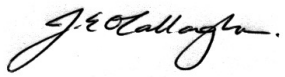
Appendix A

Better Together

The Transformation Partnership:

Improving health and social care with people in Bournemouth, Dorset and Poole

Approved by:



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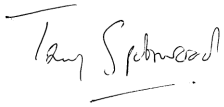

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Bournemouth and Poole Health and Well-being Board

HealthWatch

Wessex NHS England

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Summary

The Dorset area: three-quarters of a million people; Bournemouth and Poole, which together make the second largest conurbation in the South West; several towns and many small villages across a rural landscape; one of the highest proportions of older people with high impact care needs in the country. This, combined with a high number of people with resources to fund their own care, and increasing numbers of carers[1], puts us at the forefront of the demographic challenges ahead.[2]

The *Dorset-area Partnership*: three upper-tier local authorities, four NHS Foundation Trusts and a single Clinical Commissioning Group serving the whole Dorset area; already established, and ready to make real a strong and shared commitment to integrated health-care. We have sign up, too, from our Health and Well-being Boards, NHS Boards, Cabinets, Overview and Scrutiny Committees, Wessex NHS England and district and borough partners for this work.

Person-centred, outcome-focussed, preventative, co-ordinated care

This is not something new: it has been at the centre of national thinking and government initiatives for many years. But it has new force – the financial constraints of austerity coupled with a clear demographic direction of travel create the conditions for transformational change.

Initially, we will focus on the main issue: older people with significant long-term health and care support needs. We will integrate functions to create person-centred, prevention-oriented support: enabling the outcomes expressed in *National Voices* and *Making it Real*. Then we will look to expand our programme to include new cohorts and create a unified model of health and care across the Dorset area.

We have a clear approach and a partnership-wide programme to shape, coordinate and drive individual projects across four areas of intervention:

- **managing demand** - universal front-end, information and advice, reablement/ intermediate care, technology, accessible homes (via district councils);
- **improving effectiveness** - a new operating model and care management process across the three local authorities supported by one ICT system;
- **integrating commissioning** - shared commissioning functions across the CCG and the three local authorities: use of resources, pooled and aligned budgets, common principles and priorities and market positioning;
- **integrating service delivery** - integration for acute, community and primary health and social care, with enhanced community health and social care co-located services which are fully integrated with all primary health services.

Our strength in delivering this transformation is in the strong, formal commitment from the top of our eight organisations and a strong and inclusive relationship with our Health and Wellbeing Boards. We have the ability to influence other public, independent, and voluntary organisations, including them in the integrated commissioning and delivery model we are building.

We do not have all the answers: we want to engage with Government and other pioneers to find the best approach to joint commissioning, service integration, and the development of the workforce within and across organisations. But we are passionate in our desire to shape, drive and accelerate change. We are on the cusp of a great opportunity and the Transformation Challenge Award, and inclusion on the multi-agency network, would lend our programme huge impetus.

[1] The 2011 Census found that 11% of the population of Bournemouth, Dorset and Poole were providing unpaid care – higher than the national average of 10%. The number of unpaid carers in the area rose by 15% between 2001 and 2011, to almost 83,000. The equivalent national increase was 11%.

[2] Laing and Buisson estimate that nationally up to 41% of people fund their own residential care, yet only 21% of these engage with local authorities.

Introduction

This document is a response by our partnership to the Department of Communities and Local Government's Transformation Challenge Award. A similar submission has been made in response to the Department of Health *Pioneer* initiative. It describes a consolidated programme of initiatives – a transforming programme - that will develop the necessary structures, behaviours, incentives, financial models, information, processes and systems to deliver this vision for the people served by our organisations. We welcome the offer of support and in return are more than willing to engage in the wider community, actively sharing our learning and developing cooperative forums to build momentum for change across the country. We plan to use our proposed shared Programme Board and lead officers in each of the agencies to contribute to national forums and learning. Our work with the LGA on Systems Leadership across the partnership will also be of benefit to others.

The bid and the transformational programme it describes has been signed by: the Chief Executives of Bournemouth Borough Council, the Borough of Poole and Dorset County Council; The Chief Executives of the four NHS Foundation Trusts (Dorset County Hospital, Poole Hospital, The Royal Bournemouth and Christchurch Hospitals and Dorset HealthCare University); and the Chief Officer of Dorset Clinical Commissioning Group.

The bid received formal endorsement from the Dorset Health and Well-being Board on 12 June 2013, and from the Bournemouth and Poole Health and Well-being Board on 19 June 2013.

For Bournemouth Borough Council, The Leader of the Council John Beesley endorsed and supported the bid on behalf of the Council on 28 June 2013, in line with his scheme of delegation as set out in the Council's constitution.

For the Borough of Poole, the bid was supported and endorsed by the Health & Social Care Overview & Scrutiny Committee on 25 June 2013, and formally approved by the Leader of the Council, Elaine Atkinson, on 5 July 2013.

For Dorset County Council, the bid was supported and endorsed at Member level by the Adult and Community Services Overview Committee on 24 June 2013 and the Cabinet on 26 June 2013.

Across Bournemouth, Poole and Dorset, we have a successful track record of good quality working relationships and partnerships. We have, for example, a single Public Health Team across the three authorities, a joint Archives Service, a joint Skills and Adult Learning Service, and a single Local Enterprise Partnership. The Leaders and Chief Executives of our authorities, alongside those of our six district and borough councils, meet together regularly to discuss issues of common concern – a forum that is supported by a formal officer structure hosted by Dorset County Council. With the NHS, we have a single Clinical Commissioning Group – the third largest in the country. The success of our partnership arrangements has been reflected in many successful inspections in recent years, particularly in health and social care.

Nevertheless, we all recognise that without change, the increasing demands placed on our health and social care services by Dorset's ageing population will make those services unsustainable in the longer term, financially and in terms of available resources, skills and expertise. Our own audits and individual feedback show that, despite our efforts, there is significant waste in the system. This occurs within the operations of a single agency and between organisations delivering services to the same people. Single agencies may be able to address waste in their own organisation through tactical re-design and continuous improvement initiatives, but to reduce the waste that exists across organisations requires a transformational approach across the whole system.

Most people regard the care they receive to be acceptable or good, and often excellent. However, too many people tell us that their experience of care across the system is characterised by duplication, and of becoming 'lost' in a system. Lack of flexibility with some interventions which can be driven by the incentives and penalties inherent in the system leave people feeling helpless and

confused. These are not good ingredients for promoting self help and independence. We are at the start of our journey and do not have all the answers. The practical realities of operational integration are still at a formative stage. And at a strategic level it is clear for example that we will need to develop a detailed understanding of the rules surrounding choice and competition. We will need to reshape our organisational relationships within the partnership and develop more porous boundaries – enabling talent and resource to move more freely and purposefully around the system, as part of our commissioning role.

The partnership has the will to reach out for support to develop, test and implement new models: to Government and its expertise, particularly, DCLG and DH; and to those councils and health organisations across the country that have already made the first steps exploring new and integrated commissioning and delivery models. We therefore represent many areas that are at the same stage of development. We have a history of engaging in peer learning and review and regard this as essential for improvement.

