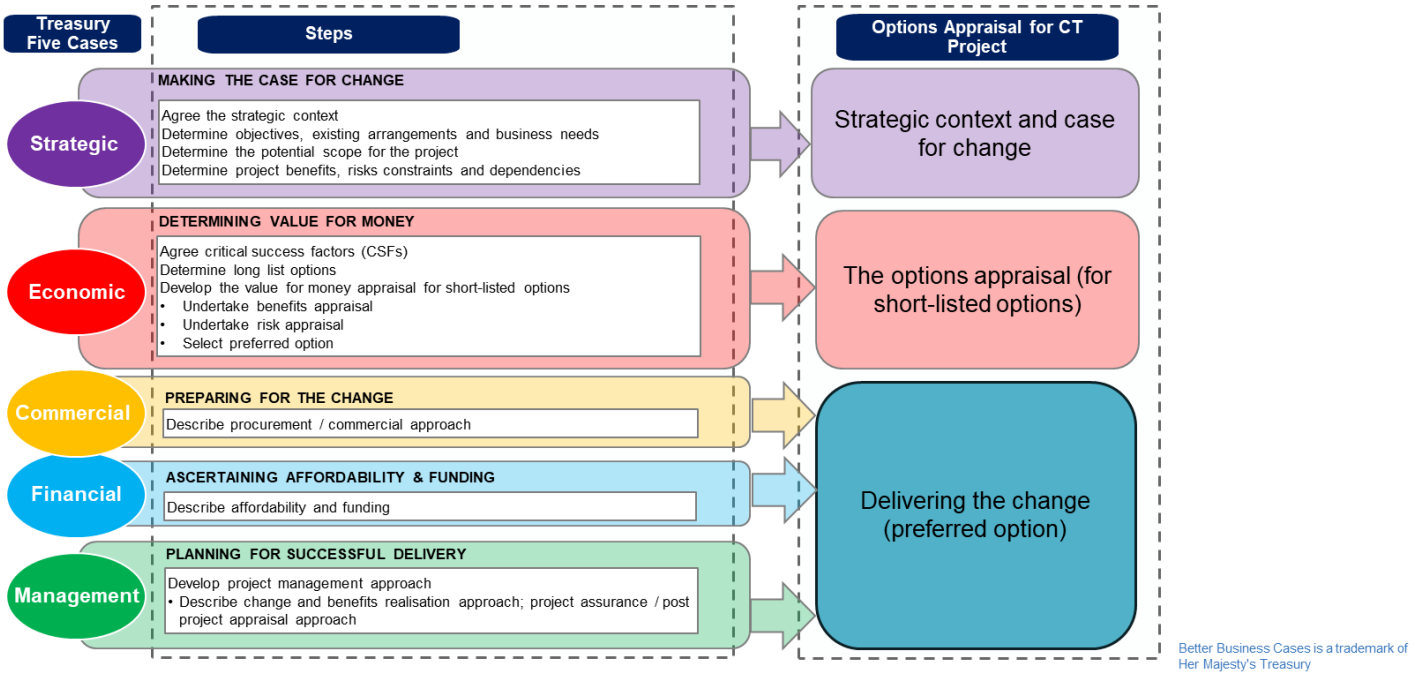


[2] It should be noted that an end-to-end CT model has an iterative end-to-end process, hence the numbered steps are not linear in the process.

2.4 Options appraisal approach

The Options Appraisal utilises an adapted version of the Five Case Model developed by Her Majesty's Treasury and is the Government's framework for business cases for major Government projects. It represents best practice in public sector business cases. The diagram below shows how the structure of this document maps onto the HMT Five Case Model. This combines the Commercial, Financial and Management cases (focussed on the preferred option) as 'delivering the change' to reflect proportionality for this project.

Figure 10: Options appraisal approach



The options appraisal is developed in stages. Key stakeholders have been engaged throughout the work, and their insight and contributions have fed into the:

- Development of objectives, critical success factors and options;
- Appraisal of options;
- Development of the options appraisal.

2.5 Stakeholder engagement

Various approaches were used to engage with stakeholders throughout the diagnostic and options appraisal. Management of the project was undertaken via a Core Project Team consisting of colleagues from BCP ASC Commissioning and PA Consulting. Project deliverables were presented, discussed, and approved at the CT Project Board at agreed milestones. The CT Project Board membership consisted of key stakeholders from BCP who had input into the design of the options appraisal and have a clear role in future implementation of the preferred option. Direct engagement with other stakeholders was undertaken through one-to-one meetings and workshops during the diagnostic phase with care practitioners consulted via an online survey to ensure that a comprehensive range of views, opinions and insight fed into the options appraisal.

Table 3: Diagnostic and Options Appraisal engagement

Engagement method	Reach	Engagement purpose
Health and care practitioner survey	Completed by 53 practitioners who work across all three patches, specialist services and hospital teams.	Gather practitioner views on the current CT service and the role CT currently plays in ASC and could play in the future

Stakeholder interviews	14 colleagues from across relevant BCP teams (Kate Baker, Laura Henderson, Betty Butlin, Lynda Anderson, Jonathan O'Connell, Teresa Stanley, Pete Courage, Tim Branson, Seamus Doran, Kieren Johsnon, Zena Dighton, Amy Hurst, Lorraine Mealings, Andrea Barnes)	Input to diagnostic review of existing service, providing views on experiences of the service, including strengths and potential development areas
Financial validation with BCP Finance	BCP ASC Finance Lead (Anna Fresolone)	Developing, testing and validating the financial inputs and assumptions in the Options Appraisal
Core Project Group Meetings (weekly for the duration of the project)	2 ASC Commissioning colleagues (Zena Dighton, Emma Senior)	Managing project progress and iterative testing of the options appraisal and other deliverables as these developed
CT Project Board	13 CT Project Board Members (Jonathan O'Connell, Kate Baker, Betty Butlin, Tim Branson, Zena Dighton, Emma Senior, Amy Hurst, Lorraine Mealings, Anna Fresolone, Jill Johnson, Adrian Hale, Andrea Barnes, Sharon Jones)	Agree service vision and design principles, Critical Success Factors (CSFs) and options in the options appraisal Conduct qualitative scoring of options Review and signoff options appraisal

3 Our case for change for CT in BCP

This chapter will define the context and the drivers for change in relation to the use of CT in BCP. We will describe the strategic vision around living independently and staying well in BCP, the current CT service, and the ways in which it could be enhanced to meet the vision. We will conclude by setting out the agreed strategic objectives across BCP for a change in CT provision.

3.1 The context for change in BCP

Bournemouth, Christchurch and Poole (BCP) Council has, in its ASC Strategy 2021 – 2025, set out to improve the quality of life, health and wellbeing of residents in the Council area. The overarching priorities of the ASC Strategy are:

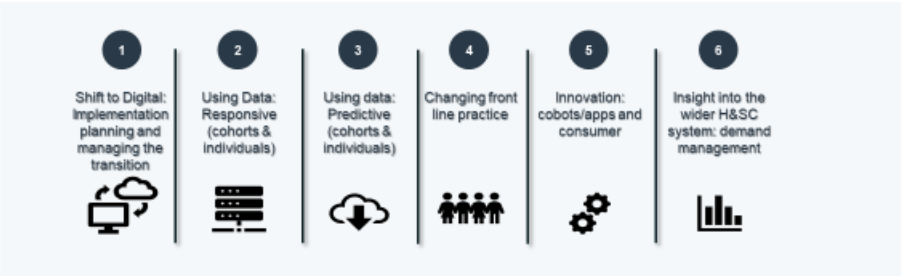
- Engage with individuals and communities to promote well-being
- Support people to live safe and independent lives
- Value and support carers
- Enable people to live well through quality social care
- Deliver services that are modern and accessible

The Corporate Strategy Delivery Plan, under the Fulfilled Lives priority, specifically references extending the use of assistive and digital technology to enable independence and enhance people's quality of life, which is echoed in BCP's ASC Strategy. Furthermore, the Market Position Statement for Adults outlines an ambition to strengthen the offer of assistive technology across Bournemouth, Christchurch and Poole, and ensure it is included from the time people first engage with adult social care at the front door.

Nationally, there is a driver for change in the upcoming Digital Shift (also known as the Digital Switchover). By 2025, the analogue infrastructure in the UK will be fully replaced with a digital version. This presents an opportunity to use technology to support a greater number of people, as the technology may help to meet needs in a better, faster or cheaper manner compared with analogue systems. Due to uncertainty regarding the timing of the CT Digital Shift, the scope to plan for this change in detail at this time is limited, although any changes to the CT approach in the Council must be made with awareness of the Digital Shift, so that future options for development are not impeded by decisions made today.

The digital shift will afford BCP with opportunities to experiment with new digital CT equipment and demonstrate the benefits it can offer. As the digitisation of CT looms closer, there needs to be coherent strategic thinking to optimise the opportunities digitally enabled care brings.

Figure 11: The Digital Shift provides an opportunity to accelerate the transformation of CT services



It is important, however, not to lose sight of people and their carers; the first question should always be 'what needs are out there and how could digital equipment help us to meet these'.

3.2 The case for change

Like all Councils, BCP is facing increasing service demand. Currently, residents aged 75 and over account for 75% of requests made to ASC services each year. The pressures are clear given that the current population of 395,600 is expected to rise to 420,900 by 2028. With this growing population size, the number of residents aged 65 and over is expected to grow by more than 30% between 2021 and 2040; from 86,900 to 115,000. This leaves Commissioners across the health and social care landscape in BCP are facing the combined challenges of increasing populations, people with more complex needs and reducing budgets. The current CT service, whilst successful in delivering a well-regarded basic service for citizens, has not yet realised its full potential.

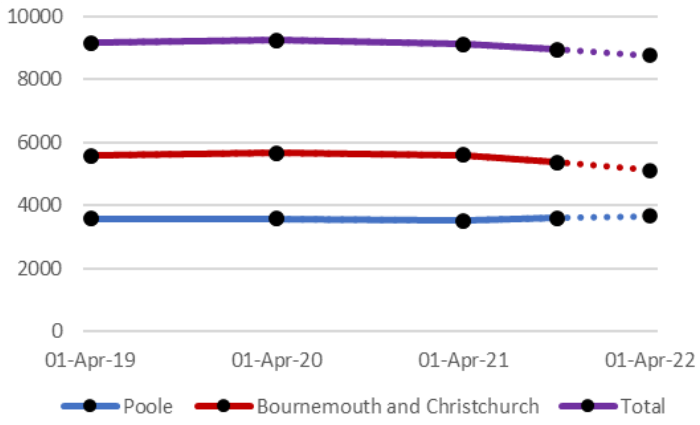
BCP recognises that the CT offer is limited and that there is untapped potential to achieve outcomes for residents and the wider ASC system. The creation of the unitary council in 2019 has, however, introduced operational challenges in relation to Care Technology (CT) services; there are two legacy systems and processes, from Poole and Bournemouth, which have both been in play. The reorganisation has, however, also presented an opportunity to define ambitious strategies and shape future ways of working. There is a clear ambition within BCP to use technology to enhance services and quality of life for residents, along with a recognition that technology has a part to play in all forms of care.

3.2.1 The current CT service

BCP's Care Technology Service sits within the Housing directorate and is split into Bournemouth Careline (which also serves Christchurch) and Poole Lifeline. Residents can access the service via two routes: Private Pay or Community Alarm. Private Pay users pay for the installation and ongoing costs for monitoring and response[3], while Community Alarm users access CT via housing schemes.

As of 1 October 2021, 8949 residents accessed the service, with the majority of these (60%) in Bournemouth and Christchurch. The majority of service users (57%) accessed the service via the Private Pay service. Data relating to service user numbers, installations and uninstalls all demonstrate that the CT service size has remained largely static over the past three years. Whilst this has coincided with the Covid-19 pandemic, many comparable local authority numbers saw services grow during this period as people became increasingly reliant on technology support.

Figure 12. Total Monitored Lifeline and Careline Service Users

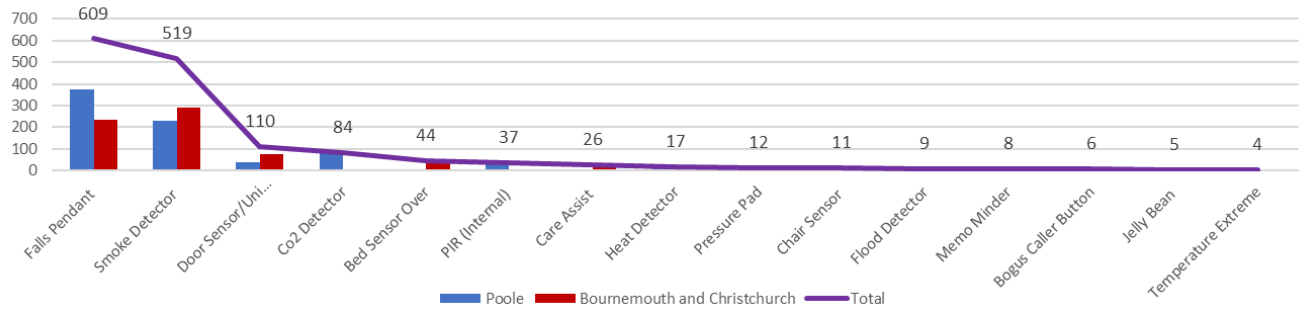


It is not possible to accurately identify the current number of service users accessing the service who have ASC needs as users referred via ASC routes are a subset of the Private Pay cohort. Anecdotal feedback suggests that approximately 25% of new referrals are received via ASC routes. Referrals for standalone devices are not reflected in the total service user volume, as BCP does not provide a service beyond installation of the device. Furthermore, there is currently no mechanism for identifying the number of service users with ASC needs who leave the service.

[3] a response service is currently available in Poole, although there are aspirations to broaden this offer to the whole of BCP.

