Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.ukas well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Dorset County Council, Borough of Poole and Bournemouth Borough Council**
Clinical Commissioning Groups	**NHS Dorset CCG**
Boundary Differences	**A common Part 1 has been produced for both Health and Wellbeing Boards with detailed separate Part II plans. Both parts have been shared.**
Date agreed at Health and Well-Being Board:	**10/09/2014** **Final version agreed for submission 19/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£15,843**
2015/16	**£54,563**
Total agreed value of pooled budget: 2014/15	**£15,843**
2015/16	**£56.663M**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Dorset CCG
By	Paul Vater
Position	Chief Financial Officer
Date	Submission agreed 19 September 2014

Signed on behalf of the Council	Dorset County Council
By	Catherine Driscoll
Position	Director for Adult & Community Services
Date	Submission agreed 18 September 2014

Signed on behalf of the Council	Dorset County Council
By	Sara Tough
Position	Director for Children's Services
Date	Submission agreed 18 September 2014

Signed on behalf of the Council	Borough of Poole
By	Jan Thurgood
Position	Strategic Director, People
Date	Submission agreed 19 September 2014

Signed on behalf of the Council	Bournemouth Borough Council
By	Jane Portman
Position	Deputy Chief Executive
Date	Submission agreed 19 September 2014

Signed on behalf of the Health and Wellbeing Board	Dorset Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Rebecca Knox, Dorset County Council
Date	Submission agreed 18 September 2014

Signed on behalf of the Health and Wellbeing Board	Bournemouth & Poole Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Janet Walton– Borough of Poole
Date	Submission agreed 19 September 2014

Signed on behalf of the Health and Wellbeing Board	Bournemouth & Poole Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Nicola Greene, Bournemouth Borough Council
Date	Submission agreed 19 September 2014

c) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
D1: Better Together Business Plan	**Plan for implementing transformation programme** **https://www.dorsetforyou.com/media.jsp?mediaid=192879&filetype=pdf**
D2: Dorsetforyou Better Together site	**Link to communications and workshop materials** **http://www.dorsetforyou.com/better-together** **Link to Locality Vision Interactive Toolkit** **https://www.dorsetforyou.com/416302**
D3: Dorset Urgent and Emergency Care Strategy 2014-2016	**Draft Strategy attached**  Draft Urgent Care Strategy (2).pdf
D4: (JSNA) Joint Strategic Needs Assessment Dorset, Bournemouth and Poole	**Joint local authority and CCG assessment of the health and social care needs of the local population** **http://www.dorsetccg.nhs.uk/aboutus/JSNA.htm**
D5: Joint Health and Wellbeing Strategies for Dorset and Bournemouth and Poole	**The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Boards are planning to implement from 2013 to 2016.** **http://www.dorsetforyou.com/media.jsp?mediaid=187381&filetype=pdf** **http://www.boroughofpoole.com/your-council/how-the-council-works/health-and-wellbeing-board/**
D6: Carers Strategy for Dorset 2013 – 2016 **Carers Strategy for Bournemouth and Poole - 2013-2016**	**Carers needs analysis, priorities and implementation plans from 2013 to 2016:** **http://www.dorsetforyou.com/media.jsp?mediaid=148279&filetype=pdf** **http://www.bournemouth.gov.uk/SocialCareHealth/Carers/CarersJointCommissioningStrategy2010to2013.pdf**
D7: National Dementia Strategy: Living with Dementia **Living well with memory loss and dementia in Dorset Bournemouth, Dorset and Poole**	**Action plan to improve awareness, training, practice and service development to support people with dementia.** **https://www.dorsetforyou.com/media.jsp?mediaid=192724&filetype=pdf**

Local Delivery Plan Carers' Dementia Information Resource for Dorset, Bournemouth & Poole	**https://www.dorsetforyou.com/media.jsp?mediaid=195872&filetype=pdf**

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

"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

The Partnership will integrate functions to create person-centred, prevention-oriented support: enabling the outcomes expressed in National Voices and Making it Real, focused initially on older people with significant long-term health and care support needs
Then it will look to expand the programme to include new cohorts and create a unified model of health and care across the Bournemouth, Poole and Dorset area. The cross authority nature of this partnership aims to make it easier for service users to navigate between cross boundary arrangements. Organisational constraints will be highlighted and addressed as part of the cultural change work planned in the new locality teams. This will need to include surrounding authorities and especially Yeovil and Salisbury hospitals which serve our populations.