Programme vision: Integrated care and support

"Bringing services together to respond to what is important to the people we serve"

The *Dorset-area Partnership* is committed to transforming health and social care services across the Dorset area, to enable and deliver a sustainable improvement in health and care outcomes through:

Person-centred, outcome-focussed, preventative, co-ordinated care

Information and advice: The "front end"

People's experiences have helped us prioritise what changes need to happen first to improve the effectiveness of our services. Our aim is to overcome the existing organisational, system, cultural and financial barriers that can get in the way of delivering co-ordinated care and support to the people and communities that we serve. We know that straightforward and convenient access to information and consultation through a range of channels (e.g. on-line and electronic, telephone and face-to-face) enables people to understand their needs, their condition, their care or treatment options (including financial options), and what they need to do to access services. They will need to find this coherent. We want the experience to be one of a coordinated set of services.

Early intervention and prevention

The person will be offered services that are more community-based, and are preventative, whether these are clinical or care-based (for example screening and diagnostic services; respite and support for carers, or other interventions designed to prevent or minimise the risk of a person's condition deteriorating to require secondary care and admission to hospital). Similarly, those who have to be admitted will be able to access the necessary support – both clinical and care-oriented - that will prevent an early return to hospital, particularly as an in-patient. Wherever it is clinically and economically appropriate, out-patient services will be increasingly community and home-based to reduce the personal disruption that accompanies visits to often remote hospitals.

Coordinated care

They will find that services, and just as important, the process to access services (e.g. making appointments, co-ordinating tests, managing travel to specialist services) will be effective and efficient, reducing stress and time-use by the person, as well as being more cost-efficient for the provider.

A person will often have unpaid carers (family, friends, etc) who will find that they are considered as invaluable co-producers and who may be in need of support themselves. They will experience a similar coordination of services that are easy to identify and access, that support them in their role of carer and are themselves coordinated with services that may be required to support the carer's own health condition and care needs.

Person-centred care

The person's experience described here will be consistent, across all conditions, especially those with multiple or long-term conditions (LTCs). The people providing care and health services will regard the person as the focal point around whom everything else is coordinated. They will manage and operate processes that are designed around the person and connect seamlessly to ensure that information flows are optimised and that all the necessary steps in a process are coordinated, and have flexibility from the person's point of view.

Outcome-focussed

The organisations will work collaboratively to deliver the required outcomes for the person and have incentives to do so. These outcomes are described below under **Benefits: Financial and non-financial.**

A new system: whole system integration

As a total health and social care community, we spend £1.2 billion a year across Dorset. To address growing demand and increasing public expectations in the context of constrained and reduced resources, the partners recognise that we have to radically rethink how we approach managing, and reducing, this demand.

In setting up a new system of integrated care the Dorset-area Partnership will need to consider several types of integration. For example the recent national evaluation of the Department of Health's Integrated Health Pilots[3] described four main types of integration: functional; organisational; professional; and clinical. The breadth and degree of integration should also be considered, such as horizontal integration which focusses on linking services that are on the same level of the process of healthcare. In doing so it may involve competing or collaborating organisations, networks or groups. Vertical integration focusses on bringing together different levels of care under one management umbrella (e.g. drawing together hospital and community services). We are not looking for a model in which one size, or one approach, fits all.

The degree or nature of integration can also work at a **macro** (population wide); **meso** (for a care group); or **micro** (individual) level. These considerations are important when assessing the impacts of integration on an individual's experience of care and treatment. The overall evidence for the impact of integrated care appears to be limited and much of it comes from Europe and the United States. It is possible to identify evidence for improvements in experience outcomes for people but much harder to evidence cost savings. Unfortunately much of the evidence base to date focusses on small scale change, which does deliver benefits, but it is the larger scale change that may be required to deliver the reduction in fixed costs especially between agencies.[4] These aspects are recognised in our approach specifically in achieving change at the scale needed to make a difference. We need to work at sufficient breadth and degree to affect individual and population outcomes.[5]

The Nuffield Trust suggests that a focus on *either* horizontal or vertical integration – rather than *both* – at any one point in time, could result in disruption between integrated primary and community services on the one hand, and vertically integrated care pathways (that take patients from first contact to specialist to ongoing care) on the other.[6]

The context of the Dorset, Poole and Bournemouth partnership demonstrates that we have the key ingredients and commitment to support the development of a new system. This will be based upon an approach which uses lead commissioning, draws on evidence from localities (13 across Dorset, Poole and Bournemouth), recognises the benefits of horizontal and vertical integration and has a common understanding of the challenges, principles and ambition it is working to.

The Dorset-area Partnership will progress integration based on evidence of what works locally, and the development of integrated locality health and social care teams will be fundamental to addressing the increasing emergency attendances and admissions and supporting the work of the Dorset Urgent Care Board (see *Appendix A: Better Together Programme Brief* diagram 1).

Our starting point therefore will be on how we collectively commission services together in order to help address a funding gap of £110 million by 2017 (see *Appendix A*: *Better Together Programme Brief*, p9, Financial Information – Funding Gap).

[3] RAND Europe, Ernst & Young LLP (2012) National Evaluation of the Department of Health's Integrated Care Pilots: Final Report. London: Department of Health

[4] Thistlethwaite P. Integrating health and social care in Torbay. London: The King's Fund.

[5] Curry N, Ham C (2010) Clinical and service integration: the route to improved outcomes. London: The King's Fund.

[6] Shaw S, Rosen R, Rumbold B (2011) What is Integrated Care – Research Report, Nuffield Trust

The core components of the new system are:

a) Increasing the pace and scale of initiatives aiming to provide 'care closer to home' to achieve targets on shifting from institutional care to self-help and community based systems

b) Develop whole systems outcome based commissioning to reflect best value. The range of outcome measures that would drive these commissioning intentions are described under the *benefits* section.

c) Develop new ways of working within and between agencies which aim to maximise and measure the added value of providing direct support to people who need help.

d) Working with communities and individuals to help themselves by providing timely enabling interventions which reduce the need for crisis or longer-term statutory services.

e) Informed by evidence of what works locally, nationally and internationally and from the experience of our populations and people who use our services when developing new approaches.

The partners recognise that we must deliver these core components within the next five years to be able to achieve a sustainable Health and Social Care system for the future. Our high level programme priorities reflect the immediate actions needed to improve service responsiveness and start to divert and manage the increasing demand for institutional and acute care. The longer-term objectives reflect our intention to re-commission services against a clearer set of whole-system outcomes which are delivered through integrated commissioning arrangements. The programme for integrated commissioning will include focussing on demand management, developing the new infrastructures for services and sharing market management, contracting and procurement responses.

The focus on outcomes and the dependency of multiple providers to deliver the outcomes will require clear and transparent governance and a contracting approach that rewards collaboration and mutual support and does not allow providers (in extremis) to cause failure in others through any inadequacy. The commissioners will also allow providers time and scope to invest in service re-design, support for coordination (e.g. integrated information systems) and drive continuous improvements.

Our organisations that make up the Dorset-area Partnership and its commissioned delivery organisations will be administered efficiently and effectively to maximise the value of building and other assets.