Equipment usage as of 1 October 2021 demonstrates that the offer is traditional, predominantly offering pendant alarms, falls alarms or environmental sensors. There is currently little evidence of an enhanced and developmental equipment offer, for example GPS trackers or use of apps. This is supported by practitioner feedback via the conducted survey conducted during the diagnostic phase.

Figure 13. CT equipment available to everyone, including ASC and Private Pay users



Despite a smaller service user volume, more monitoring calls are made each year in Poole. Feedback suggests this in linked to the response service that is available only in this patch.

In addition to all aspects of the CT service (installation, monitoring, physical response etc) the team performs statutory out of hours services. The team structure is as follows:

Figure 14. Current CT team structure

CT Management		Operational Staff[4]	
1	Head of Service & OOH Manager	2	Senior Operator
1	Deputy Telecare & OOH Manager	6	Installers
3	Telecare & OOH Supervisor	32	Operators
		2	Admin Support

3.2.2 Diagnostic review findings

The diagnostic review assessed the as-is and identified several key themes spanning strategic, operational, and enabling factors. Firstly, it identified evident ambition and significant support across ASC and Housing for the increased use of Care Technology to help achieve Council and directorate priorities. This presents a clear opportunity to embed Care Technology in Council services, ASC practice and ASC support planning. However, in order to achieve this, future service development must not simply be a review and expansion of the equipment that is offered to residents.

Despite the ambition and support, there is a gap when considering strategic overview and ownership. There is no CT strategy or clear articulation of how the current service offers are being aligned and developed to meet the Council's strategic objectives. Furthermore, there has not to date been BCP-wide ownership to bring a focus and consistency to the development of CT services across ASC. The work to date has instead been concentrated on unifying the service offer following the LGR.

Building on the above, it is apparent that current service activity and resourcing is operationally focussed. The current structural framework limits innovation, development and CTs ability to become a tool which ASC can use for meeting a wider range of needs and helping to achieve Council objectives. There are pockets of service development activity, but these have been discrete projects and they do not form part of a cohesive wider CT development programme.

The current CT service is not embedded within ASC culture and practice; it is seen as the 'responsibility and control' of a few however there is a clear appetite from practitioners for greater use of CT. Survey responses demonstrated that while 87% of respondents thought the use of CT was "important" or "very

[4] a combination of F/T, P/T, casual staff and vacancies

important" to their role, just 23% had "high" or "very high" confidence when discussing CT with people. CT tends to be used to support Older Adults and there is little evidence that CT has been considered, or used, to meet a range of outcomes across different cohorts and needs.

The service has remained static. Service user volumes have remained broadly unchanged over the last three years, while the equipment offer has not evolved. In Bournemouth and Christchurch, the equipment offer has been perceived as increasingly restricted following efforts to unify the service offer across BCP.

The existing 'Poole' model delivers against its original remit with dedicated management; however, it will be challenging to scale in its current form when considering factors such as OTA resourcing for CT assessments and the manual approach to benefit analysis. Some outcomes are recorded, but the scale does not match the Council's ambition.

3.3 Vision and objectives for a future CT service

The CT Project Board reviewed and agreed the CT diagnostic described above in November 2021. This demonstrated that there was a need for change, and this options appraisal was commissioned to review the potential options for delivering CT across BCP in the future.

The BCP CT Project Board agreed a vision for the future service and 'design principles' for any future CT offer, which have been used to formulate a series of critical success factors that will be used to measure the degree to which the service achieves the vision and in the appraisal of the options.

Figure 15: Vision for a future CT service

The Council's ambition is to **transform the CT offer so that:**

Our Care Technology service is flexible, sustainable and trusted by all. It is embraced at the first opportunity to enable independence and enhance the quality of life for people across BCP. Care Technology is a cornerstone of our digitally enabled care approach that is embedded in practice and easy to access.

Figure 16: Design principles for a future CT service

Design Principles – these are the overall principles required to deliver the vision and should underpin the design of the future service so that CT will:

- Be equitable and accessible across BCP, including via self-service
- Be a personalised service that supports strengths-based approaches
- Support improved outcomes and reduce reliance on support for both care receivers and care givers
- Be a sustainable and scalable offer that delivers financial benefits for the Council
- Develop and deploy skills and capabilities in the most effective way
- Be accessible to a broad workforce, including external partners

3.4 Benefits of an improved CT service

Successful delivery of the CT service in BCP could bring the following benefits. Section 4 will look at three options and ascertain the degree to which the agreed Critical Success Factors (CSFs) and these benefits will be achieved under each option.

Figure 17: Benefits of CT change

Benefit type	Setting of care/ cohort	Benefit
	Homecare – existing OA citizens	CT enables reduction in homecare packages for existing OA citizens

Benefit type	Setting of care/ cohort	Benefit
Service outcomes – financial (for the purposes of this options appraisal)	Homecare – new OA citizens	CT reduces or prevents need for homecare for new OA citizens
	Residential / nursing care (non-LD)	CT delays entry to residential / nursing / respite care for new OA citizens
	Supported Living – existing LD service users	CT reduces need for support for existing LD Supported Living citizens
	Supported Living – new LD service users	CT reduces or prevents need for support for new LD Supported Living citizens
	Existing citizens with CT	CT enables reduction in existing care packages
Service outcomes – non-financial (for the purposes of this options appraisal, but could be quantified in the future)	Older people with dementia / mental health needs	CT supports people to live more independently. The impact of which could support other agencies e.g. police and health as well as BCP
	Other service users with complex needs	Various outcomes dependent on the need (e.g. promoting medication adherence, safer homes, travel support, epilepsy support, increased independence)
CT Service benefits – quantifiable but non-financial	Referrals	Increase in referrals as a % of total cohort size
	Connections	Increase in live connections
	Installation	Shorter time between referral and CT installation
	Staff satisfaction with the service	Increase in care practitioner satisfaction with the service (this is not currently measured)
	Citizen satisfaction with the service	More widespread measurement of citizen satisfaction of the service (this is not currently measured)

3.5 Risks and dependencies associated with a change

Any potential change comes with a degree of risk. These will be explored in more detail in Section 5, but may include:

- **Engagement:** BCP is a large and relatively new organisation and has, like many local authorities, had historically high staff turnover in ASC. These factors all present a risk to staff capacity and therefore capacity to engage with any CT project.
- **Commercial / financial:** Whilst quality of life benefits for service users is the primary purpose of any change to the CT offer, it is also intended to deliver financial benefits to the council. Any failure to successfully deliver or embed the change poses a risk to the achievement of these financial benefits and would bring in to question the value for money of the change.
- **Delivery and implementation:** any organisational change results in a delivery risk such as the project failing to meet scope, quality, time or budget requirements.
- **Digital shift:** the Digital Shift will have a substantial impact on future CT services, the impact of which needs to be understood further and could pose additional constraints and require additional resource during any change programme.
- **Change fatigue:** the relatively recent formation of BCP as a council and efforts to align legacy CT services from Bournemouth and Poole have been significant changes for the BCP CT team. As a result, any further change will need to be managed sensitively to mitigate the risk of change fatigue.
- **System limitations**: the impending migration to bring together BCP care records from Mosaic and Care Director is a significant undertaking for BCP staff and attempting to undertake CT transformation simultaneously poses significant risks. The CT service uses the Tunstall PNC monitoring system, to which it has a long-term contract, which can pose some limitations.

4 The future options for the service

This section will appraise the different options that have been developed in response to the defined scope. It sets out the approach to the appraisal of options, a description of each option, including the baseline 'status quo' and appraises the costs and benefits of each of the options in comparison to the status quo. This section will conclude by recommending the option that offers the best value for money, the preferred option.

4.1 Critical Success Factors for CT in BCP

Critical success factors (CSFs) are the attributes essential for successful delivery of the project against which the initial assessment of the options for the delivery of the project should be appraised. The success factors for the project must be crucial, not merely desirable, and not set at a level that could exclude important options at an early stage of identification and appraisal.

The table below describes the CSFs for investment in the BCP CT service. These are based on the design principles set out in Section 3.3.

As set out in the service vision, BCP is seeking a CT service that is flexible, sustainable and trusted by all, embraced at the first opportunity to enable independence and enhances the quality of life for people across BCP.

For each option a qualitative analysis against the CSFs, and quantitative analysis of costs and benefits was performed. The combination of the qualitative assessment and quantitative assessment will form the basis of the decision as to the preferred option.

The following CSFs were developed with and agreed by the CT Project Board.

Figure 18: CSFs for investment in CT

	Theme	CT Project Critical Success Factors
1	Improved outcomes and experience	• People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible • Discharge from hospital is supported appropriately with CT • People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT
2	Improved efficiency	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
3	Service capacity and capability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake
4	Value for money and financial sustainability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes

	Theme	CT Project Critical Success Factors
		• Practitioner understanding of the offer and process is enhanced, driving increased uptake
5	Deliverability	• CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support • There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes • Practitioner understanding of the offer and process is enhanced, driving increased uptake

4.1.1 Qualitative Appraisal Approach

The qualitative appraisal has been completed by assessing the extent to which each option meets the CSFs outlined above. Members of the CT Project Board completed a survey to score each of the options against each CSF out of 5, with the average of these responses providing the score. Adding the score for each of the 15 CSFs provides an overall qualitative score out of 75.

Figure 19. Qualitative scoring key

4.1.2 Quantitative Appraisal Approach

The quantitative appraisal has measured the value for money of each option through analysis of the costs and benefits of each option, in comparison to the status quo option.

The approach to the quantitative analysis is as follows:

- The financial appraisal focuses on the costs and benefits of providing CT to ASC eligible service users. Whilst the CT service provides support to PHP and private pay (non-ASC eligible) users, financial information provided shows that this is largely cost neutral or generating a small surplus.
- Under the current BCP charging approach, the equipment provided to ASC eligible users is funded by ASC budgets, but the user is required to pay for the monitoring and physical response, where this is taken up. For the purposes of Options 2 and 3 it has been assumed that the monitoring component of the service would be funded by ASC budgets to remove this as a barrier to uptake of the service that may prevent benefits from being achieved. However, the modelling assumes that physical response would remain option and be paid for by the user on a cost-neutral basis.
- The number of new CT service users grows based on new ASC users being added through churn and the availability of a transformed CT service (i.e. care practitioner training, simplified referral processes and so on) along with new pathways for additional user cohorts,
- Gross benefits will be realised by targeting a range of citizens where CT can reduce existing care package costs and avoid alternative provisions, such as residential admissions. Analysis of financial benefits has been completed for several cohorts. These cohorts were scoped, defined and agreed in consultation with BCP CT Project Board members. The cohorts appraised financially are as follows, although these vary by option to reflect the different scope of transformation:
  - Homecare OA citizens (existing and new)
  - Residential / nursing citizens (new)
  - Supported Living LD citizens (existing and new)
  - Citizens with CT (existing)
  - Homecare LD citizens (existing and new)
- Gross costs are based on variable cost components increasing with incremental CT service volumes plus other fixed costs.

- The net position shows the costs and benefits associated with citizens receiving CT, incremental to the status quo[5].
- The assumptions made have been informed by a combination of data provided by BCP, stakeholder feedback from the engagement set out in 2.5, and PA and Hampshire County Council's experiences in delivering and advising other local authority CT services, which have achieved significant financial benefits. These assumptions were also tested with the Project Board member responsible for Finance.

It should be noted that the options use estimated actual current costs for delivering the CT service in BCP, based on the data received from Housing and ASC during the diagnostic engagement.

Throughout the Options Appraisal conservative estimates have been used to minimise the risk of benefits being overinflated. This includes the proportion of users accessing the service and the subsequent proportion achieving a benefit being reduced compared to those achieved elsewhere. Applying this principle, the financial modelling has also uplifted the equipment costs in all options to reflect the likely cost increases as a result of the upcoming digital switch.

A detailed description of the CT financial modelling approach is appended to this options appraisal and is available at 6.4.

4.2 Introduction to the Options

There are three options for appraisal in this options appraisal. This shortlist of options was agreed at the CT Project Board.

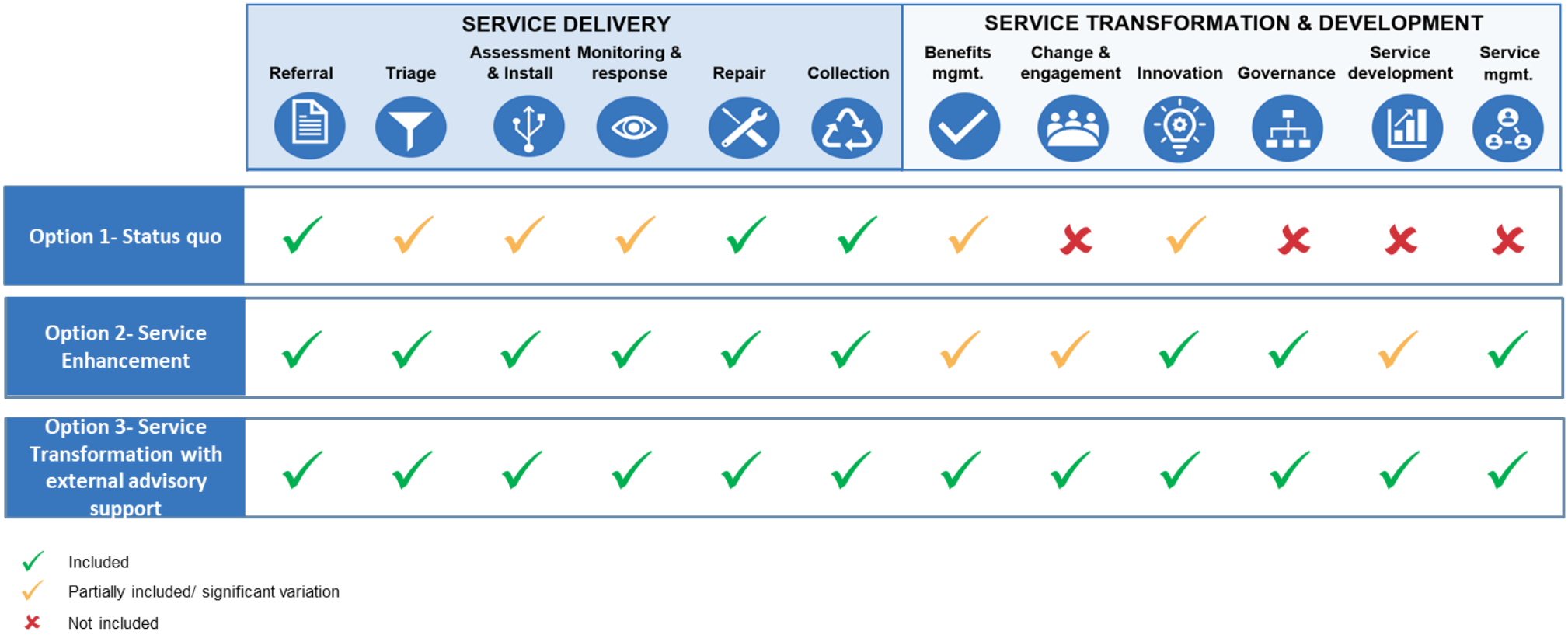
A transformed service will offer the technology solutions and supporting infrastructure to offer a broader service to BCP residents – in terms of the number of service users, as well as the breadth of technology and pathways available. The cohorts modelled in this options appraisal are indicative of the likely approach, but specific pathways will be defined through implementation planning.