The Partnership has agreed that the work to create a new model of care is the single most important piece of work we will undertake and central to the key changes we want to see in the way services are commissioned and provided. These changes need to ensure we deliver the outcomes expressed in National Voices and Making it Real, this includes other cohorts of people who need support such as those with a learning disability and mental health needs.

The challenge is to approach these changes in a way that is person-centred, achievable and ensures quality, safe services but will also be financially sustainable. These points are reflected in our agreed outcomes. There are three planned major programmes of work. The Better Together programme, which includes the work of the Urgent Care Board, and a proposed Clinical Services Review.

The Better Together Partnership has a clear approach and a partnership-wide programme to shape, coordinate and drive individual projects across five areas of intervention:

- **Responding to need** – the 'front-end' of support such as easy to access points of contact, improved information and advice, reablement/ intermediate care, technology, accessible homes (via district councils);
- **improving effectiveness** - new ways of working for social care fieldwork services, especially for assessment and support planning processes across the three local authorities, and improved information sharing with Health, supported by an integrated 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 working with providers to develop the market for care and support;
- **integrating service delivery** - integration for acute, community and primary health and social care, with enhanced community health and social care co-located services fully integrated with all primary health services and delivered by multi-disciplinary teams
- **Sharing delivery** - of local authority provided services across Bournemouth, Poole and Dorset.

Local demography and demand

Dorset health and social care services are facing increasing pressure, and 're-adjusting' the current system will not be enough. Estimates by POPPI (Projecting Older People Population Information System) suggest that between 2014 and 2030 the number of individuals aged 65 years and over living within the three local authority areas will increase from 34,500 to 46,400 (by 34%) in Bournemouth, from 114,800 to 154,300 (a 34% increase) in Dorset and from 32,900 to 45,000 (a 37% increase) in Poole.
Source: **www.poppi.org.uk** - Figures are taken from Office for National Statistics (ONS) subnational population projections.

Currently we know that about 1 in 5 people in Dorset are living with a long term condition or disability that impact on their health (Dorset Joint Strategic Needs Assessment).

The rate of demand on services across the county is increasing. Comparing 2013/14 and 2014/15 there has been:

- A 34% increase in ambulance dispatches and a 26% increase in those recommended to attend emergency departments.
- Emergency Department attendances for Dorset have increased, with approximately 850 additional attendances per month (across the 3 in-county acute trusts), *but where a high proportion of patients are discharged with no further care required.*
- The 111 service has seen an average increase in call volume of around 485 patients per month.

- Emergency admission data indicates that across Dorset, on average there are 375 more admissions per month in 2014/15 that in 2013/14, with the majority of these patients admitted through the emergency Departments.
- Nearly two thirds of people admitted to hospital are over 65. In Dorset the latest figures show that almost 55% of all adults admitted via A&E were over 65.

  (Dorset Urgent and Emergency Care Strategy 2014-16)

Within the overall Better Together programme the Better Care funding will be used to support two key elements of **responding to need** especially through the Urgent and emergency Care Strategy and **integrating service delivery** through the use of new commissioning arrangements and pooled budgets and implementing integrated locality teams.

b) What difference will this make to patient and service user outcomes?

The aims and objectives of the integrated system for Dorset is a whole system approach for adult care and health, resulting in improved health and social outcomes for residents, and greater personalised support for individuals and their families, in particular initially the frail elderly and people with long term conditions.

The Better Together programme has put together slides on 'What it will mean for you?' These are attached in the related documentation.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The three programmes of work, Better Together, Urgent Emergency Care and Clinical Services Review will need to achieve financial sustainability for the health and social care system by addressing the fragmented nature of some patient or service user experience of help and by meeting current needs and projected demographic disease trends.