Based on earlier work on *Total Place*[7], and performance information, we recognise that current arrangements for financing the existing structure of services can and do work against delivering our ambition of achieving a person centred, co-ordinated system of health and social care, and the best use of resources. In developing the new integrated commissioning model we intend to test and then implement new financing tools which support rather than work against our ambition. These will include:

- Shared financial planning by aligning and then, where it is needed, pooling budgets to support whole system working.

- Use an overarching framework or agreement for using pooled funds supported by specific schedules which can be added for agreed shared activity, thereby reducing the work associated with numerous separate agreements.

[7] Bournemouth, Dorset and Poole Total Place Pilot – Final Report 2009

- Governance arrangements such as Health and Well-being Boards and shared joint scrutiny arrangements which recognise legal duties and accountabilities but also evaluate quality and value for money and reporting success against outcomes.

- Chief Officer over-sight of the macro use of resources between partners to monitor the impacts and demand and changes across the health and social care system, supported by a common set of financial and performance information.

- Investment in locality and community initiatives which seek to promote self help and divert demand.

Leadership across the new system will need to be developed to drive the cultural change that is needed within and across agencies. Leadership facilitation and support will be provided by the Local Government Association (LGA) to the Chief Executives of the partner organisations as the programme sponsors. The facilitated Leadership workstream will develop the principles expected to be applied to their respective organisations. It will also evaluate and address cross-agency issues that are getting in the way of achieving an integrated service experience for the population.

The front-line cultural change for the multi-agency teams will be supported by an external facilitating partner using customer-focussed approaches. The intention is to get change working at the leadership and front-line level based on putting the individual first and practising the principles in the vision. It would be expected that front-line teams will identify barriers to progress which will be raised as issues for the leadership or sponsor group.

Within the programme, establishing a shared ICT and more importantly shared business processes between the local authorities and into the future with health partners is regarded as an essential. Customer focussed approaches highlight the amount of waste or activity that adds no direct value to the person needing help. The programme would seek to ‘baseline' this and measure productivity. As an illustration a 5% improvement in productivity across the agencies could contribute £60 million towards the funding gap. This is based on a total expenditure of £1.2 billion.

Tailoring services to the individual will be fundamental to achieving best value. Off-the-shelf or generalised programmes of care and treatment can miss what interventions can be most effective. Dorset was a pilot for personal health budgets which was based on similar approaches used by local authorities for direct payments and personal budgets. The new models for commissioning would be looking to build on this to allow greater flexibility between agencies to meet needs – for example setting up individual pooled budgets.

The programme: Integrated care and support

Four layers of intervention that the Programme will include are described below. Prior to this, however, the Programme Management Office will need to address some overarching requirements to deliver the change. These are:

- Maximising the supports available from the LGA Systems Leadership Programme and the DCLG Transformation Network'

- Undertake and coordinate communications, consultation and engagement work across the various projects and programmes as well as for the overall vision. The role of HealthWatch will be very important in developing and monitoring this work.

- Coordination of Human Resource expertise across the agencies and broader workforce development activity, for example in market analysis work.

- Utilising financial and information management expertise nationally and locally to inform and provide evidence for strategic decisions.

- Bournemouth, Dorset and Poole Local Enterprise Partnership is also prioritising Social Care and Health workforce issues from an economic perspective, and mutual benefits of the Better Together Programme for the work of the LEP will be explored.

The governance diagram in the Programme Brief at Appendix A represents these areas of work.

The programme itself consists of four layers of intervention to achieve the vision. They are:

Managing demand

- Developing a shared "front end" of support between the partners with specific initiatives on:

  a) A new web-based information and advice system.

  b) An advice and support service in hospitals for those who do not meet the criteria for local authority social care services.

  c) A universal information and advice service to help anyone wanting to access or buy care (in their home or residential care) to receive good quality financial advice and to buy additional support services (such as help with choosing a care home).

  d) Shared reablement and intermediate care model across Poole, Bournemouth and Dorset.

  e) Working with the district and borough councils of Dorset to develop integrated information and support to improve access to aids, assistive technology, adaptations and accessible home.

- Complementary work is planned immediately by the Dorset Urgent Care Board to take action to address pressures on the urgent and emergency care system. Specific initiatives include:

  a) Increasing the number of frail older people receiving proactive case management.

  b) A greater risk stratification approach when targeting interventions.

  c) Increasing the number of people supported by rapid response services seven days per week.

  d) Strengthening GP and other out-of-hours services.

e) Supporting care homes to avoid emergency referrals particularly focussing on quality improvements and skill development especially for end-of-life care.

f) Expanding single point of access and education of people on the use of emergency services.

g) Rolling out of NHS 111 arrangements, including increasing call handling capacity.

Improving effectiveness

- To provide cultural and service change by undertaking customer-focussed approaches with specific cohorts of people and developing improved responses. The cohorts will include carers, those with long term conditions, those awaiting discharge from hospital and end-of-life care.

- Develop a new operating model between the three local authorities supported by one ICT system. This will involve a "root and branch" review of processes, aiming to reduce bureaucracy and save costs on future ICT procurement.

- Jointly commissioning multi-disciplinary teams across the 13 localities with the right skills mix and capacity to deliver consistent integrated working with local primary care services.

- The Dorset Urgent Care Board will resource, through an investment of £4m, plans to work at a number of levels by:

  a) Auditing at a practice level all emergency admissions and using the evidence to inform the improvement plan.

  b) Reviewing the effectiveness of virtual wards and multidisciplinary wellbeing.

  c) Reviewing response rates for access to key parts of the process informing admission decisions such as blood and radiological test results.

  d) Developing a seven-day response across health acute, community, and social care services, recognising that this development needs to take place across the services to be effective.

  e) Having a designation of expected date of discharge on admission as the default position to improve planning.

  f) Flexing community service capacity to include in-reach to reduce length of stay in hospital.

  g) Reviewing continuing care processes and linking to new approaches to commissioning care in an integrated way.

The Transformation Challenge Award, alongside Pioneer support from the Department of Health, will help us accelerate these initiatives to achieve the change we are looking for by using national expertise and experience.

Integration of commissioning

- To develop shared commissioning arrangements across the CCG and the three local authorities using:

  a) A common set of principles and priorities.

b) Shared resources through pooled and aligned budgets, supported by macro-level shared financial planning.

c) A common market position statement and shared market management between the local authorities and the NHS, to promote quality and value for money.

d) A review of local authority directly provided services.

e) Sector-wide workforce planning to assess gaps in skills availability and cross-agency trends, and then respond with joint workforce developments.

- To attract new suppliers to make investments into the area by virtue of being a large-scale commissioner, thereby stimulating local economic growth.

Integration of directly provided services

- To develop vertical and horizontal integration, which could include acute, community and primary health and social care.

- To commission new multi-disciplinary teams working closely with primary care services and jointly using capital assets between partners.

- To support closer working at a GP locality level, through identified practitioner links and risk stratification work – especially for people with Long Term Conditions.

The programme approach will support existing initiatives where there are shared objectives. Specific interfaces will include:

a) The Dorset Urgent Care Improvement plan

b) The Dorset Integrated (Accessible Homes and Independent Living) Project

c) Agency efficiency and savings programmes

d) The Dorset, Bournemouth and Poole Health and Wellbeing strategies

Benefits: Financial

We propose to work with the DCLG and the LGA through the Public Services Transformation Network and through our existing involvement in the Systems Leadership programme to implement the changes set out in Better Together. One of the most challenging areas for us to address is financially assessing cross-agency benefits and measures in a way which is robust enough to form the basis for macro resource co-ordination and reallocation.