- **Option 1 - *Status quo*** represents the current position. The status quo CT service assumes there will no change to the current offer, with the exception of those already underway. This means the status quo would continue to primarily offer services to older people and CT is offered to ASC eligible users in addition to a care package in most cases.
- **Option 2 – Service *Enhancement*** builds on the current service with an enhanced specification. The service would expand to reach a larger number of users and consists of all of Option 1 plus more support for younger adults with LD needs, for example in Supported Living.
- **Option 3 - *Transform*** builds on the cohorts in Option 1 and Option 2 by including a specific technology offer to OA (which could include pathways such as dementia) and younger adults (<65s) across all service areas. The transformed service will reach a greater number of people receiving CT, through a sustained programme of culture change, enabling teams across the Council to signpost to CT services, including a self-service option. It is assumed that transformation is driven by externally commissioned support, however this could be delivered internally if BCP determine that the capacity and capability exist.

A more detailed description of the options is provided below.

[5] Incremental net benefits are a relative comparison to Option 1 and are a recommended financial appraisal approach by HMT.

Figure 20: Overview of options appraisal options



4.3 Option appraisal: Option 1 - Status quo

Within all options appraisals, good practice dictates that any potential changes be assessed in relation to the current situation. This option represents the baseline current service and is a basis for comparison with other options. It assumes that investment and volumes of users accessing the CT service remain broadly static in line with current trends. There are currently ~1,307 eligible ASC users accessing CT and anticipated shrinkage in the service is such that by the end of the 5th year there is expected to be 1,283 users.[6]

Figure 21: What Option 1 looks like

The status quo CT service assumes there will **no change to the current offer**, with the exception of those already underway. This means the status quo would continue to **primarily offer services to older people** and **CT is offered to ASC eligible users in addition to a care package in most cases**.

The current service offers a range of CT equipment with the vast **majority of referrals resulting in the provision of falls detectors and smoke detectors**. There is ad hoc addition of new devices to the offer but these are not identified via a formal service development process.

The current service delivers the core CT operational functions, and this option reflects the gradual alignment of the service model across BCP. However, this option will not provide many of the enabling functions of an integrated end-to-end service, such as enhanced governance, change and engagement or robust and consistent benefits measurement.

4.3.1 Qualitative appraisal

The service would continue to reach the same core user base, predominantly focused on OA. Without additional investment, the service would also not have the skills and capacity to access new user groups and new forms of technology on a consistent and formal basis. As there is no major change taking place under this option, there are limited delivery risks.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 28/75. The detailed rationale for scoring given is provided in 6.2.1.

[6] The current number of ASC eligible users is a best estimate as it is not possible to accurately identify the current number of service users accessing the service who have ASC needs. Users referred via ASC routes are a subset of the Private Pay cohort. Anecdotal feedback suggests that 25% of new referrals are received via ASC routes and this has assumption has been used to derive the 1,307 figure. This is the same approach that was applied in the diagnostic.

Figure 22: Evaluation of Option 1 against CSFs

Theme	Critical Success Factors	Score
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	3
	Discharge from hospital is supported appropriately with CT	4
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	1
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	1
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	1
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	1
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	1
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	2
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	2
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	2
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	1
	Generates opportunities and strengthens the case to access additional funding	1
Deliverability	The CT project delivers the agreed scope to quality, time and budget	5
	Provides adequate resource and capability to deliver and embed the change	2
	Offers effective change management, including communications and engagement, to drive service improvement	1

4.3.2 Quantitative appraisal

The existing CT service is maintained as it is currently. Some financial benefits may be being generated under the current service but the prevailing culture that does not consistently use CT to delay or avoid costlier forms of care, prevents these from being maximised. The mechanism in place to capture, quantify and validate these benefits is limited and labour intensive and packages are not avoided or reduced as a result, and therefore limited financial benefits are being achieved in Option 1.

The table below shows that the estimated costs of providing CT to ASC eligible users over the next 5 years is **£1.94m**.

The methodology and assumptions for these costs is outlined in a detailed 6.4.

Table 4: Quantitative appraisal of Option 1

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
# of users receiving CT	1,302	1,298	1,293	1,288	1,283	6,465
# of users leaving the CT service (based on average # of users leaving the CT service in FY 2020-21 and FY 2021-22)	325	323	322	321	320	1,611
# of new users joining the CT service (based on average # of users joining the CT service in FY 2020-21)	320	319	317	316	315	1,587
Equipment, Installation, Monitoring & Maintenance Costs	£0.39MM	£0.39MM	£0.39MM	£0.39MM	£0.38MM	£1.94MM
Other Fixed Cost	-	-	-	-	-	-
Total CT Service Costs	**£0.39MM**	**£0.39MM**	**£0.39MM**	**£0.39MM**	**£0.38MM**	**£1.94MM**

4.4 Option appraisal: Option 2 – Service Enhancement

CT will be delivered through a simplified and improved referral pathway. Option 2 (service enhancement) builds on the status quo (Option 1) by increasingly supporting younger adults with LD needs, for example in Supported Living. The provision or regular CT training opportunities and increasing profile of the service shifts CT towards being a core part of the first offer, enabling CT solutions to reduce / avoid need for more costly forms of care.

Figure 23: What Option 2 looks like

Option 2 – Service Enhancement consists of all of Option 1 plus more support for younger adults with LD needs, for example in Supported Living. CT solutions are able to reduce / avoid need for more costly forms of care. This includes technology solutions for cases with greater complexity, including the full potential benefits of LD supported living benefits through a pathfinder supporting advanced CT assessments

In addition to Option 1, this option:

- Provides staff with opportunities for regular CT training sessions and offer CT guidance through a range of materials on the Council's Intranet
- Practitioners benefit from a simplified referral process
- implementation of formal approaches to service governance and management, including at a strategic level
- The introduction of a formalised approach to CT innovation, including a consistently applied evaluation methodology for new technology
- Enhancement of retrospective reporting of benefits using sampling applied to all service users to evidence financial benefits of the service on a consistent basis that can be applied to budgeting

There is anticipated to be a moderate increase in ASC eligible service users as a consequence of these service enhancements.

4.4.1 Qualitative appraisal

Option 2 – The Service Enhancement option meets the CSFs to a greater extent than Option 1 - Status quo, increasing user volumes and developing a clearer referral pathway. This option presents a greater risk to BCP than Option 1 as there is a requirement for change. Delivery risks could include the failure to meet time, cost and quality requirements. The breadth of the service will be relatively limited and is unlikely to grow significantly over the longer term without additional investment.

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 47/75. The detailed rationale for scoring given is provided in 6.2.2.

Figure 24: Evaluation of Option 2 against CSFs

Theme	Critical Success Factors	Score
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4
	Discharge from hospital is supported appropriately with CT	4
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	2
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	3
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	3
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	3
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	2
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	3
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	4
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	3
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	3
	Generates opportunities and strengthens the case to access additional funding	3
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4
	Provides adequate resource and capability to deliver and embed the change	3
	Offers effective change management, including communications and engagement, to drive service improvement	3

4.4.2 Quantitative appraisal

This enhances the CT service, supports small numbers of younger adults (LD) and expands the offer for older adults (OA), leading to a moderate growth in the CT service and moderate benefits.

Across five years this option results in a total incremental gross benefit of £4.54m and a total incremental cost of -£1.6m.[7] Therefore, this results in an incremental net benefit of £2.95m. This represents an average net benefit per installation of £1,153.

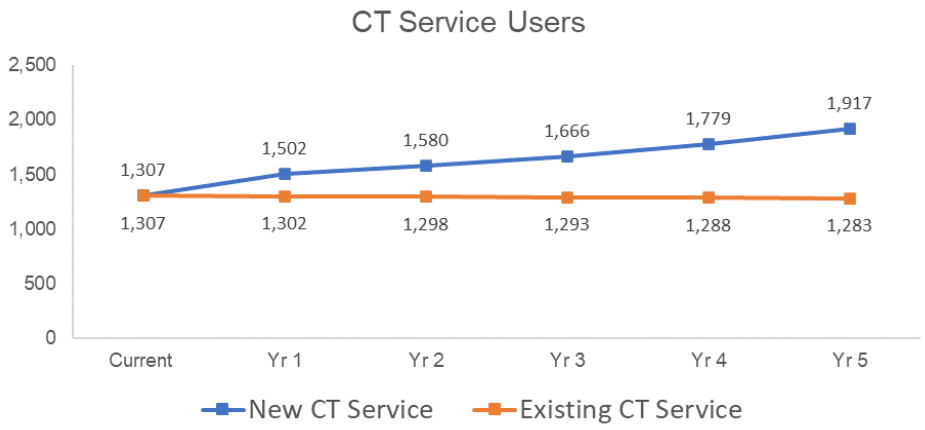
[7] All negative figures are a cost to BCP.

Table 5: Quantitative appraisal of Option 2

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.15MM	£0.22MM	£0.17MM	£0.15MM	£0.13MM	£0.82MM
Gross benefits from new ASC citizens	£0.35MM	£0.59MM	£0.76MM	£0.94MM	£1.09MM	£3.72MM
Total Incremental Gross Benefit	**£0.50MM**	**£0.81MM**	**£0.93MM**	**£1.08MM**	**£1.22MM**	**£4.54MM**
On-going incremental CT service cost[1]	-£0.21MM	-£0.20MM	-£0.24MM	-£0.30MM	-£0.36MM	-£1.30MM
One-off transformation cost[2]	-£0.20MM	-£0.10MM				-£0.30MM
Total Incremental Costs	**-£0.41MM**	**-£0.30MM**	**-£0.24MM**	**-£0.30MM**	**-£0.36MM**	**-£1.60MM**
Incremental Net Benefit	**£0.09MM**	**£0.51MM**	**£0.69MM**	**£0.79MM**	**£0.86MM**	**£2.95MM**

The service user growth of this option compared to Option 1 - Status quo is detailed in the figure below. This includes a provision for 'churn' i.e. both adult social care citizens leaving the service, as well as citizens accessing CT who no longer need the service.

Figure 25: Number of citizens in the CT service under Option 2 - Enhance



4.5 Option appraisal: Option 3 – Service Transformation with external advisory support

This option mainstreams CT effectively across social care, encouraging practitioners to consider it as part of the 'first offer'. It requires sustained focus, resource, and effort on the cultural and behaviour change of practitioners. Sustained change is achieved when health and care practitioners confidently advocate CT within care packages and recognise that it continually and demonstrably delivers the desired care outcomes.

Figure 26: What Option 3 looks like

Option 3 – Service Transformation requires the greatest investment in order to build upon the cohorts in Option 1 & 2 by including a specific technology offer to OA pathways (which could include pathways such as dementia), younger adults (<65s) and people with MH needs across all the service areas. CT solutions are able to reduce / avoid need for more costly forms of care. This could include the following:

- Targeted support for individuals living with early-stage dementia with a range of support mechanisms to promote independence and reduce the burden on carers e.g. taking medication promptly, managing lives more independently, support to leave the house safely
- Addressing social isolation and independence through adapted technology or consumer technology e.g. enabling people to access services easily, live more independently and keep in touch with family/friends
- Support to younger adults with disabilities e.g. support to travel independently using mobile apps

The breadth of the service is increased to reach a greater number of people through a sustained programme of culture change, enabling teams across the Council to signpost to CT services. Achieving and sustaining successful cultural and behaviour change relies on a campaign to win hearts and minds of all those people interacting with the service (referrers, citizens, potential CT users, carers, providers from across the public, private sector and voluntary sector). This is not a one-off exercise, but an ongoing approach embedded within this service model. In addition to the improvements in Option 2, this option includes:

- Regular tracking of benefits based on individual users in a consistent and automated way
- Full programme of culture change activity including training, case studies and regular engagement supporting the roll-out of a self-service offer
- Proactively engaging in the market to test and implement new innovations
- Capacity and capability for ongoing service development

4.5.1 Qualitative appraisal

Option 3 – Service Transformation meets the CSFs to a much greater extent than Option 2 – Service Enhancement. This approach increases volumes by reaching a broader range of users including those with complex needs. The change will be more likely to generate and sustain momentum as there will be a managed change and engagement programme. However, change of this scale carries higher delivery risks and the project will need to be carefully managed in order to meet time, cost and quality requirements. To provide the capacity and capability to deliver transformation of this scale and to mitigate against the aforementioned risks, ongoing external advisory support has been assumed for this option[8].