The Better Together programme was developed in 2013 as a result of a successful partnership bid for the Transformation Challenge Award via the DCLG. It was awarded £750,000 and match funded by the CCG and three local authorities with a further £1Million. During 2013 the partnership also secured an additional £800,000 funding from Health Education Wessex to develop local workforce planning and capacity. The Better Together programme has therefore had a non-recurring transformation budget of £2.5Million to support integrated work of both Dorset Health and Wellbeing Board and Bournemouth and Poole Health and Wellbeing Board.

The Better Together programme has developed change initiatives looking at: shared commissioning, workforce planning, shared information and communication technology, developing locality teams, expanding early help networks and finally collective approaches to supporting carers. The business plan outlines these in more detail but expected changes will include:

- Shared Commissioning Framework and Market Position Statement across the sector
- Sector wide workforce plan and cultural change programme with front-line teams promoting person-centred working
- Integrated health and social care summary record and information governance arrangements to support joint working
- Integrated locality teams across Bournemouth, Poole and Dorset providing care co-ordination and care-finding functions
- Developing links between community and voluntary services with statutory services especially new locality teams and enhancing local capacity and networks
- Shared service delivery across Bournemouth, Poole and Dorset local authorities
- Integrating strategic work with Carers especially over new Care Act 2014 requirement yet maintaining locally developed networks.

The Better Care funding will be used in the future (2015/16) especially to implement the new locality team model with enhanced care-finding capabilities. This also links to the national conditions. The protecting social care element of the fund will enable continuation of early help and carer support which will play a critical role in reducing the number of emergency admissions. The work around pooled budgets for the BCF is part of the shared commissioning programme as principles of risk sharing are developed across other areas of intervention.

The need to support people to retain independence is recognised by the Health and Wellbeing Boards especially the impact this can have on the demand for services. There is support for the work under the Disabled Facilities Grants (DFG) to help keep people in their own homes and the need to use telecare and telehealth to support self-care. Dorset, Poole and Bournemouth will be establishing a joint contract for community equipment services which will form part of the wider BCF pooled budget.

Dorset County Council is leading a partnership with the District Councils and local health partners to commission an integrated accessible homes service. The DFG element of the BCF will be pooled from year two with other funding streams from the Districts, County Council and CCG to pull together a range of currently separate interventions into a person's home. This includes major adaptations, telecare, centres for independent living, home improvements and use of a trusted assessor role for occupational therapy. These initiatives will support the Better Together and BCF outcomes and contribute to a reduction in those admissions where unsuitable housing or support in the home is a contributory factor.

The Urgent and Emergency Care Strategy work has been the source for many of the priority schemes identified in the BCF submission for the short to medium term.

The themes included in the strategy are:
- demand and prevention, promoting pro-active management and self-help, efficiency in the continuum of care, use of technology and reviewing ambulatory care
- improving access and information to the public
- focussing work on frail and complex patients, promoting person centred care including mental health services and providing care closer to home
- improving patient flow such as developing a new pathway for frail older people and improving efficiency around discharge planning

The Clinical Services Review will be drawing on the work of the Better Together Programme and Urgent and Emergency Strategy but will also focus on clinical interventions across the acute and community health services with a view to achieving a clinically and financially viable system. The work of the review will take place during 2014/15 and 2015/16 and therefore will inform and provide the mechanism for the required shift of resources around the health and social care system.