The Public Service Transformation Network experience on developing and evaluating community budgets will be invaluable in getting to the level of detail needed to provide sufficient agency confidence to release or move resources. We are particularly interested in the learning from Manchester, West Cheshire and Essex on investment across boundaries and the technical development of cost-benefit models.

We intend to draw upon technical expertise to analyse our current set of demographic activity and financial data and then formulate baseline positions. We believe such approaches would be very helpful for other areas too, as the model is comprised of one county council, two unitary councils and six district and borough councils.

We have established a cross agency finance officers group who will be working with specialist advisors and technicians to generate the cost benefit models for the Chief Officer and Member

Sponsors. For example we will need to assess spending patterns and identify fragmented high-cost interventions as well as estimate the cost impacts of change. This should be based on evidence but weighted to reflect accuracy assumptions ie sensitivity analysis, optimism bias. These tools will help us in determining levels of confidence, both locally and possibly nationally with learning.

We are undertaking complementary work with the LGA Systems Leadership programme to address the cultural issues that work across organisations and to build up the relationships needed to lead the changes. We have dedicated support for 20 days over the year for this purpose.

Benefits to be explored and quantified during the early stages of the programme include:

- **Enhanced market and local economic development** arising from more opportunities to invest at scale in health and care private, social enterprise and voluntary and community provision.

- **Benefits accruing from economies of scale** e.g. single not multiple teams, simplified access to services (including information and advice services), single IT system, commissioning/ buying power, single access points.

- **Enhanced commissioning and planning capacity** to build successful strategies, plans and delivery capability linked to shared workforce alignment, capital investment and joint asset management. This will be supported by refined intelligence on demand and optimum interventions which could be applied in other settings.

- **Benefits accruing from integrated services**, e.g. reduces the need/requirement for often expensive dialogues between organisations about who pays for/provides a service.

- **Benefits accruing from economies of flow** – movement of work between services and around the system.

- **Benefits accruing from the right response** made in a more timely way.

- **A more attractive business proposition for service providers**, making social enterprise and local authority trading companies a more viable proposition e.g. services which in one authority are not a viable proposition become viable when three authorities are considered.

- **Reduced levels of inappropriate demand** as a consequence of improved work flow, business processes and shared information.

Work is underway between the partners to establish baseline positions on performance and the use of resources. The three councils are undertaking the ADASS Use of Resources toolkit self assessment exercise to assist with performance and efficiency issues. Indicative information shows that councils are at different places across different measures, but work is needed to achieve an optimum balance of resources between community based provision (Communityland) and residential and nursing care (Careland). Best practice indicates a 30% expenditure in Careland provision against a current performance (2011-12) such as 57% for Dorset. Part of the macro overview of the new system by Chief Officers will include this expected shift of 20%[8].

Similar macro resource measures are being explored within the health community to reflect best practice, for example the balance of expenditure between acute and community health care. Currently we spend £484m, 53% of the CCG resource on Acute Services and £94m, 10% on Community Health Services (excluding mental health £108m, 12%).

[8] Boulton J (2009) Use of Resources.

There are a number of financial outcome measures that can assist us with the macro, meso and micro view of resource usage. These measures will form part of the system performance information for Chief Officers. They include:

- Use of hospital resources: Delayed transfers of care from hospital, e.g. (ASCOF2C)[9].
- Non-elective length of stay and occupied bed days for >65s.
- Emergency department attendances for >65s and emergency admissions for acute conditions that would not normally require hospital admissions (NHSOF3A)[10].
- Acute re-admissions within 30 days of discharge from hospital (NHSOF3.6) and proportion of older people who are still at home 91 days after discharge from hospital / into reablement / rehabilitation services (ASCOF2B / NHSOF3.6).
- Proportion of people using social care who receive direct payments (ASCOF1C), and numbers of people receiving personal health budgets.
- For use of residential and nursing home resources: Permanent admissions to residential and nursing homes, per 100,000 population (ASCOF2A).

Benefits: Non-financial

We will describe and then measure the non-financial benefits in a number of ways, such as:

- **Achieving personal outcomes:** Simplified system/ processes for customers – fewer boundary related issues. better lives, more control, more choice and greater dignity.
- **Reduced inequalities of outcome** across our local populations.
- **Enhanced staff outcomes**: Improved quality and quantity (availability) of staff within the whole local sector; better jobs and job roles; improved productivity, attendance, morale and work satisfaction resulting from reducing the frustration associated with waste, blockages and crisis management which impact on their ability to help people; more development opportunities due to cross-agency delivery; reduced turnover in the sector.[11]
- **Political collaboration** in this area can be applied in other areas of public service to achieve benefits for the whole population, and make the most efficient use of the "public pound".

The measures that could be used to assess the baseline position for people's experience of services and quality of life outcomes could include:

- Patient / Service User feedback: HSCIC[12] User Experience Survey adult social care. 7 core integration questions used as interim measures for patient experience at the interfaces between NHS services; overall satisfaction of people who use services with their care and support (ASCOF3A); and proportion of people who use services and carers who find it easy to find information and support (ASCOF3D). Measures for the sharing of information to monitor people "telling their story" more than once.
- Staff feedback surveys and analysis of complaints/ compliments from participating agencies.

[9] Adult Social Care Outcomes Framework 2013-14

[10] National Health Service Outcomes Framework 2013-14

[11] National Minimum Data Set (NMDS) Sector-wide data on caring professions, Skills for Care.

[12] Health and Social Care Information Centre

- Carers' feedback such as: HSCIC User Experience survey of carers; Overall satisfaction of carers with social services (ADCOF3B); and proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF3C).

- People's confidence and control over managing their own care could include: proportion of people who use services who have control over their daily life (ASCOF1B); proportion of people feeling supported to manage their own condition (NHSOF2.1); proportion of people using social care who receive self directed support (ASCOF1C).

- Quality of life outcomes for people with long-term conditions (NHSOF2); in social care (ASCOF1A); and for carers (NHSOF2.4 / ASCOF2D).

The role of the Health and Well Being Board, and particularly HealthWatch, will be key in both supplementing the feedback on the effectiveness of services and monitoring the financial and non-financial benefits of the changes to a new system of support.

Conclusion

The vision and programme outlined in this document is ambitious and wide-reaching. We intend it to be pursued with pace: the next five years will see a fundamental change to the way our organisations work together to commission and deliver world-class, person-centred health-care to the people of the Dorset area.

It is a massive challenge, notwithstanding the shared commitment and drive of the *Dorset-area Partnership*. We will experience significant change at all levels: new governance and structures around integrated commissioning; new approaches to outcome-oriented contracting with incentives for investment, sustainability, and market development; developing integrated processes, and information systems; and not least, encouraging new behaviours, skills and capabilities in our – and our providers' - people.

We are confident that we have the passion, drive and commitment to deliver our programme, and the ability to overcome organisational, financial and behavioural crises that are inevitable with such far-reaching change.