The qualitative scoring exercise undertaken by CT Project Board members generated a qualitative score of 66/75. The detailed rationale for scoring given is provided in 6.2.3.

[8] The external party would work closely with BCP colleagues to deliver the transformation. However, this could be delivered internally should BCP identify sufficient resource and be confident in the available capability.

Figure 27: Evaluation of Option 3 against CSFs

Theme	Critical Success Factors	Score
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4
	Discharge from hospital is supported appropriately with CT	4
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	5
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	5
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	5
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	4
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	4
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	5
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	5
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	5
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	4
	Generates opportunities and strengthens the case to access additional funding	4
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4
	Provides adequate resource and capability to deliver and embed the change	4
	Offers effective change management, including communications and engagement, to drive service improvement	4

4.5.2 Quantitative appraisal

Option 3 transforms the CT service, supports a larger number of younger adults (LD/Mental Health/PD etc), and expands the offer for OA, leading to a higher growth in the CT service and higher benefits.

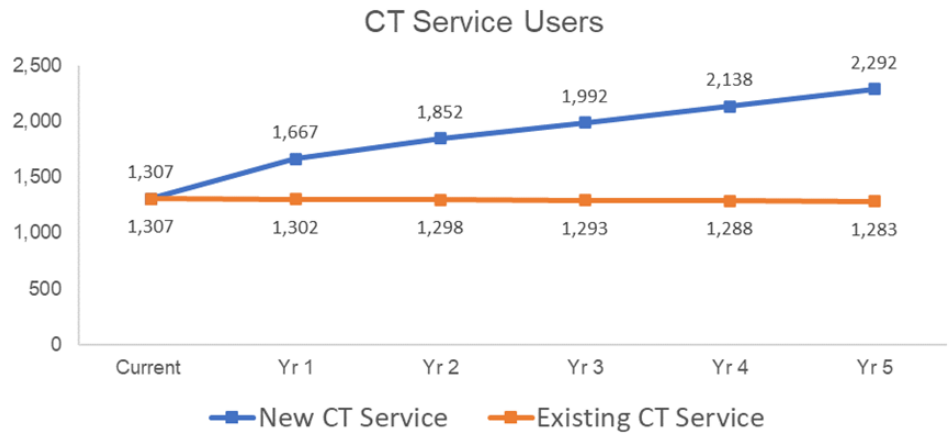
Across five years this option results in total gross benefit of £7.44m and a total incremental cost of -£2.44m. Therefore, this results in a net benefit of £5m. This represents an average net benefit per installation of £1,559.

Table 6: Quantitative evaluation of Option 3

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Gross benefits from new ASC citizens	£0.62MM	£0.97MM	£1.16MM	£1.39MM	£1.57MM	£5.70MM
Total Incremental Gross Benefit	**£0.97MM**	**£1.44MM**	**£1.51MM**	**£1.69MM**	**£1.84MM**	**£7.44MM**
On-going incremental CT service cost[1]	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off transformation cost[2]	-£0.35MM	-£0.15MM				-£0.50MM
Total Incremental Costs	**-£0.68MM**	**-£0.47MM**	**-£0.37MM**	**-£0.43MM**	**-£0.49MM**	**-£2.44MM**
Incremental Net Benefit	**£0.29MM**	**£0.97MM**	**£1.14MM**	**£1.26MM**	**£1.35MM**	**£5.00MM**

The service user growth of this option compared to Option 1 - Status quo is detailed in the figure below. This includes a provision for 'churn' i.e. both adult social care citizens leaving the service, as well as citizens accessing CT who no longer need the service.

Figure 28: Number of citizens in the CT service under Option 3 – Service Transformation



To achieve the predicted growth in the service, an average of ~54 CT installs have to be completed for ASC eligible users per month during the 5-year period, approximately 28 per month more than in Option 1.

Throughout the diagnostic and options appraisal phases, conservative estimates have been used in the model. For example, while the model projects that 45% of homecare users in year 1 would receive a CT package that reduces their homecare needs by 2 hours, it is likely benefits will be more significant than this. This demonstrates that there is room for the service to grow in BCP. This growth would, however, need to be managed effectively in order to ensure that the service can continue to perform optimally.

4.6 Conclusion

In assessing both the qualitative and quantitative factors for the three options, the CT Project Board has concluded the following:

4.6.1 Option 1 – Status quo

Maintaining Option 1 - Status quo will see the volume of citizens accessing the CT remain static in line with current trends. The type of referrals will continue to focus on basic support for older people with moderate needs, thus losing the opportunity to support a greater number of people to live independently. It does not represent a tangible change versus the current situation and therefore does not meet many of the CSFs. However, as there is no significant change the delivery risks are low.

4.6.2 Option 2 – Service Enhancement

Option 2 – Service Enhancement improves the current service by growing users and expanding support to more younger adults (<65) with LD needs and increasing the number of older adult users. There is a

moderate growth in the CT service and moderate benefits. The anticipated growth in the service is such that by the end of the 5th year there is anticipated to be 1,917 citizens accessing the service compared to 1,283 expected under Option 1.

This option therefore partially meets the critical success factors with moderate risk and reward.

4.6.3 Option 3 – Service Transformation

Option 3 – Service Transformation builds significantly upon Option 2; it mainstreams CT effectively across social care encouraging practitioners to consider it as part of the 'first offer' for a wider range of citizen needs. It therefore requires sustained focus, resource and effort on cultural and behaviour change of practitioners. It transforms the CT service by supporting a larger number of younger adults (transitions/LD/Mental Health/PD etc) and expands the offer for older people with complex needs, including via the introduction of a self-service access route, leading to a higher growth in the CT service and higher benefits.

This option fully meets the CSFs and delivers significant reward, but with correspondingly higher level of risk and transformation costs, although it is anticipated these will be offset to deliver an overall net benefit. The scale of transformation required under Option 3 is assumed to require external transformation and ongoing advisory support, but this may not be required should BCP determine the required capability exists internally and capacity can be created accordingly.

4.6.4 The preferred option

The preferred option, as agreed and recommended by the CT Project Board on 20 July 2022 is Option 3 – Service Transformation. Option 3 aligns with the BCP's ambition to significantly improve the CT service and integrate it into part of the 'first offer' of support, including via self-service access routes. It has the biggest potential to improve user outcomes and is also forecast to achieve the largest net financial benefit to the system, although it is the highest risk option.

5 Delivering the future CT service successfully

This section relates to how the preferred option, Option 3 – Service Transformation, will be delivered. It will focus on procurement and commercial implications, funding and affordability and the robust management and implementation arrangements required to make the change happen successfully.

5.1 Procurement and commercial implications

Procurement and commercial implications may include transformation and advisory partner support, new equipment supplier partnerships and potential staffing changes.

Should BCP determine that the most effective method of delivering the preferred option is through the support of a transformation partner, there are several established public sector frameworks for pre-competed CT advisors to support this. The Innovation workstream would define any new supplier partnerships required prior to launch of the transformed approach to the service.

There may also be staffing implications from any service change. Any staffing implications will be understood in more detail post-options appraisal and will be developed in line with the required BCP processes. In order to achieve Option 3 – Service Transformation, a variety of delivery models could be reviewed following the options appraisal phase in order to ensure that this aligns to BCP's ambition and delivers the best outcomes for citizens. Any commercial or procurement implications of a different delivery model, if required, will be defined in more detail once requirements are understood.

5.2 Costs of delivery and how the service will be funded

This section focusses on funding and affordability for the preferred option, Option 3 – Transform over the medium term. The 5-year total funding requirements are of £4.38m. This is an additional funding requirement of £2.44m compared to the Status quo – Option 1 (existing CT service costs), representing the one-off transformation costs[9] and ongoing incremental costs. It is anticipated that the service will be funded through existing budgets in line with funding for the current service, and costs are expected to be offset by gross benefits of £7.44m. This investment therefore results in a net benefit of £3.06m over 5 years.

Figure 29: Total 5-year funding requirement

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total 5-Year
Option 1 estimate of current costs	-£0.39MM	-£0.39MM	-£0.39MM	-£0.39MM	-£0.38MM	-£1.94MM
On-going incremental Option 3 CT service cost	-£0.33MM	-£0.32MM	-£0.37MM	-£0.43MM	-£0.49MM	-£1.94MM
One-off Option 3 transformation cost	-£0.35MM	-£0.15MM	-	-	-	-£0.50MM
Total Option 3 Costs	**-£1.07MM**	**-£0.86MM**	**-£0.76MM**	**-£0.81MM**	**-£0.87MM**	**-£4.38MM**
Funded through:						
Gross benefits from existing ASC citizens (OA & LD homecare, LD Supported Living and existing CT citizens)	£0.35MM	£0.47MM	£0.35MM	£0.30MM	£0.27MM	£1.74MM
Total ASC funding and benefits for existing ASC citizens	**£0.35MM**	**£0.47MM**	**£0.35MM**	**£0.30MM**	**£0.27MM**	**£1.74MM**
Net funding requirement - assuming benefits from existing ASC citizens only	**-£0.73MM**	**-£0.39MM**	**-£0.41MM**	**-£0.51MM**	**-£0.61MM**	**-£2.64MM**
Gross benefits from new ASC citizens	*£0.62MM*	*£0.97MM*	*£1.16MM*	*£1.39MM*	*£1.57MM*	£5.70MM
Net funding requirement - assuming benefits from existing and new ASC citizens	***-£0.11MM***	***£0.58MM***	***£0.76MM***	***£0.87MM***	***£0.96MM***	**£3.06MM**

[9] £500k transformation costs have been modelled across years 1 and 2 with a breakdown of these costs shown in 6.3. This is the expected transformation budget, including contingency, but BCP may consider identifying additional transformation funds to support embedding the change on an ongoing basis should this be deemed necessary

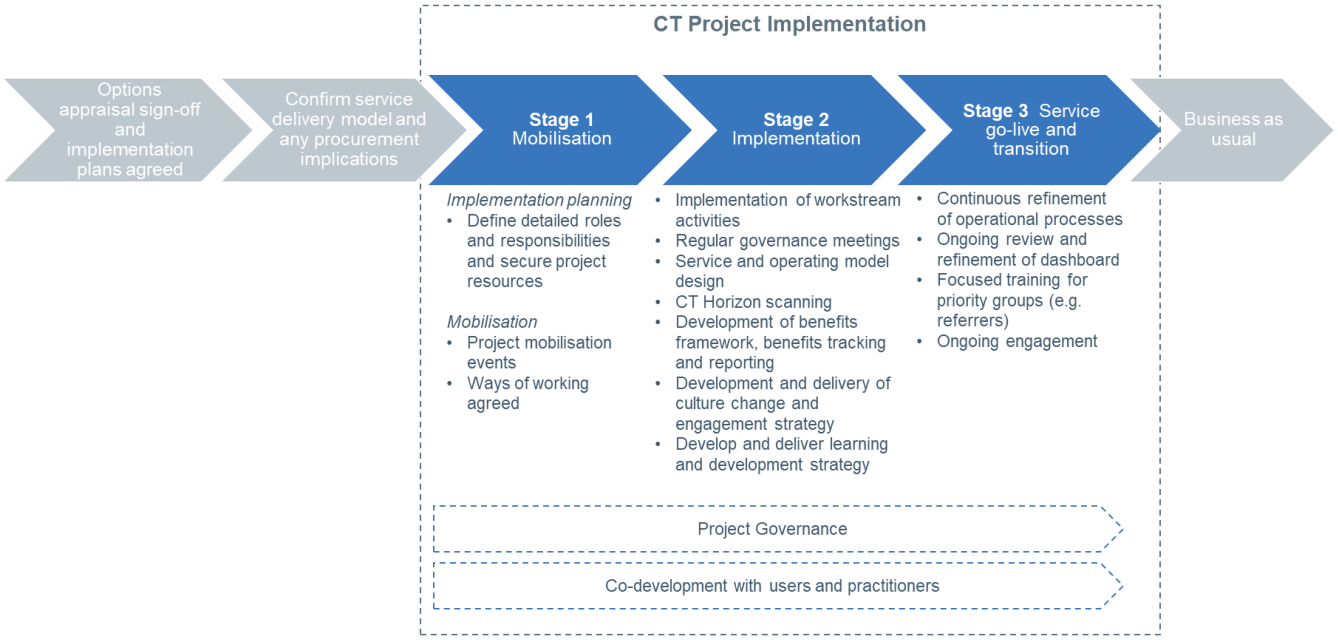
5.3 How the project will be delivered

This section describes in more detail the actions that will be required to ensure the successful delivery of the project in accordance with best practice. The actions and approaches outlined relate to the post options appraisal implementation phases of this project.

5.3.1 Project approach

Following the approval of the options appraisal and any service delivery model implications, there are three key stages of the project before transition to business as usual, these stages have been outlined below.