The main high level changes expected within the next four to five years are as follows:

Current (2014/15)	Expected (2019/20)
• Partially integrated health and social care teams in mental health and learning disability, with some examples of locality working for older people	• Integrated locality teams across Bournemouth, Poole and Dorset with care co-ordination and extended hours in place
• Challenging sustainability issues for the three local acute hospitals and community health providers.	• Completion of Clinical Services Review with reconfigured modern and clinically sustainable services.
• Numerous ICT systems with low levels of inter-operability making real time information availability difficult.	• Integrated health and social care record improving practice on admission avoidance and discharge planning.
• A significant number of small scale schemes which do not fit together to give a coherent urgent and emergency care response and facilitate prompt discharges from hospital	• Expansion of reablement and rehabilitation capacity supported by a range of new services which assess people in their homes rather than hospital and extend the availability of intensive support out of daytime hours
• Good range of community and voluntary services but they are not necessarily linked to the statutory services making it harder to put in place full discharge planning or identifying those who may need help at an early stage.	• Early Help programme will work closely with the development integrated locality teams to widen the range of supports as part of care co-ordination.
• Access to information and support especially for people who fund their own care or are fairly independent is variable.	• New information and advice service My Life My Care will be fully operational supported by a new range of services aimed at short-term interventions to enable people to plan effectively for their own support and care needs. The focus will be on

	personalised support across agencies, which meets the new Care Act requirements.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

All parties recognise that without change the increasing demands placed on the 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 especially to local authorities.

Funding reductions and Government initiatives such as the Better Care Fund aim to re-model services and funding streams, this creates stress and shortage in particular areas which cannot be addressed by individual organisations – they require change across the system

The system itself needs to be re-designed, focusing on a coherent approach across all service providers or agencies. The eight principal health and care organisations will work together as the Dorset-area Partnership to deliver a strategic programme of change: the Better Together Programme, with the key aims of:

- Managing long-term conditions, especially those amongst the increasingly large cohort of older people living in, and migrating to, the Dorset area
- Reducing the demand (need) for high cost care (acute hospital interventions and long-term residential and nursing care)
- Enabling much more care to be delivered locally and enabling people to live independently for as long as possible

In assessing the high impact schemes that should be prioritised as part of the BCF plan the Better Together Programme board and Urgent Care Board have considered the following evidence:

- Detailed locally CCG commissioned analysis by the King's Fund and Oak Group
- Learning from being one of the participating partnerships in the Public Service Transformation Network, most notably the North West London Whole Systems Integrated Care Toolkit.
- Best practice recommendations from the King's Fund "Making best use of the Better Care Fund"
- Participating in the Local Government Association "Use of Resources" benchmarking exercise especially covering reablement and rehabilitation models across Bournemouth, Poole and Dorset (July 2013)
- Emergency Care Intensive Support Team local system initial findings and analysis

(September 2014)