We are not complacent. We recognise that we need help and support, and we want to reach out to others on similar journeys. We welcome the opportunity to be part of the Transformation Network, working with DCLG, the Department of Health and fellow Pioneers and Network members to implement our solution and make it real for the people of the Dorset area, and by extension, to add our weight to the wider National initiatives. We will be better together.

Better Together

Programme Brief

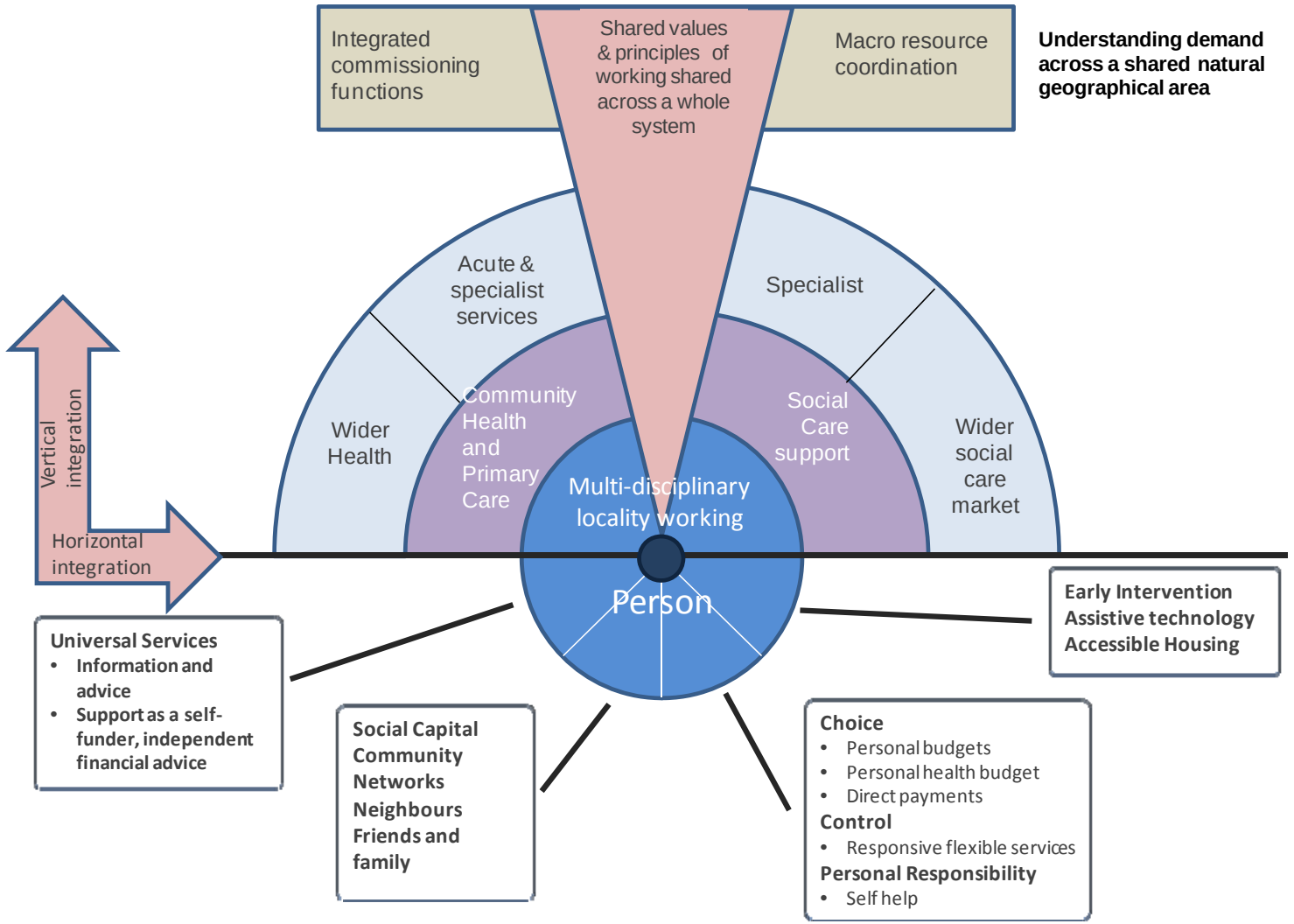
1. Programme Vision

The relationship diagram, overleaf, represents the relationships of services and support as they apply to the person seeking help. "Below the line" supports such as universal services (information and advice) and social capital (community networks, friends and family) are areas we have described as the "front-end" and are vital to diverting demand from the more expensive tertiary and secondary services shown above the line.

Running through all interventions and relationships is a common set of shared values and principles which inform the way we work. This customer-focussed approach will help improve the efficiency of interventions across these tiers of support. The Chief Officers and Commissioners will be assessing how these relationships are working to deliver good outcomes for people and the best use of shared resources (macro resource coordination).

Initially, vertical integration in terms of services will improve outcomes for people needing help in between these tiers. Later in the programme, horizontal integration will improve collaboration of supports and services working to address a similar level of need. This recognises that change needs to take place at a practice level (micro), service configuration level (meso), and a whole system level (macro) in order to fully realise the benefits we are looking for.

2. Better Together – relationship diagram



3. Quick Wins

1. A shared “front end” of support between the three local authorities and establish robust links into Health “single point of access” arrangements, comprising:
   (a) Shared information and advice service.
   (b) Shared support and advice services in the acute hospitals
   (c) New self-funder support services which will become self-financing. To include access to financial advice, brokerage and out-sourced social work assessment
   (d) Shared reablement model across Poole, Bournemouth and Dorset based on universal access arrangement
   (e) Working with the district and borough councils of Dorset, the development of robust links, and possible co-location, with the new integrated information/advice/service access arrangements for aids, adaptations and accessible homes

2. A new operating model and revised and integrated business processes between local authority fieldwork teams, supported by a shared ICT system, in order to provide responsive services able to work more closely with health partners in preparation for greater integration into the future.