Figure 30: Project approach

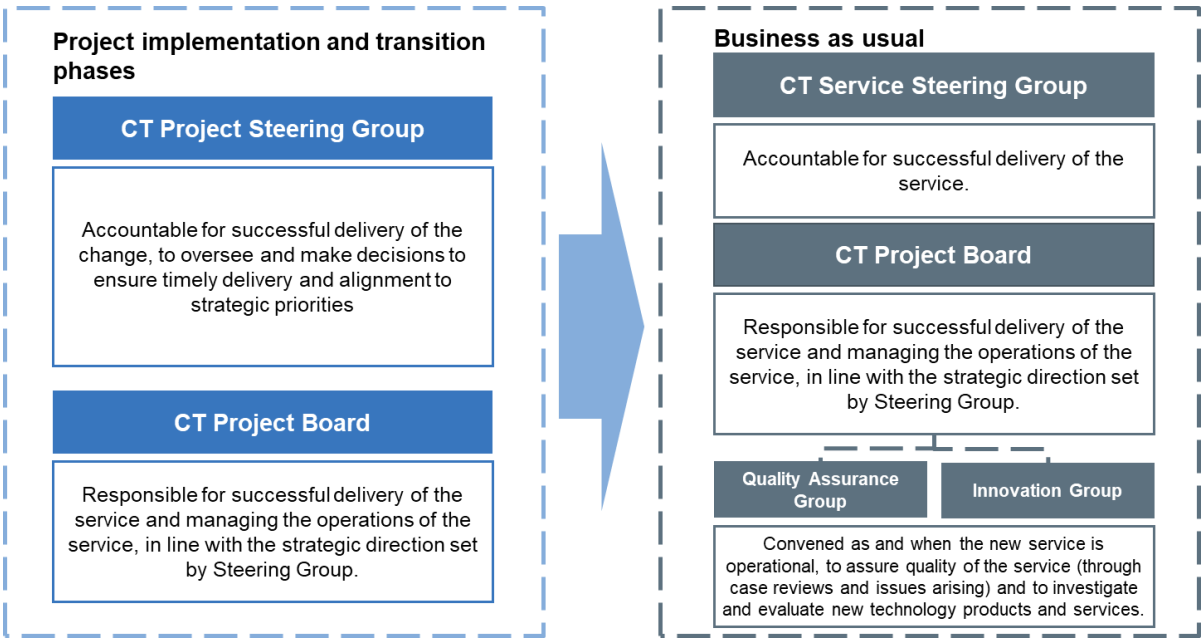


5.3.2 Governance

The project will be delivered within existing BCP governance arrangements and is expected to involve the following:

1. **CT Project Steering Group:** a strategic group responsible for decision-making accountable for overall delivery of the CT Project.
2. **CT Project Board:** an operational group responsible for mobilisation, implementation and transition to business-as-usual in line with the strategic direction set by the CT Service Steering Group. It is assumed that following the implementation phase the CT Project Board will become an operational board with responsibility for quality assurance, continuous improvement, and ongoing CT innovation.

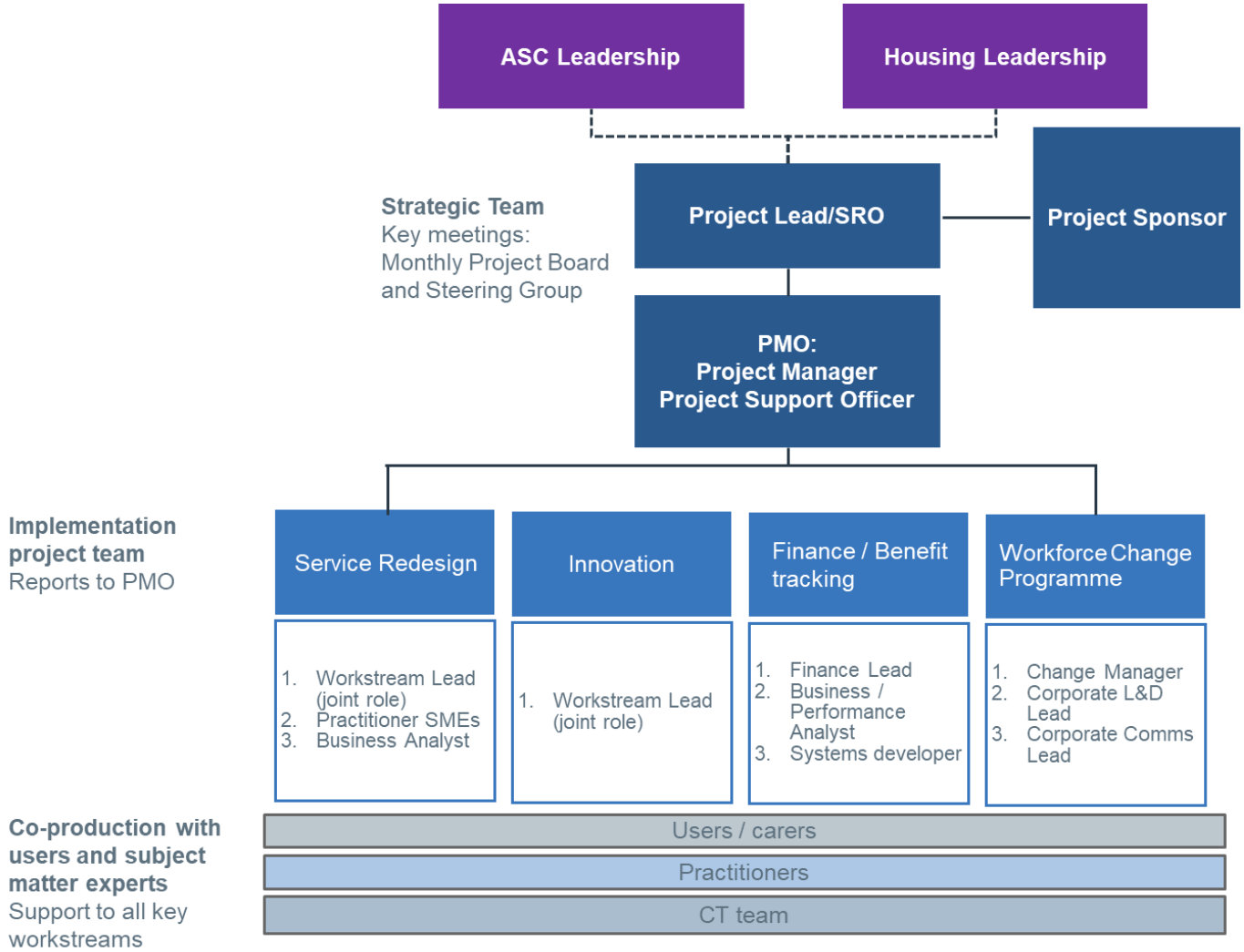
Figure 31: Implementation governance structure vs business as usual



5.3.3 Roles and responsibilities

Project resources will be required to manage the project, through the mobilisation and implementation phase. This may encompass the following roles, outlined in the figure below.

Figure 32: Suggested project resource and operating structure



These roles are described in greater detail below. Specific named individuals should be defined in a more detailed implementation and resource plan, developed following options appraisal sign-off and

procurement of any required external support, which may provide the resource for some of the following roles.

Figure 33: Project roles and requirements

Role	Description of role
Sponsor	Overall accountability for successful delivery of the project.
Project Lead / SRO	Responsible for leading the team to meet the desired project outcomes.
Project Manager	Responsible for managing the team and delivering the project to time and to budget. Also, likely to be responsible for developing governance arrangements, supporting development of policies and procedures and overseeing dependencies between workstreams.
Project Support Officer	Provides administrative support to the Project Manager and wider project.
Service Redesign and Innovation Workstream Lead	Responsible for leading the service redesign workstream and innovation workstream activity
Practitioner SME(s)	Supports service redesign workstream lead to provide expertise from a social care and health practitioner point of view. Likely to include 2-3 people across each discipline/ user cohort
Business Analyst	Supports service redesign workstream in redesigning supporting processes and systems.
Finance Lead	Responsible for finance inputs to the options appraisal and to designing a benefits framework and tracking approach.
Business / Performance Analyst	Supports benefits framework and tracking workstream in developing metrics, dashboard and reporting system.
Systems developer	Develops changes required to care management system and associated reporting systems as a result of a new referral form.
Change Manager	Supports PMO to deliver change, engagement and training activities, model and embed behaviour change across the Workforce Change Programme workstream. Designs a communications and engagement plan and approach and advises the project on communications and engagement sessions through transition. Designs a learning and development plan and learning materials and advises the project on learning and development through transition.
Corporate L&D Lead	Advises the Change Manager on the development and implementation of learning and development activity through transition.
Corporate Comms Lead	Advises the Change Manager on the development and implementation of communications and engagement activity through transition.

5.3.4 Implementation Plan

It is expected to take about seven months to fully mobilise and implement Option 3 – Service Transformation once the project is ready to mobilise. Mobilisation can only take place once funding has been secured, any delivery model implications are understood and provider arrangements have been confirmed, post-options appraisal stage.

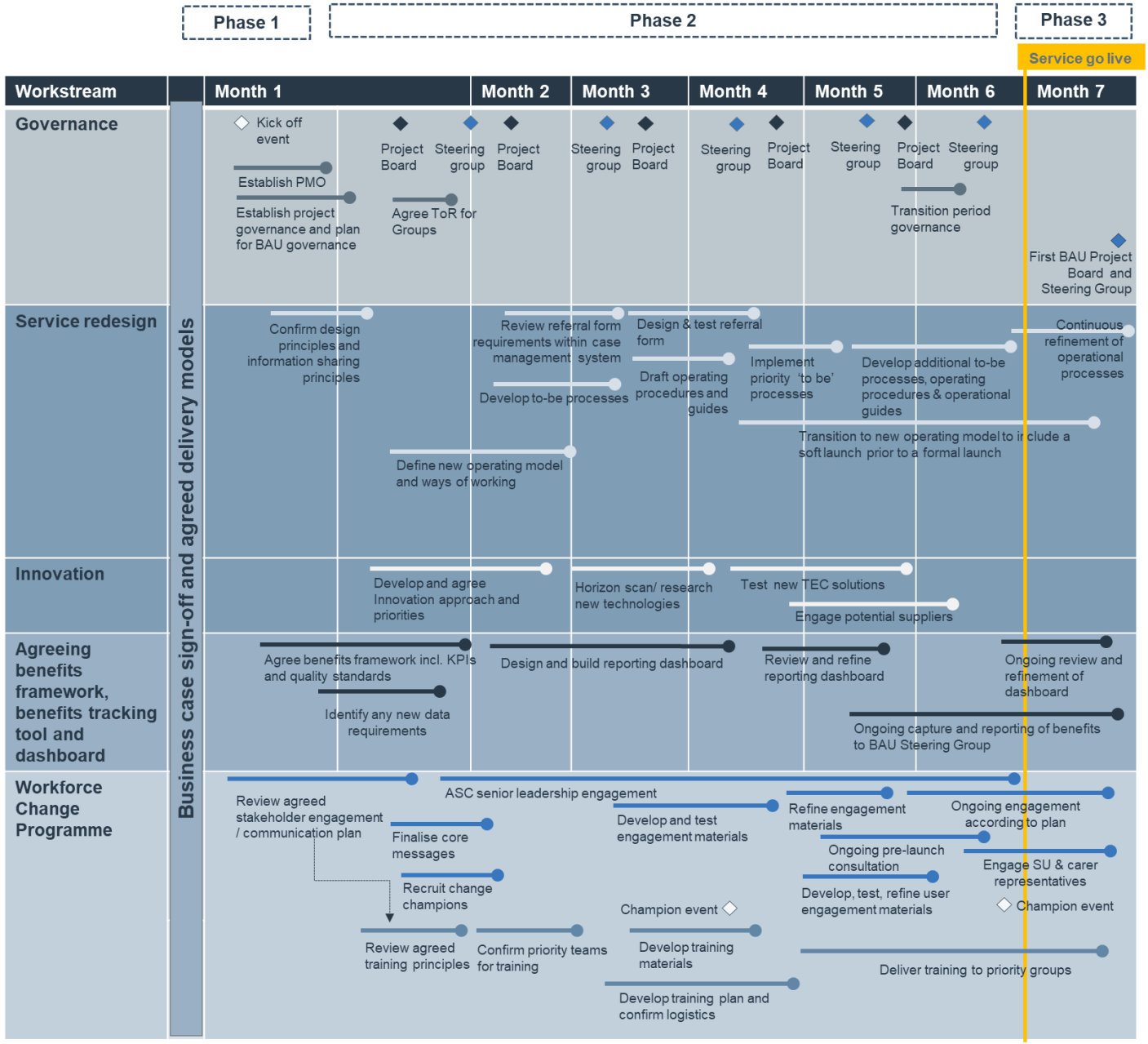
Once project roles are in place, the implementation is likely to take up to 6 months mobilisation prior to go-live and 1-month post go-live. The plan below sets out the expected implementation plan and organises activity into five workstreams:

1. **Governance:** establishing strong decisive governance structures that operate across BCP to provide inputs at the right level throughout the transformation and development of the service.
2. **Service redesign:** establishing and embedding the new operational service model across BCP. Pathway and service redesign work to co-design and co-produce new simplified referral pathways across health and social care.
3. **Innovation:** CT horizon scanning, testing new technologies and defining any new supplier partnerships required prior to launch of the new service. Developing an ongoing and iterative approach to innovation.
4. **Benefits framework:** designing and implementing a robust approach to benefits measurement and realisation that meets the needs of BCP stakeholders.

5. **Workforce change programme:** raising the profile of the service through a programme of activity around culture change, engagement, and training to increase understanding of the service and benefits that CT can have for people. Supporting referrers, commissioners, providers, and leadership across BCP to have the capacity and capability to use the service and encourage higher rates of take-up.

Figure 34: Implementation Plan

Confirm service delivery model and any commercial implications ahead of month 1



5.3.5 Pre-implementation planning and considerations

Following completion of the Options Appraisal and the subsequent governance approvals, the following planning should be undertaken to ensure readiness for implementation.

- **Governance approval-** the most immediate next step will be to present the outcome of the Options Appraisal at the required governance forums (Overview and Scrutiny Committee, Cabinet, and potentially Design Authority) to approve progression to the implementation phase.
- **Transformation funding**- prior to proceeding with implementation, BCP should confirm the source of transformation funding (a minimum of £500k over two years) considering both internal routes and other avenues such as joint funding with Health and/or grant funding.
- **Approach to charging**- the financial benefits identified through the Options Appraisal modelling are based on monitoring costs being funded by ASC budgets for ASC eligible users. This is a tried and tested approach in other local authorities and is designed to remove any barriers to uptake of the service, which would otherwise limit benefits. For example, if a user declines CT on the basis of a weekly monitoring charge (the current model) that they are unwilling to pay and this ultimately leads to a need for home care, this is a false economy. The modelling undertaken assumes that the physical response service would continue to be optional and priced on a cost-neutral basis for ASC eligible users[10]. BCP should consider and approve the future approach to charging prior to commencement of the implementation phase.
- **ASC charging reform**- it is likely the new approach to ASC charging being introduced in October 2023 will result in an increased number of ASC eligible users that would be eligible to access the funded service (subject to the above decision). Therefore, it is possible that this may impact the true 5-year funding projection of the CT service. However, over the long term it is only likely to impact the case for the transformation positively as the increased costs of additional users would offset by the additional benefits achieved through the avoidance of costlier forms of care. CT may therefore play an important role in minimising the impact of this change by suppressing domiciliary and residential care demand. When planning for the wider impacts of ASC charging reform BCP should consider the role CT can play in managing this change and the potential impacts on the business case.
- **Delivery model and team structure**- the benefits assumptions used have been developed based on services that offer personalised, in-home, outcomes-focussed assessments, typically undertaken by installers in a single visit (sometimes referred to as a 'trusted assessor' model), which have a track record of delivering significant net benefits. However, there may be alternatives to this approach, including elements of the existing BCP 'Poole model', which involves ASC colleagues undertaking this assessment, often remotely, and identifying equipment to be installed or a hybrid drawing on the best elements of these two approaches. Prior to implementation, BCP will need to confirm the future service model and consider any subsequent impact on team structures.
- **ASC record system migration**- the ongoing migration of BCP care record system to bring together legacy Bournemouth and Poole systems is a key factor in the timing of implementation. The service redesign and benefits framework workstreams require the development of new system processes and forms to collate the relevant inputs and enable automated measurement of service performance. It is, therefore, recommended that the implementation commence once this migration to Mosaic is complete.
- **Engagement with customer services/ASC front door**- the transformed approach outlined in the preferred option is predicated on CT becoming a core part of the BCP ASC offer. This requires it to be at the forefront of the mind of all health and care practitioners, who should consider the service at all stages, including as an early intervention and prevention. In other local authorities, through effective referral processes and training, front door/customer service teams have been equipped to refer directly for CT at the first point of contact. This has been successful in enabling rapid response to enquiries and early intervention to reduce demand on ASC but does require Customer Service Leadership buy-in. BCP should consider early engagement with Customer Services to understand the feasibility of a model that enables 'front door' referrals.

5.3.6 Resource requirements and plan

The table below outlines indicative resource commitments by core project roles during the Implementation Phase, some of which may be filled through the procurement of external advisory support as appropriate. Detailed transformation costs are included as an appendix.

Figure 35: Estimated resource requirements

[10] Unlike BCP, some local authorities do not offer physical response services and rely on nominated responders and the emergency services. However, where physical response is offered, this is almost always on a private pay basis

Role	FTE [11]
Sponsor	0.1
Project Lead / SRO	0.25
Project Manager	1
Project Support Officer	0.5
Service Redesign Workstream Lead and Innovation Lead*	1
Practitioner SME(s)	0.1 per role
Business Analyst	0.5
Finance Lead	0.2
Business / Performance Analyst	0.5
Systems developer	0.1
Change Manager	1
Corporate Learning and Development Lead	0.25
Corporate Comms Lead	0.25

5.3.7 Change and engagement approach

Developing 'project infrastructure' will be needed to drive a lasting change. Achieving and sustaining successful change relies on a campaign to win hearts and minds. It will not be a one-off exercise but will need to be part of an ongoing approach, which will need to be adopted by staff, citizens, carers, providers, partners, and senior leadership.

This will mean:

- Investing in securing and maintaining senior buy-in across ASC and Health
- Building a network of true CT champions across BCP, actively involved in service development and that can represent users and carers
- Setting the expectation as staff join BCP and ASC that using CT is at the heart of ASC support, at all levels of the organisation and outside of the organisation
- Co-designing and delivering a formal training programme, compulsory for anyone able to make a referral and built into induction processes for new staff
- Monitoring the source of CT referrals at team and individual level and where lower than projected, investigating, and supporting practitioners
- Telling a compelling story about the successes of the service using case stories and gathering evidence on performance
- Actively seeking, analysing, and responding to practitioner and user feedback

5.3.8 Benefits realisation approach

Measuring the financial impact of the CT service and evidencing progress towards achievement of financial targets is fundamental to successful implementation of the preferred option. An approach must be agreed that gives all stakeholders across BCP confidence in the financial benefits from transforming the service. Effectively evidencing the benefits described in Option 3 – Service Transformation requires

[11] FTE calculation has been spread across the duration of the project, however the breakdown of time may differ at different stages e.g. some roles may be full time at the start and reduce towards the end.

agreement of principles and key performance indicators that will guide the approach. This section describes some key principles and indicative KPIs.

- *Co-designing the benefits measurement framework from the outset:* developing a tailored approach to meet BCP's needs, ensuring buy-in from stakeholders.
- *Ownership by BCP:* It is important that BCP has assurance of the financial benefit that the service will realise. The approach to benefits realisation will require the active engagement of appropriate stakeholders from BCP so that the final approach and the consequent benefits are agreed.
- *Embedding benefits measurement and realisation throughout the CT pathway*: Building and validating the robust evidence base required to measure CT benefits, from the point of referral.
- *Measuring the financial impact on a granular basis*: to track both reduced packages of care as well as avoided costs, financial benefits can be measured at a granular level and aggregated up, allowing BCP to fully reconcile, audit and realise all types of benefit.
- *Manage via a balanced scorecard*: developing a series of simple, high-level key performance indicators in clear dashboards tailored for each stakeholder group. Indicative KPIs are illustrated below. These will be developed in more detail by the Benefits workstream during the implementation phase.

Figure 36: Indicative key performance indicators

Theme	Benefit / outcome	Key Performance Indicator(s)
Service outcomes	Uptake of service	Number of live connections
CT service performance	Referrals	# of referrals from BCP ASC and other routes in comparison to baseline
CT service performance	Installation time	% of standard installations completed within 10 working days from time of referral
CT service performance	Installation time	% of urgent installations completed within 48 hours (excluding weekends / bank holidays)
CT service performance	Call response time	% of calls to response centre answered within 60 seconds and 180 seconds respectively
Citizen satisfaction	User satisfaction with the service	% of users stating that they would recommend the service to others. 90% good or very good (recommended target)
Practitioner satisfaction	Practitioner satisfaction with the service	% of practitioners who state the service is 'good' or 'very good' at achieving the desired outcomes
CT staff satisfaction	CT staff satisfaction	% of favourable responses to staff engagement surveys

5.3.9 Risks and dependencies

The table below outlines the most likely risks in implementing and successfully delivering Option 3 - Service Transformation. All risks should be logged in a formal risk register, kept on review during mobilisation and implementation and reviewed at key points in delivery of the service by the appropriate governance forums. Maintaining the risk register will be the responsibility of the BCP CT Project Manager, reporting to the CT Project Board and for key risks, escalating to the CT Service Steering Group.

Figure 37: Summary of risks and dependencies

Theme	Risk	Likeli-hood	Impact	Mitigation	Likelihood following mitigation	Impact following mitigation
Capacity and capability risks	**Engagement:** BCP is a large organisation with historical high staff turnover in ASC and like many local authorities, ASC colleagues have limited capacity. This presents a risk to practitioner engagement and capacity to engage.	High	High	The implementation plan above incorporates a major workforce change programme, which includes sustained engagement through implementation, transition and beyond. Regular feedback will be sought from practitioners to test the success of this approach.	Medium	Medium
	Capability: Practitioners are not given enough support and behaviours do not change.	High	Medium	If Option 3 is delivered robustly and appropriate investment is put in place, practitioners will be supported along the journey and processes should be embedded properly. External advisory and transformation support, if commissioned, should bring experience of effective approaches to the provision of support.	Low	Low
Commercial / financial risks	**Benefits realisation**: Scepticism towards the approach to benefits realisation amongst referrers inhibits the ability of the service and the council to realise the full potential of CT.	Medium	Medium	Adopting an outcomes-focussed approach and sharing clear messages that this programme is primarily designed to achieve improved outcomes for citizens will help to alleviate scepticism. Acknowledging that there will be financial benefits, but that the options appraisal is conservative, and savings do not drive the programme, will help to manage this risk. Raising the profile of CT and its important as a core part of the care offer will also further mitigate this risk.	Medium	Low
	Benefits realisation: BCP data quality or availability and/or performance resource capacity and capability impact the quality, scope or cost or deriving a comprehensive approach to benefits measurement.	Medium	High	Pre-implementation, data, and resource requirements wil be clearly defined and articulated to ensure this is planned accordingly. Activity during implementation phase will focus on the design and delivery of a benefits realisation approach that will ensure financial benefits generated via the CT programme can be automated as much as possible, to minimise ongoing resource commitments, and ensuring that all benefits can be validated and owned by BCP. Commissioning external support with experience of working alongside Council teams to develop such approaches can provide an additional mitigation.	Low	Low

Theme	Risk	Likeli-hood	Impact	Mitigation	Likelihood following mitigation	Impact following mitigation
	Approach: Benefits modelling of this type is reliant on an outcomes-focused approach and not a service driven by technology. The success of financial benefits measurement is therefore contingent on certain elements of the service model.	Medium	Medium	If Option 3 is delivered correctly, the approach to the CT service will be outcomes based and CT will be aligned to the citizen's needs. This will minimise the likelihood of excess or inappropriate equipment being given to citizens, and maximise opportunities to realise benefits through CT.	Low	Low
	CT team costs: preferred service model requires team structure changes to deliver effectively and could bring associated change costs	Medium	Medium	Clear agreement of service model and evaluation of the impact this would have on the existing team structures. Co-design of process and policies with the CT team and other relevant stakeholders during the transformation stage. Early engagement with HR if and when appropriate.	Low	Low
	Equipment costs: digital switch results in increased CT equipment costs, potentially including replacement costs for existing monitored users	High	High	Conservative approach to modelling of financial benefits may offset increased equipment costs. Increased costs would be incurred under all options so does not make a material difference to the outcome of the Options Appraisal. Discussion with technology and systems providers to understand timescales, likely costs of equipment and any other potential solutions/mitigations.	High	Medium
Delivery and Implementation Risks	**Change and engagement:** The skills and resources needed to deliver the change (either within the project team, transformation programme and/or ASC practitioner staff or leadership) are under-estimated. The changes associated with the ASC transformation programme may cause 'change fatigue', particularly given the relatively recent large change of BCP being formed as one Council. This could create resistance to further change or distracts from the change.	High	High	This risk will need to be kept on review through transition and mobilisation – and the change will need to be managed with appropriate project management resources and processes in place so that dependencies with other initiatives across BCP are managed carefully and realistically. This may include developing shared messages across transformation projects. Successful delivery of plans outlined above should result in practitioners being supported and brought along the journey. Transformation budget includes a £50k contingency to provide additional resource should this be required.	Low	Medium
	Project delivery: The commencement of the implementation phase is reliant upon the agreement of service delivery model approach and BCP resources. A	High	High	Prioritise confirming preferred delivery model so that Stage One Mobilisation can begin as soon as practical. Engagement with other local authorities with a range of service models and experiences of transformation of CT	Medium	Medium

Theme	Risk	Likeli-hood	Impact	Mitigation	Likelihood following mitigation	Impact following mitigation
	failure to get consensus on this will delay or increase costs of the transformation, in turn delaying achievement of benefits.			services to understand the pros and cons of service model options.		
	System of record: Completion of the impending migration of system of records to align BCP on one system is delayed or has ongoing issues. This is a key dependency as completion of this enables a consistent referral process to be developed and all data capture to be consistent.	Medium	High	Planning transformation to commence following completion of migration and pre-planning system developer resource to support referral process change. Clarity of service model decisions to ensure process development has a strong foundation and there is shared agreement.	Medium	Low
	CT monitoring system: Contractual relationship with monitoring system provider (Tunstall) inhibits BCP approach to service innovation and digital migration, whilst potentially creating a potential 'supplier lock' and/or increasing transformation costs.	Medium	High	Engagement with BCP procurement to fully understand the contractual relationship with Tunstall and the levers it enables the council to pull in negotiations. Early engagement with Tunstall to understand the data the system can provide, integration capabilities and any costs associated with development requests.	Medium	Medium

6 Appendices

6.1 How outcomes might look for BCP users and staff

6.1.1 Option 2: service enhancement

Expanding offer to broader range of over 65s and small number of users with learning disabilities/difficulties needs.

Older adult (>65) with physical disability needs

Joanna is 75 with bilateral diminishing sight issues, she's been admitted to hospital twice in the last three months for falling in the home and for burning herself on the stove. She wishes to retain her independence in her own home and needs reassurance to manage daily tasks with confidence.

The solution

- **Sensory aids** in the kitchen e.g. prompts to remind her to turn the oven/stove off, delivered via a reminder device
- **Oysta GPS** device in case she falls, feels distressed or becomes unwell in the community and needs to call for help.
- **Falls detector** should she fall in the home or garden, environmental alerts linked to the lifeline and a bogus caller alarm placed near the door to alert should someone be attempting to gain entry.




LD user in supported living

Jane lives in supported living accommodation. Although she is quite independent she still needs extra support when out in the community. Jane also needs support for epilepsy.

The solution

- **Just Checking** provides discreet and anonymous movement data collection, helping to assess Jane's well-being and the detailed CT offer.
- An **Epilepsy bed sensor** helps to detect when Jane experiences a seizure and alerts the Support Staff
- An **Oysta Pearl** gives Jane greater access to the community and help when required (accessing help, falls detection, tracking).