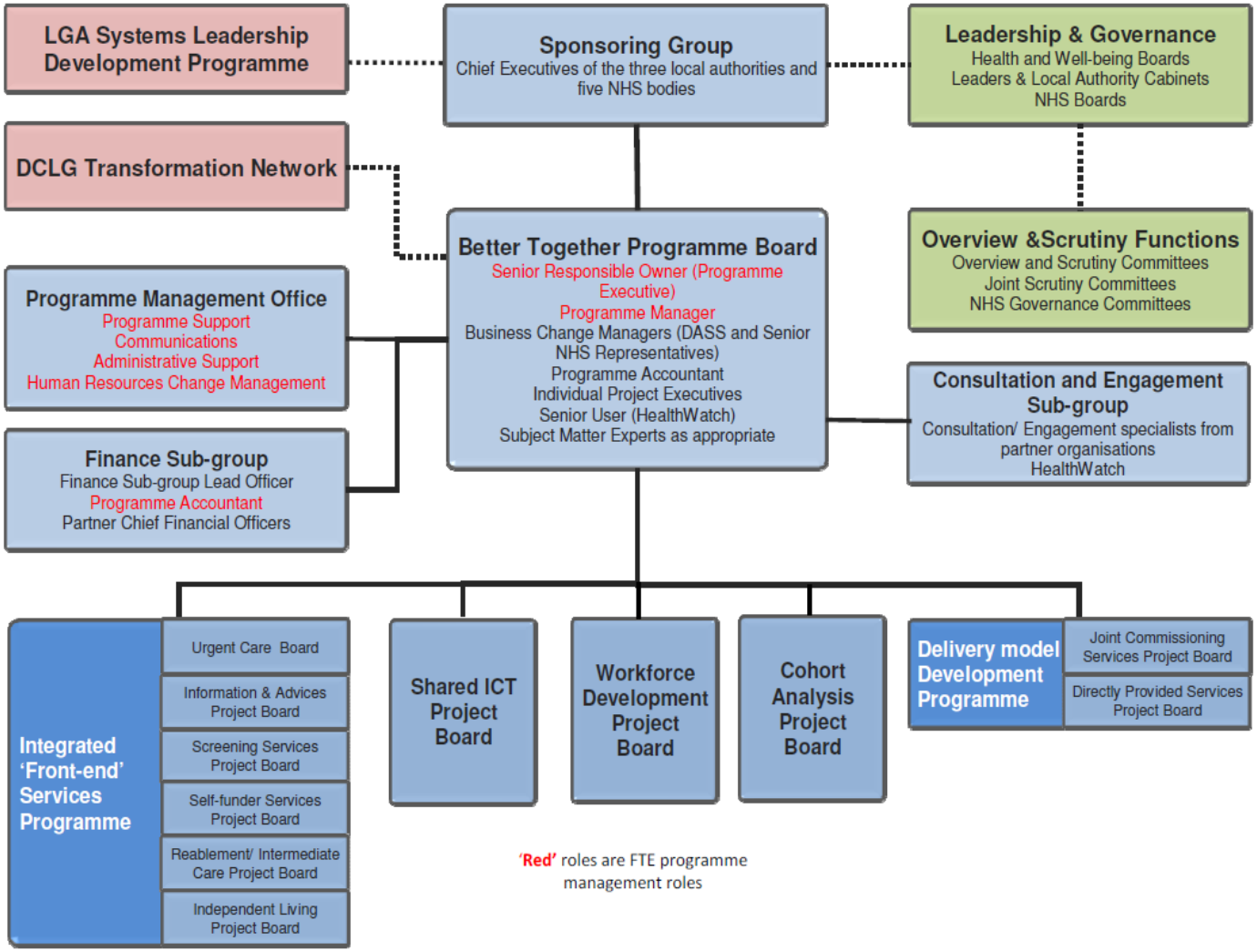
3. Shared commissioning structures and practice across the three local authorities, Public Health and the Clinical Commissioning Group.

4. A common market position statement and shared market management.

4. Governance

Board relationships

The governance mechanism for the Dorset Area Partnership's transformation programme is outlined in the diagram below. Key roles and relationships are listed on the following page.



The **Better Together Programme Board** is placed at the heart of the programme's governance structure.

The board receives its authority from the Sponsoring Group which represents the partner organisations through their executives.

Political leadership and influence exists through the Sponsoring Group and hence the Programme Board via established cabinet-based democratic mechanisms present in each local authority and their NHS Board equivalents.

The necessary overview and scrutiny function is also discharged through established local authority processes via the political leadership and the executive of the partner organisations.

The programme has higher-level partners which have an advisory and influencing relationship through the Programme Board: the LGA Systems Leadership Development Programme; the DCLG Transformation Network, and the Urgent Care Board.

The Board is supported in its work and decision-making through the Programme Management Office and the Finance Sub-Group.

A series of Project Boards oversee the development and implementation the projects that make up the Better Together Programme. These are grouped initially into four 'sub-programmes': Integrated Front-end Services, Shared ICT, Workforce Development and Cohort Analysis; and, Delivery Model Development.

5. Key Programme Roles and Responsibilities

Sponsoring Group

Key responsibilities of the Sponsoring Group are:

- Establishing the organisational context for the programme
- Authorising the Programme Mandate and approving funding for the programme
- Resolving strategic and directional issues between programmes
- Approving the progress of the programme against strategic objectives
- Championing the programme, leading by example, living the values implied by the change
- Providing continued commitment and endorsement to the programme at executive and communications events
- Advising and supporting the Senior Responsible Owner

Confirming the successful delivery and sign-off at the closure of the programme

Senior Responsible Owner

Responsibilities of the Senior Responsible Owner (SRO) are:

- Owning the Vision for the programme
- Providing overall direction and leadership for the delivery and implementation of the programme
- Securing the investment required to set up and run the programme
- Being accountable for the programme's outcomes
- Chairing the Programme Board and being accountable for the governance arrangements
- Owning the Business Case
- Managing the interface with key senior stakeholders
- Managing the key strategic risks facing the programme

Maintaining the alignment of the programme to the partnership's strategic objectives

Programme Manager

The responsibilities of the Programme Manager are:

- Day-to-day management of the programme from 'identification' to 'closure'
- Planning and designing the programme and proactively monitoring its overall progress, reporting the progress at regular intervals to the Senior Responsible Owner, managing and resolving risks and issues
- Ensuring key documents are created and updated as necessary
- Defining the programme's governance framework
- Monitoring the programme's budget and the expenditures and costs against benefits that are realised as the programme progresses
- Collaborating with the Business Change Managers to ensure that the timing and content of planned programme deliverables are feasible in the relevant business areas
- Maintaining overall integrity and coherence of the programme and developing and maintaining the programme environment to support each individual project within it
- Starting projects at the right time for the programme
- Effective monitoring and coordination of the projects and their interdependencies
- Closing projects
- Ensuring that the delivery of products or services from projects meets programme requirements within time, budget and quality
- Facilitating the appointment of individuals to the project delivery teams and ensuring maximum efficiency in the allocation of resources and skills within the projects dossier.
- Managing third party contributions to the programme
- Managing the communications with stakeholders
- Initiating extra activities and other management interventions wherever gaps in the programme are identified or issues arise.

Business Change Managers

Business Change Managers (BCM) must be senior people from the parts of the organisations that will need to change the way they work.

The responsibilities of a Business Change Manager are:

- Ensuring that the programme meets the interests of the Sponsoring Group in their own business area
- Collaborating with the Programme Manager to ensure that the work of the programme that affects their own business area will deliver all the necessary products or services
- Assisting in the identification and definition of benefits relevant to their business area
- Implementing, in their own business area, the mechanisms by which benefits are measured
- Ensuring that the continued accrual of benefits can be achieved and measured after the programme has been completed
- Ensuring that the timing of the delivery of project outputs into their business area is optimal for the continuity of business as usual
- Winning 'hearts and minds' of business colleagues through regular communication and involvement in change activities
- Preparing their business area for the transition to new ways of working
- Taking the management lead in the integration of the changes into the business while ensuring that business as usual is maintained during the transition
- Maintaining people's focus on realising beneficial change.