What do outcomes look like for the practitioner

- Joanna and Jane's support staff **receive opportunities for quarterly CT training sessions** and there is **CT guidance on the Council's Intranet** including advice on what equipment is available
- Practitioners **benefit from a simplified referral process**
- **High risk equipment is proactively maintained / checked** so that practitioners have confidence that the equipment will not periodically malfunction

6.1.2 Option 3: service transformation

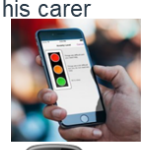
Expanding offer to higher number of adults with complex LD needs, mental health, dementia and physical support needs (over 18s), in addition to cohorts in option 2

Young adult with LD needs

Tom is young man with a learning disability who wishes to live more independently. However, his epilepsy puts him at risk when he is out of the home.

The solution

- The Brain in Hand app reminds him what solutions he can use when he is in situations that make him vulnerable. He also uses his app to help him catch a bus instead of using the taxi.
- An epilepsy sensor linked to a carer pager alerts his carer instantly if he has a fit.
- His Oysta incorporates falls detection, and allows him to quick dial his carer or the SOS button to talk to the monitoring team while he is out.
- His medication dispenser enables him to self-manage his medication


Isolated older adult

- Mr Khan lives with his wife and has recently received a dementia diagnosis. He feels frustrated and lost since his driving licence was revoked. His wife is incredibly anxious that he will get lost and wander.

The Solution

- Oysta with geofencing (safe zones) enabled – if Mr Khan moves beyond the safe zones, a family member would be alerted and could track his location on a tablet or call his device
- Property exit monitors – tells family member when he leaves the property
- Sensor memo reminders - plays a recorded message to ensure Mr Khan picks up his Oysta before going out



- **What do outcomes look like for the practitioner - In addition to outcomes in Option 2**
- **The TEC service regularly horizon scans to identify and test new technologies. Tom and Mr Khan's support staff are kept updated on the new technologies** available to help their clients, so if new needs arise they know what is available.
- They **receive regular training and support** (including **targeted training and engagement sessions** for the teams that are not referring regularly), are **able to access an equipment showroom and receive regular news bulletins and updates** on the CT service

6.2 Detailed qualitative appraisal

Through a survey process, members of the CT Project Board scored each of the options against each CSF. An average of this scoring was taken to provide a score between 1 and 5 for each CSF using the following RAG key. This provided a total qualitative score out of 75 for each option. The detailed rationale for the scoring is provided below for each option.

The rationale provided in the following tables to support the CT Options Appraisal qualitative scoring has been derived from a combination of sources:

- BCP stakeholder engagement, including the CT diagnostic and the Options Appraisal workshop (SE)
- Comments provided in the qualitative scoring survey (QS)
- PA/HCC wider sector knowledge and experience (WSK)

The source of each rationale provided is shown on the following slides using the codes SE, QS and WSK as set out above.

RAG	Description
1	The option does not meet the Critical Success Factor and/or there are significant risks or limitations to the options ability to meet the Critical Success Factor
2	
3	The option partially meets the Critical Success Factor and/or there are risks or limitations to the options ability to meet the Critical Success Factor
4	
5	Option expected to fully meet the Critical Success Factor

6.2.1 Option 1 (status quo) detailed qualitative scoring and rationale

Theme	Critical Success Factors	Score	Rationale
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	3	• There is a strategic recognition that CT has the potential to improve outcomes by enabling people to live more independently at home, however, the service is not maximising its potential as referral levels are static. *(SE)* • The service is limited, with the majority of users being from the OP cohort and receiving basic packages – meaning that opportunities to support more people or enhance support are not being maximised. *(SE)* • Operationally, the service delivers a competent core service with performance against KPIs, such as call response times, reinforcing that the service is effectively run. *(SE)*
	Discharge from hospital is supported appropriately with CT	4	• Urgent referrals include cases where CT will facilitate a rapid and safe hospital discharge, although this often results in equipment being installed without a home-based assessment. *(SE)* • The responsiveness of the service to support hospital discharge is often praised by referrers and is a key priority strategically, which is recognised and carried through by the service operationally. *(SE)*
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	1	• There are barriers to the CT referral process that are hindering the growth of the service, including limited publicly available information and no self-service access. *(SE, WSK)* • Some Social Workers feel that the current CT assessment approach adds complexity, although others advocate for the approach. *"Currently only OT Assistants in the Poole patch are allowed to assess and issue equipment… all this seems to add layers to the provision of equipment." (SE)* • There is a lack of consistent understanding of CT across the council that is a symptom of the integration of legacy Bournemouth and Poole services. *(SE)*
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	1	• While the service and OTAs advocate for CT as a part of the first offer, some Social Workers see this as a supplement to care packages rather than an effective method of reducing or avoiding other forms of care *(SE, WSK)* • CT is not accessible via the Contact Centre, reducing the ability to use the service for preventative and early intervention purposes. *"It has been a real challenge to get anything to do with AT happening at the contact centre." (SE)*
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	1	• No current advisory offer to enable residents to maximise the value of existing consumer technology (e.g. Amazon Alexa) *(SE)*
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	1	• No change to the existing offer, beyond the gradual alignment of legacy services, meaning minimal activity to increase uptake. *(SE)* • Most diagnostic survey respondents had not received any CT training. *(SE)*

Theme	Critical Success Factors	Score	Rationale
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	1	• The majority of data collected by the current service is recorded in manual spreadsheets and there is limited evidence of this being used to generate insight or manage supply or demand. *(SE)* • Data is not automated, meaning any incidents of CT informing care professional activity is ad-hoc and informal. *(SE)*
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	2	• The available range of equipment has been developed over time but there is still a perception amongst some social workers that the offer is limited. *(SE, WSK, QS)* • Where new CT equipment is added to the service offer, this is usually market or supplier driven, rather than needs driven, and there is no consistent and formal evaluation process. *(SE)* • There are clear opportunities to expand the offer through both pathway and equipment innovation. *(SE, WSK, QS)*
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	2	• No expansion of service resulting in continued minimal and ad-hoc CT support of younger adults or people with learning disabilities *(SE)*
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	2	• Mechanism in place for measuring financial benefits of the service is labour intensive and time consuming and is not consistently or robustly audited or used to inform ASC budgets *(SE)*
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	1	• No formal financial benefits target agreed for the current service and this would not be introduced as part of this option *(SE)*
	Generates opportunities and strengthens the case to access additional funding	1	• No change to service means that is no strengthening of the current case for accessing funding opportunities resulting in no additional opportunities beyond those currently available *(SE, WSK)*
Deliverability	The CT project delivers the agreed scope to quality, time and budget	5	• No change meaning that no additional costs incurred *(SE, WSK)*
	Provides adequate resource and capability to deliver and embed the change	2	• No change meaning that no additional resource or capability is required (SE, WSK)
	Offers effective change management, including communications and engagement, to drive service improvement	1	• No change management or significant service improvement offered by this option (SE, WSK)

6.2.2 Option 2 (service enhancement) detailed qualitative scoring and rationale

Theme	Critical Success Factors	Score	Rationale
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4	• Improvements in the referral process and it's consistency across the council will improve the current service significantly but the limited cultural change activity may not be sufficient to secure practitioner and wider stakeholder buy-in. (SE, QS, WSK) • The increased emphasis on equipment innovation and support for some younger adults on a more formal basis is an improvement in comparison to Option 1. (WSK)
	Discharge from hospital is supported appropriately with CT	4	• A strength of the current service, Option 2 continues to deliver the high level of responsiveness to hospital discharge referrals but with an increasing effectiveness due to process improvements and an expansion of the equipment offer. (SE)
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	2	• Whilst some process improvements provide people and carers with an enhanced experience, no self-service option is developed under Option 2. (SE, WSK) • Development of training and other service materials provide some additional information that are adapted for public consumption but in the absence of a self-service referral route, these have a minimal impact. (WSK)
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	3	• Undertaking a CT enhancement programme and embedding CT specific training raises the profile of the service but the absence of an extensive culture change programme means it may not fully capture "hearts and minds" and may see a reversion to type post enhancement rollout. (SE, WSK) • Referral process improvements help position CT as a core part of the first offer but enhancement does not effectively incorporate the Contact Centre as a key referral source, limiting prevention impact. (SE, WSK)
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	3	• Implementing a formal approach to service governance at a strategic level and an innovation evaluation methodology results in an increased range of technology compared to Option 1, reaching a wider range of users, including LD Supported Living. (SE, WSK, QS)
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	3	• Referral process improvements and regular training result in great understanding of the service amongst practitioners, however, the lack of an extensive ongoing culture change programme means that this impact may only be short-term. (SE, WSK)

Theme	Critical Success Factors	Score	Rationale
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	2	• Referral process improvements automate some elements of data collection but does not allow for integration with other data or for insight to be generated automatically. This means insight generation to inform practitioner interventions and management of supply and demand remains ad-hoc and manual. (WSK)
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	3	• Implementing a consistently applied innovation evaluation methodology results in an increased range of technology compared to Option 1. (WSK) • Regular training of care professionals and an increased awareness of the service generates increased levels of feedback facilitating a shift towards needs-based approach to equipment innovation. (SE, WSK, QS)
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	4	• Service scope is increased to proactively provide CT to people with learning disabilities in a supported living setting through a specific and targeted process. (SE, WSK, QS) • Wider rollout of use with younger adults and people with long term conditions in the community continues to be limited due to the absence of self-service access or significant ongoing communications activity. (SE, WSK, QS)
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	3	• Referral process improvements enable additional non-financial benefits to be measured on a semi-automated basis. (SE, WSK) • A sampling approach to financial benefits builds on the existing method, whilst reducing the level of manual activity required. (SE, WSK) • Methodology and assumptions are agreed with finance and other relevant stakeholders to ensure the outputs consistently and appropriately inform budget setting. (WSK)
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	3	• Financial benefits are achieved in traditional ways for CT, through the avoidance or delay of homecare and residential care but there are limited examples of direct savings being achieved via package reductions (LD Supported Living). (WSK, SE, QS)
	Generates opportunities and strengthens the case to access additional funding	3	• Raised profile and increased awareness of CT result in additional opportunities but the success of any funding applications is impaired by limited data and evidence due to lack of automation. (SE, WSK, QS)

Theme	Critical Success Factors	Score	Rationale
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4	• Whilst change compared to Option 1 is significant, the scale of change is small relative to Option 3. Changes have limited interaction with external parties providing a level of internal control that increases the likelihood of the project delivering to time and budget. (WSK, QS) • Delivery of scope to time is subject to internal capacity and is vulnerable to operational or other change activity taking priority and impairing progress. (SE, WSK)
	Provides adequate resource and capability to deliver and embed the change	3	• Existing CT team have limited capacity to deliver change at this scale with current staffing levels and operational demands. (SE, WSK, QS) • Reduced scope compared to Option 3 makes internal delivery of change achievable but is subject to release of additional internal capacity with the relevant skillset (change, project management etc). (SE, WSK, QS)
	Offers effective change management, including communications and engagement, to drive service improvement	3	• Change management capability would need to be provided to supplement the knowledge of the existing team and will have a short term impact but lack of ongoing culture change will likely see communications and engagement activity tail off, failing to embed a culture of continuous improvement. (SE, WSK, QS)

6.2.3 Option 3 (service transformation with external advisory support) detailed qualitative scoring and rationale

Theme	Critical Success Factors	Score	Rationale
Improved outcomes and experience	People are equipped and confident to use CT enabling them to feel safe and supported to live independently in their own home for as long as possible	4	• Transformation of the referral process embeds best-practice, removing barriers to referral and increasing uptake of the service. (SE, WSK) • A wider range of cohorts benefit from CT with LD (homecare and supported living) a core part of the offer and increasing rollout to mental health and other pathways. (SE, WSK, QS) • An upskilled CT team and increase in practitioner awareness drives a change in attitude towards technology, empowering people to use CT as a vehicle to improved independence. (SE, WSK, QS)
	Discharge from hospital is supported appropriately with CT	4	• A strength of the current service, Option 3 continues to deliver the high level of responsiveness to hospital discharge referrals but with an increasing effectiveness due to process improvements and an expansion of the equipment offer. (SE)
	People and Carers are supported to access CT easily, including via self-service options, with access to information to make informed choices about care packages and use of CT	5	• Full transformation of the referral process integrates self-service as an option for service users, enabling them to trigger the first stage of a referral. (SE, WSK) • External communications and engagement activity as part of an extensive culture change programme provide a range of materials accessible to the public to promote the service. (SE, WSK) • Engagement with the Contact Centre and other relevant Council departments ensure people can be signposted to the self-service referral route from a range of sources enabling earlier intervention. (SE, WSK)

Theme	Critical Success Factors	Score	Rationale
Improved efficiency	CT is embedded as a default part of the first offer, enabling a shift from traditional service provision to CT support	5	• Removes the reliance on a group of core referrers and makes CT referrals the responsibility and right of all through self-service access. (SE, WSK, QS) • Culture change programme equips the contact centre to discuss CT in the first conversation, providing the information to allow users to make informed choices. (WSK) • Transformation activity raises the profile of CT further than Option 2 with training and other communications stressing the importance of CT as part of the first offer, aligning this to clear service eligibility. (SE, WSK, QS)
	There is an increased range of affordable CT and advisory support on offer and meeting an increased range of outcomes	5	• Implementing a formal approach to service governance at a strategic level and an innovation evaluation methodology and embedding this through ongoing culture change activity results in an increased range of technology compared to Options 1 and 2. (SE, WSK, QS) • The proactive rollout of the service to a wider range of users, including LD and Mental Health drives a needs-based approach to service and equipment innovation. (SE, WSK, QS)
	Practitioner understanding of the offer and process is enhanced, driving increased uptake	4	• Process redesign is co-produced with practitioners, building confidence and removing barriers to access. (WSK) • Extensive culture change activity provides all practitioners with a baseline level of knowledge, the awareness of where to access additional resources and support and exposure to the service on a regular basis through communications and engagement events. (SE, WSK)