Finance Sub-Group

The Finance Sub-group's responsibility is to:

- Ensure that the Programme Business Case is financially viable across all partner authorities
- Ensure that Cost Benefit Analyses are coordinated across the partnership
- Ensure that the economic benefits flow into individual partners' financial strategies
- Ensure changes in government funding are consolidated with the Programme Business Case

6. Programme Activity and Projects

Activity	Responsibility	Proposed Completion[1]
1. Joint Transformation Challenge Sponsors appoint Senior Responsible Owner (SRO)	Better Together Programme Board	September 2013
2. Establish programme governance arrangements and integrated commissioning governance with resourcing plan	Better Together Programme Board	November 2013
3. Agree workstream leads and appoint project teams	Better Together Programme Board	November 2013
4. Establish Transformation Network Joint Working Agreement and present an Outline Business Case for the programme	Better Together Programme Board	November 2013
5. Construct model and detailed programme plan for 2014-16 timetable	Better Together Programme Board	November 2013
6. Establish Programme arrangements for: o Older people services – at CCG level through existing board o A shared "front end" of support between the three local authorities and establish robust links into Health "single point of access" arrangements. Specific initiatives include: o Shared information and advice service. o Shared advice and support services in the acute hospitals. o New self-funder support services which will become self-financing. To include access to financial advice, brokerage and out-sourced social work assessment. o Shared reablement model across Poole, Bournemouth and Dorset based on universal access arrangement. o Working with the district and borough councils of Dorset, the development of robust links, and possible co-location, with the new integrated information/advice/service access arrangements for aids, adaptations and accessible homes.	Better Together Programme Board	February 2014

[1] Timescales assume Transformation Challenge Award resource

Activity	Responsibility	Proposed Completion[1]
7. Promote cultural and service change by undertaking a joint exercise on understanding customer and patient demand with specific cohorts of people and developing improved responses. Cohorts to include: (a) those undertaking primary caring roles (b) those with long term conditions (c) those awaiting discharge from hospital (d) those receiving end of life care The analysis and understanding of need direct from a customer perspective will inform joint service design and operating principles. The outcomes of the new services will be monitored against a baseline position and control groups. These models can then be applied across joint teams.	Workforce Development & Cohort Analysis Project Board	Feb 2014
8. Commission cultural change facilitator	Better Together Programme Board	July 2013
9. LGA Systems Leadership Development Programme	Better Together Programme Board	June 2014
10. Develop a new operating model and review business processes between local authority fieldwork teams supported by a shared ICT system. The objective is to provide responsive services able to work more closely with health partners in preparation for greater integration into the future.	Better Together Programme Board. Shared ICT Project Board.	Jan 2015

Activity	Responsibility	Proposed Completion[1]
11. Establishment of integrated strategic commissioning arrangements across Bournemouth Poole and Dorset: o Agree the governance arrangements and delegated decision making mandates o Establish priorities for service transformation that reflect current local and national imperatives o Agree and publish a joint health and social care commissioning plan o Set up aligned or pooled financial arrangement with appropriate governance o Establish genuine joint arrangements for commissioning and contracting with health social care providers	Better Together Programme Board. Joint Commissioning Services Project Board	April 2014
12. Initial Programme: establish transformation programme at pan Dorset level Phase 1: o Commissioning – vision, strategy etc o Commercial – contracting and procurement o User/carer and clinical engagement o Information governance/data sharing o Communications o HR – workforce planning, culture training	Better Together Programme Board	October 2013
13. ADASS use of resources – review of progress	SRO	July 2013
14. Establish enablers programme at pan Dorset level Phase 2: o Finance – aligned or pooled budgets o Communications o Commissioning Implementation o Information governance/data sharing	Better Together Programme Board	Commencing Jan 2014
15. Integrated Commissioning governance arrangements in place across Dorset including draft Partnership agreements, board accountabilities and reporting, risk and benefits share	SRO	June 2014
16. Integrated Commissioning Programme brief and workstream PIDs, including commitment to clear programme and project timetables	SRO	Feb 2014
17. Financial planning assumptions and contract mapping for joint service contracts	CCG, Health Trusts and Local Authorities	Dec 2013
18. Integrated commissioning arrangements in place with clear leadership	SRO	March 2014

Activity	Responsibility	Proposed Completion[1]
19. Draft service specifications for 2014-15 contracts (timetables subject to formal contract notice periods with providers and CCG contestability plans)	Joint Commissioning Services Project Board	April 2014
20. Engagement with Stakeholders and service providers on draft service specifications	Joint Commissioning Services Project Board	April 2014 onwards
21. Agree procurement route and contract terms	Better Together Programme Board	April 2014
22. Service specifications issued for procurement	Joint Commissioning Services Project Board	Jan 2014 onwards
23. Local guidance on process for integrated planning between partners	Better Together Programme Board	July 2014
24. Formal appointment of integrated commissioning leads and teams where required and agreed	CCG and Joint Commissioning Services Project Board	Sept 2014
25. Integrated plan process for 2015-16	Better Together Programme Board	Feb 2015
26. Initial first tranche jointly commissioned contracts in place	Lead commissioners/ Joint Commissioning Services Project Board	April 2016

7. Key Risks and Issues

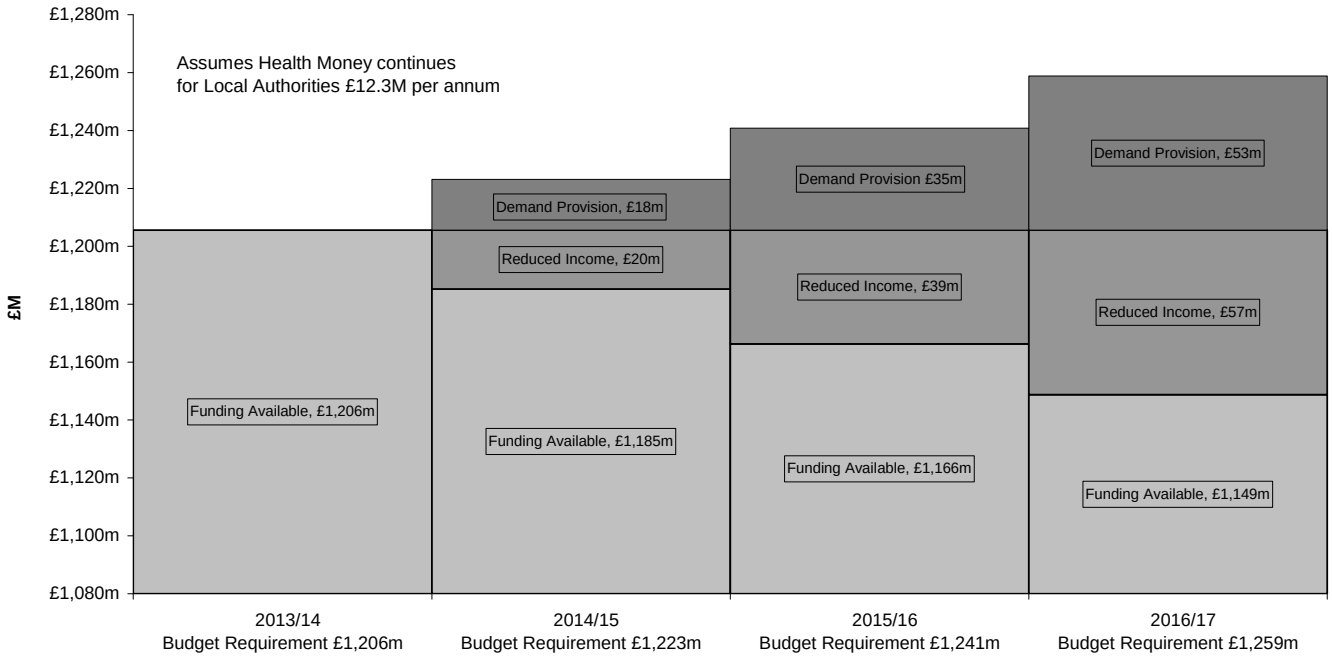
Risks - anticipated threats to the benefits					
Description	**Likelihood**	**Impact**	**Risk Owner**	**Mitigating Action**	**Action Owner**
Non-acceptance/disagreement from one or more key stakeholders (Health Trusts, CCG, Local Authorities) about direction of travel/plan	Possible	High	Sponsors	Acceptance criteria established and Programme reshaped to take this into account	Sponsors
Lack of continued political support for to the programme from the leaderships of the three local authority signatories	possible	High	Sponsors	Leadership development programme	Jill Barrow (LGA)
Lack of continued support from the CCG/ NHS Trust Boards	possible	High	Sponsors	Leadership development programme	Jill Barrow (LGA)
Lack of organisational capacity to deliver full transformation	possible	High	Better Together Programme Board	Reallocation of resources	Sponsors
Lack of adequate cultural change/ workforce planning to support transformation	possible	High	Better Together Programme Board	Targeted workforce development programme workstream, with consultancy support	Sponsors
Capacity of existing service provider landscape capacity may be of insufficient scale/ inconsistently situated	possible	High	Better Together Programme Board	Ongoing review of impact of programme on service providers and initiatives to facilitate growth and introduction of new providers into the market	Sponsors
Programme seen as an "add on" to normal business therefore given insufficient priority by one or more stakeholders	possible	High	Better Together Programme Board	Senior leadership to push/stress importance of project. Communications and change management to ensure criticality is understood and 'bought into' by the partner organisations	Transformation Programme Board
Programme overlap with existing work	Possible	Medium		Planning with reference to partner organisations' BAU and in-flight or planned change initiatives	Transformation Programme Board