Theme	Critical Success Factors	Score	Rationale
Service capacity and capability	Data is automated and insight generated is used effectively and proactively to manage supply and demand	4	• Referral process transformation ensures capture of all inputs required to monitor performance against agreed KPIs (WSK) • Data from a range of sources is collated in an automated dashboard to enable immediate oversight of supply and demand and facilitate increased effectiveness of service management. (WSK) • Process developed to identify insight, such as escalating needs, from call monitoring data. (SE, WSK)
	New CT is evaluated on a regular basis and deployed as and when it is appropriate to people's needs	5	• Additional ongoing capacity and capability provides the resource for regular innovation activity (SE, WSK, QS) • Expansion of offer to reach a wider range of cohorts creates a broader pool of stakeholders to identify needs that could be met with technology and a shift towards needs-based innovation. (SE, WSK, QS) • External support brings wider experience of CT solutions and pathways from elsewhere to provide an initial indication of potential innovation priorities. (WSK)
	The scope of the service is expanded to increasingly support younger adults, people with long term conditions and people with learning disabilities	5	• A core focus of Option 3 is expansion of the offer to support younger adults, people with long term conditions and people with learning disabilities. This is facilitated through a widespread culture change programme reaching practitioners from a wide range of specialisms. (SE, WSK, QS) • Tailored pathways enable the referral process to be adapted accordingly to capture any cohort specific insight. (SE, WSK) • Commissioned advisory support offers expertise to support rollout to new cohorts, enabling this process to be expedited, learning the lessons of other local authorities. (SE, QS)

Theme	Critical Success Factors	Score	Rationale
Value for money and financial sustainability	Provides a clear mechanism for robustly measuring the financial and non-financial benefits of the CT service	5	• Regular automated approach to benefits measurement developed in alignment with agreed KPIs and transformed referral process. (SE, WSK, QS) • Quarterly and annual audit processes designed and implemented to include finance colleagues and ensure financial benefits can be appropriately considered in budget setting. (WSK) • Transformed referral process captures additional non-financial benefit insight to evidence the quality of life impact of the service. (SE, WSK, QS)
	Delivers on target financial benefits within agreed timeframes, through avoided and reduced costs of care	4	• Growth of service through additional pathways and cohorts and increased update due to culture change activity drive growth in referral numbers and achievement of greater gross financial benefits than in other options. (WSK) • Financial benefits performance visualised within service dashboard to enable immediate analysis of performance against target. (WSK)
	Generates opportunities and strengthens the case to access additional funding	4	• Scale of transformation and culture change activity generate a 'buzz' around CT and supports engagement with wider system partners about the role of CT in achieving strategic ambitions. (SE, WSK, QS) • Evidence of impact generated through improved data provision enables stronger funding applications. (WSK, QS)
Deliverability	The CT project delivers the agreed scope to quality, time and budget	4	• Commissioning of external support enables the transformation expectations to be set out to the provider and quality, time and budget to be managed contractually (WSK) • Additional budget required due to provision of external support, although offset by the potential for quality that this brings. (SE)
	Provides adequate resource and capability to deliver and embed the change	4	• Drawing on external support provides resource and capability to conduct a transformation of this scale, without significantly impacting on existing CT team resources. (SE, WSK) • Capability is enhanced through sector knowledge and experience elsewhere of supporting party. (SE, WSK) • Ongoing culture change activity is planned according to desired level of external support to ensure change is embedded and stakeholders do not revert to type following the transformation. (SE, WSK, QS)
	Offers effective change management, including communications and engagement, to drive service improvement	4	• Communications and engagement form a central part of culture change on an ongoing basis, embedding an expectation of continuous improvement. (SE, WSK, QS)

6.3 Breakdown of transformation costs and roles

The following costs correspond to the financial model for Option 3. Costs are based on high-level assumptions based on BCP backfill or external roles and any other expenditure anticipated.

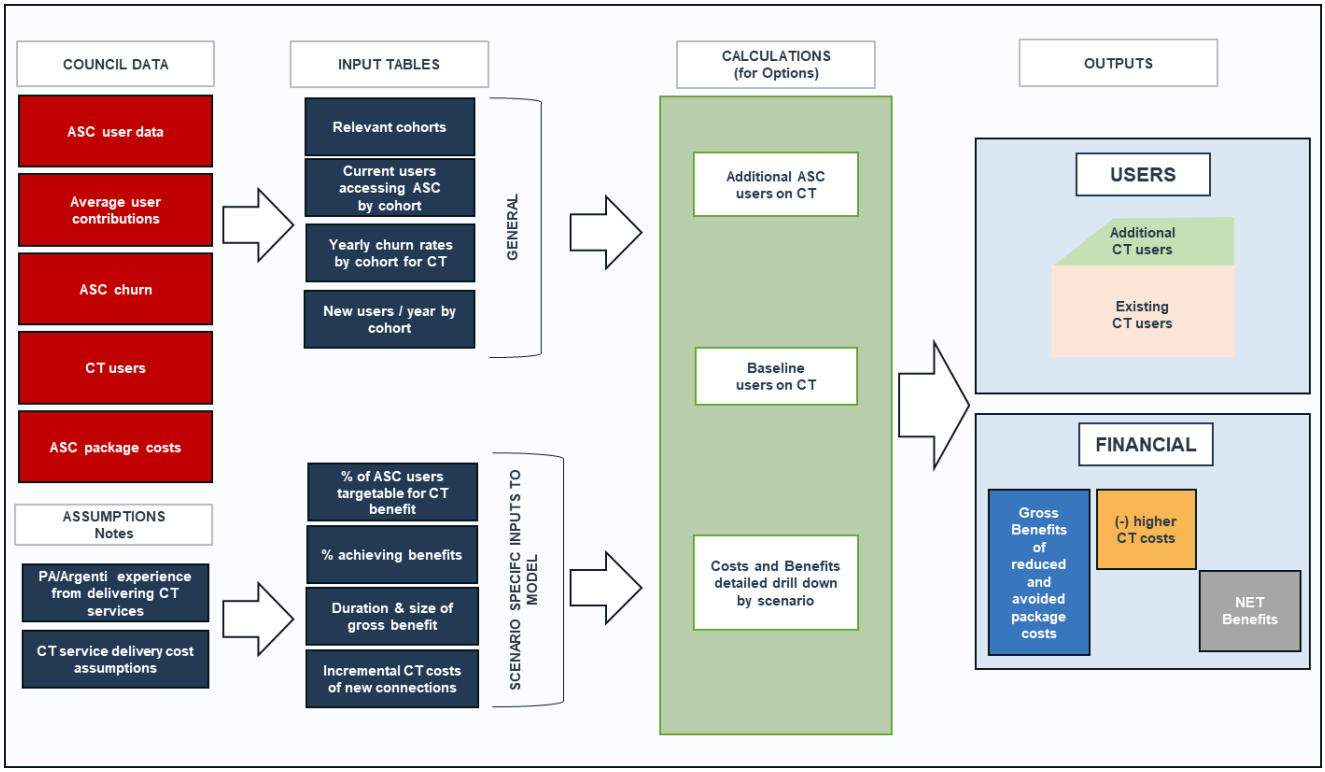
Table 7: High-level transformation costs

Workstream / activity	Indicative cost (£)	Description
Project Management and Leadership	£100k	• Full time PM • Backfill for leadership roles in the project
Service redesign	£80k	• Service Redesign Lead
Agreeing benefits framework	£150k	• Business / Performance Analyst • Development of a benefits tracking dashboard • Systems development
Workforce change programme	£120k	• Change Manager and Comms / Engagement Lead • Launch communications • Potential external training resource needed
Contingency	£50k	
Total	**£500k**	

6.4 Quantitative appraisal methodology and assumptions

CT financial modelling approach

The image below provides a very high level summary of the mechanics of the model used to estimate the potential financial impact of CT in the options appraisal.



Measuring CT financial impact as part of the appraisal

The table below shows the possible financial impacts of CT interventions for a range of ASC cohorts that have been modelled.

Cohort Ref	Setting of care / cohort	Cohort	Impact	Measurement	Option
A	Homecare- OA users	Existing users	CT enables reduction in homecare package for existing OA users	Fewer hours of homecare per week	Option 2 and 3
B	Homecare- OA users	New users	CT prevents need for homecare for new OA users	Avoided hours of homecare per week	Option 2 and 3
C	Residential / nursing care	New users	CT delays entry to residential / nursing for new OA users	Avoided weeks of residential care	Option 2 and 3
D	Supported Living – LD users	Existing users	CT reduces need for support for existing LD Supported Living users	Fewer hours of support for waking nights, sleep-ins, 1:1 or 2:1 support	Option 2 and 3
E	Supported Living – LD users	New users	CT prevents need for support for new LD Supported Living users	Avoided hours of support for waking nights, sleep-ins, 1:1 or 2:1 support	Option 2 and 3
G	Homecare- LD users	Existing users	CT enables reduction in homecare package for existing LD users	Fewer hours of homecare per week	Option 3
H	Homecare- LD users	New users	CT prevents need for homecare for new LD users	Avoided hours of homecare per week	Option 3

Methodology Notes

- The number of new CT service users grows based on new ASC users being added through churn and the availability of a transformed CT service (i.e. care practitioner training, simplified referral processes and so on) along with new pathways for additional citizen cohorts
- Gross benefits will be realised by targeting a range of users where CT can reduce existing care package costs and avoid alternative provisions, such as residential admissions
- Gross costs are based on variable cost components increasing with incremental CT service volumes plus other fixed costs
- The net position shows the costs and benefits associated with users receiving CT, incremental to the status quo
- Assumes that ~25% of users with a private pay CT service have an adult social care eligible need
- The assumptions made have been informed by a combination of data provided by BCP, practitioner feedback through 1:1 meetings and PA's experience in delivering CT services in other local authorities, which have achieved significant financial benefits.

Sources of data and assumptions

Data on costs and benefits within this analysis have been sourced from the following:

- Data on costs have been sourced where possible from BCP Adult Social Care & Public Health service
- Where costs are not available, or the 'to-be' service model is expected to entail a significant change in cost versus current, we have made assumptions based on PA's experience of reviewing and delivering CT services in other local authorities
- Assumptions on potential financial benefits have been developed based on PA Consulting's experience of delivering services elsewhere (see note below) and BCP local sources.

Note on PA Consulting's wider CT experience

PA Consulting, in partnership with a specialist CT monitoring provider and CT installation and assessment provider, delivers, or has delivered, CT services to a number of Councils under the 'Argenti' service. Argenti currently delivers CT services in Hampshire County Council and London Borough of Barnet and has previously worked in the the South of Essex County Council and Dorset County Council. PA has also undertaken advisory work on CT services in 20+ councils nationally.

Financial Modelling Inputs and Assumptions (User Numbers)

Data Items	Source	Updated Figures (Business Case)
Number of ASC users (by type of provision)	BCP data	1,153 OA users accessing homecare (ST & LT) and direct payments as of 31st March 2022
		738 OP users accessing residential and nursing care (ST & LT) as of 31st March 2022
		466 users with LD accessing supported living as of 31st March 2022
Yearly churn rate of existing ASC users	Other similar sized councils	OP homecare & direct payments: 66.9% per year OP nursing/ residential/ respite: 33.8% per year LD supported living: 10.4% per year LD Home care: 11.7% per year
Future annual growth of ASC user numbers	Modelling assumption	OP homecare & direct payments: -1.7% per year OP nursing/ residential/ respite: -6.8% per year LD supported living: 23.9% per year LD Home Care: 0.3% per year
Total number of existing users accessing CT	BCP data	5,229 users accessing monitored CT ~25% of Total private pay users **1,307 users as of March 22**
Yearly churn rate of users accessing CT	Modelling assumption	24.8% per year (based on the average leavers in FY2020-21 and FY 2021-22 as a ratio of current size of the CT service)
Yearly CT service growth	Modelling assumption	-0.4% per year (based on the average net change in the service in FY2020-2021 and FY2021-22 as a ratio of current size of the CT service)

Financial Modelling Inputs and Assumptions (Rates)

Data Items	Source	Updated Figures (Business Case)
Cost of 1 hour of Home Care	BCP Data	£20.14 per hour
Avg. weekly cost of a Residential Care/ nursing/ respite package		£915.00 per week
Avg. cost of LD supported accommodation		£923.49 per week
Avg. citizen contribution for home care		26% *(based on BCP data)*
Avg. citizen contribution for residential Care		25% *(based on BCP data)*
Avg. citizen contribution for LD supported accommodation		7.0% *(based on BCP data)*

Financial Modelling Inputs and Assumptions (Costs)

Data Items	Source	Figures	Notes
Equipment cost	Modelling Assumption	£342 for Essential £684 for Advanced £1,512 for Specialist (** definitions below)	1) Assumed that the service will be transformed going forward and more technology will be available to users. Costs based on PA's experience from other councils 2) Uplifted by 1.8 to reflect likely cost of digital equipment
Install & Assessment Costs	BCP data	£36 for Assessments £18 for Installation	1) Based on the transformed model described in our diagnostic, we have modelled that assessments are carried out for every install
Monitoring Costs	BCP data	£2 per user per week for monitoring	
Other Variable Costs	Modelling Assumption	£2.5 per user per week	Cost based on PA's experience from other councils.
Transformation cost	Modelling Assumption	£300,000 (option 2) £500,000 (option 3)	Includes: - Culture change, training and engagement - Project management - Service redesign - Benefits framework redevelopment *Scope of activity varies by Option*

** **Essential** – Basic CT package e.g. Just a 'button and a box'; **Advanced** – Slightly more intensive CT package, e.g. falls detector, flood detector as well as button and a box; **Specialist** – Intensive, high-value CT package, for example including a monitored epilepsy sensor