Risks - anticipated threats to the benefits					
Description	**Likelihood**	**Impact**	**Risk Owner**	**Mitigating Action**	**Action Owner**
This work diverts attention from more urgent savings activities	Possible	Medium	Better Together Programme Board	Recognition of distinction between 'important' and 'urgent'. Focus on end-goal of programme benefits	Transformation Programme Board
Staff and unions react negatively to proposals	Possible	Major	Better Together Programme Board	Clear and timely communications. Development of communication strategy and plan. Set clear conditions from the outset. Engage staff and unions early on	Transformation Programme Board
Resource commitment/ investment not forthcoming or insufficient for the level of change required	Possible	Major	Better Together Programme Board	Be clear from the outset about the level of investment/resource required. Clear business case.	Transformation Programme Board
Rewards for investment in one area of the system are accrued in a different part of the system e.g. acute service benefits from investment (increased cost) in social care	Possible	Major	Better Together Programme Board	Strong business case, engage all major stakeholders. Good cost benefit profile. View as a single system - understand systemic impact	Transformation Programme Board

Issues- current threats to the benefits				
Description	**Priority**	**Issue Owner**	**Action**	**Action Owner**
Forms of integration require prioritising/ ordering (i.e. vertical integration, horizontal integration, joint commissioning)	High	Sponsors	Sponsor prioritisation and planning seminar	
Tracking programme financial benefits and resource shifts against budgets	Medium	Better Together Programme Board	Develop tracking mechanisms	Transformation Programme Finance Sub-group

8. Financial Information

A. DIAGRAM 2 - BUDGET FUNDING GAP



Budget Gap	£0m	£38m	£74m	£110m

B. BASELINE: Quantum of current spend on health and social care in the Dorset county area

Information supplied by NHS Dorset Clinical Commissioning Group, Dorset County Council, Bournemouth Borough Council and Borough of Poole Council. The Table below shows that the total gross spend on Adult Health and Social Care across the Dorset area is £1.205 billion.

Authority	Gross Spend 2013/14 £m
NHS Dorset Clinical Commissioning Group*	915.0
Dorset County Council	140.8
Bournemouth Borough Council	76.0
Borough of Poole Council	55.0
Public Health*	18.8
	1,205.6

* Public Health and CCG spend is attributable to the whole population and not just Adults.

C. INDICATIVE COSTS ATTRIBUTABLE TO STAGE 1 PROJECTS

- **shared information and advice service**
- **shared advice and support in acute hospitals**
- **Self funder services**
- **Shared reablement model**
- **Understanding customer and patient demand and developing improved responses**
- **Shared ICT system**
- **Programme Management**

Project element	**Estimated cost**
Shared information and advice service Full modular system including Resource Allocation system, support planning & e:marketplace capability	175,000
Shared advice and support services in acute hospitals (E-mail Dorset CC Contract Officer dated 12 June 2013) Extension of advice and support services to Poole and Dorchester over two years.	400,000
My Care, My home New self-funder support includes access to financial advice, brokerage and out-sourced social work assessment. Cost of website signposting system and on-going systems management support to generate improved management information. One year pilot.	70,000
Shared reablement model Cost of integrated reablement, rehabilitation and recovery service: transition to new service redundancy costs	500,000
Cohort work - cultural change (information based on experience at Plymouth Council) Understanding customer and patient demand and developing improved responses	250,000
Project team	704,700
Shared ICT system (workings from Poole) Poole's specification work can be used. Quick to market over two years. The costs relate to achieving the choice of system, no hardware or operation costs are included.	320,000
Total	**2,419,700**

In addition, contributions of up to £250k each over two years have been agreed by Dorset County Council, Bournemouth Borough Council, Borough of Poole and Dorset Clinical Commissioning Group.

9. Constraints

- Formal Section 75 arrangements will be required, since there is no automatic empowerment for The NHS and local authorities to undertake each other's functions.
- Organisational capacity, particularly during any shadow running of new management arrangements for combined operations.
- Immediate funding pressures will be a constraint when defining short, medium and long term activities and objectives

10. Assumptions

- Ownership of the vision by all key stakeholders
- Support from wider stakeholder groups
- Political acceptance of the way forward
- £2m financial support from DCLG Transformation Challenge Award
- Resource commitment and input from all key stakeholders
- Proposal does not conflict with other long term strategic plans/intentions (either written or at concept stage), local and national, or lead to competing developmental resources

11. Programme Capability

Dorset County Council will provide: the Senior Responsible Owner, Programme Manager, Programme Support, Programme Accountant, Configuration management and administrative support, and Strategic Communications. DCC will also coordinate multi agency Finance, Human Resources and Legal sub-groups.

Each of the partner organisations will provide: Business Change Managers for the Programme Board; User, Supplier, and subject matter expert representation for individual component projects within the programme as required.

The DCLG Transformation Network will provide: Subject matter support and expertise as required.

The Local Government Association will provide: 20 days of expert consultancy to support systems leadership development across the eight partner organisations.

12. Initial, Outline Programme Plan