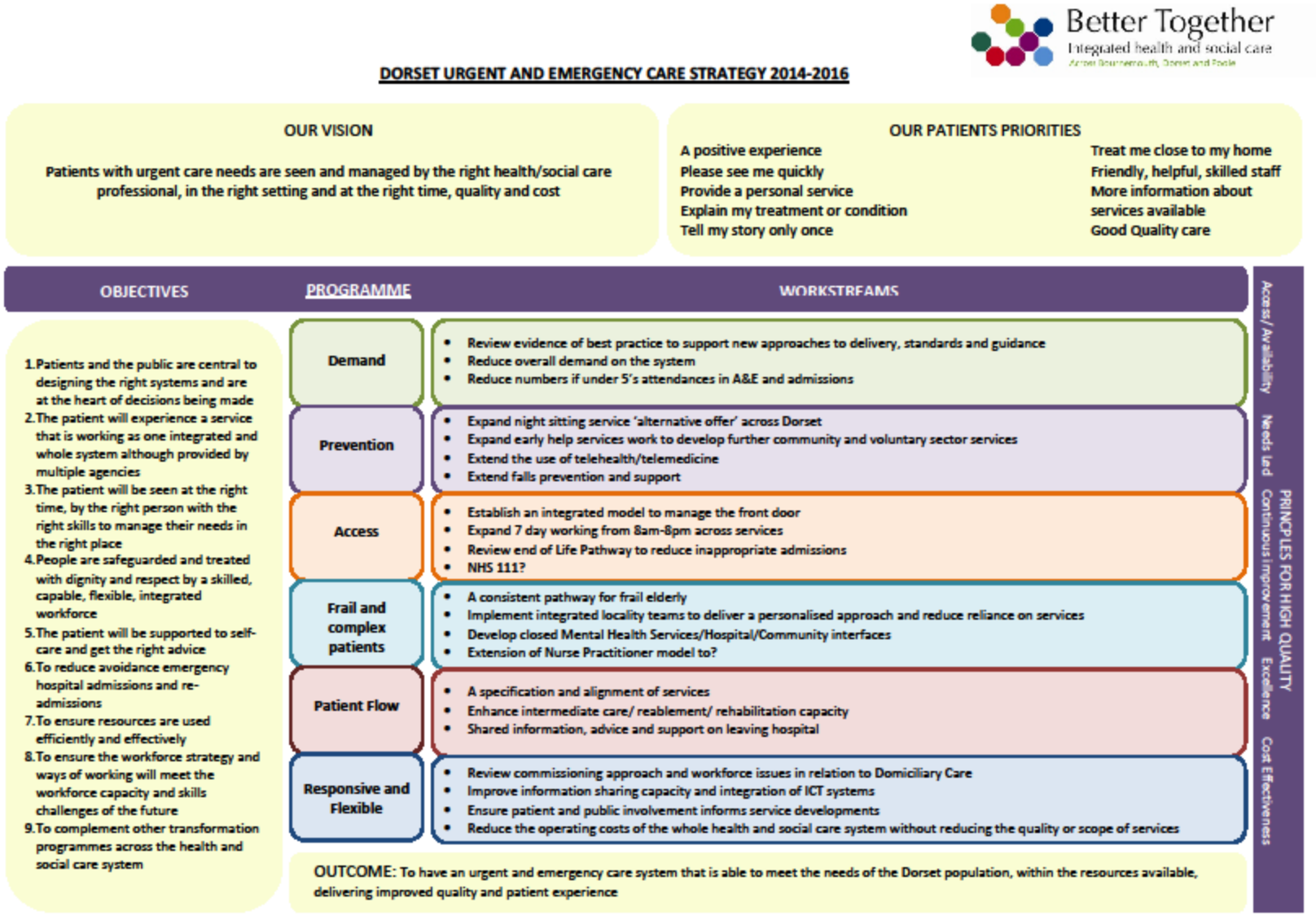
- The Francis enquiry report (2013)
- NHS Outcomes Framework 2014/15 sets out high level national outcomes and is divided into five domains which have specific indicators covering the scope of the BCF initiatives
- Sir Brian Keogh (Transforming Urgent Care Services in England, Urgent and emergency Care Review End of Phase 1) 2013. Blueprint for Urgent and Emergency Care.
- Dorset and also the Bournemouth and Poole Health and Wellbeing Strategies for 2012-2016 which set out key priorities based on the Joint Strategic Needs analysis. These highlight the broader determinants of health and wellbeing
    - Reducing inequalities
    - Promoting healthy life styles and preventing ill health
    - Joint work on early intervention
    - Reducing circulatory disease
    - Reducing harms caused by diabetes
    - Improving care for people with dementia
- Local analysis from the South Western Ambulance Services.

One of the key workstreams, to date, of the Better Together Programme is the development of integrated locality teams for frail older people and people with long term conditions. The programme has developed a draft specification ready to commission the new model for 2015. A risk stratification approach will be used to inform the case finding and early identification role of the proposed teams. Through the use of the risk stratification tool the locality team will have a good understanding of the local population and will use data to identify individuals likely to need services. A business case is currently being developed for October based on modelling of demand and population needs, supported by the current costs of the services and factoring in assumptions of extended hours and care co-ordination. The Better Together Programme is part of the Public Service Transformation Network and has drawn on expertise especially from the North West London whole systems integrated care toolkit.

The Urgent and Emergency Care Frail elderly Pathway work and Urgent and Emergency Care Strategy has drawn on analysis commissioned by the CCG during 2013/14 from the King's Fund and Oak Group. The review included a large point prevalence study of admissions across acute medicine, older people's medicine and the community hospitals. The review findings identified that:

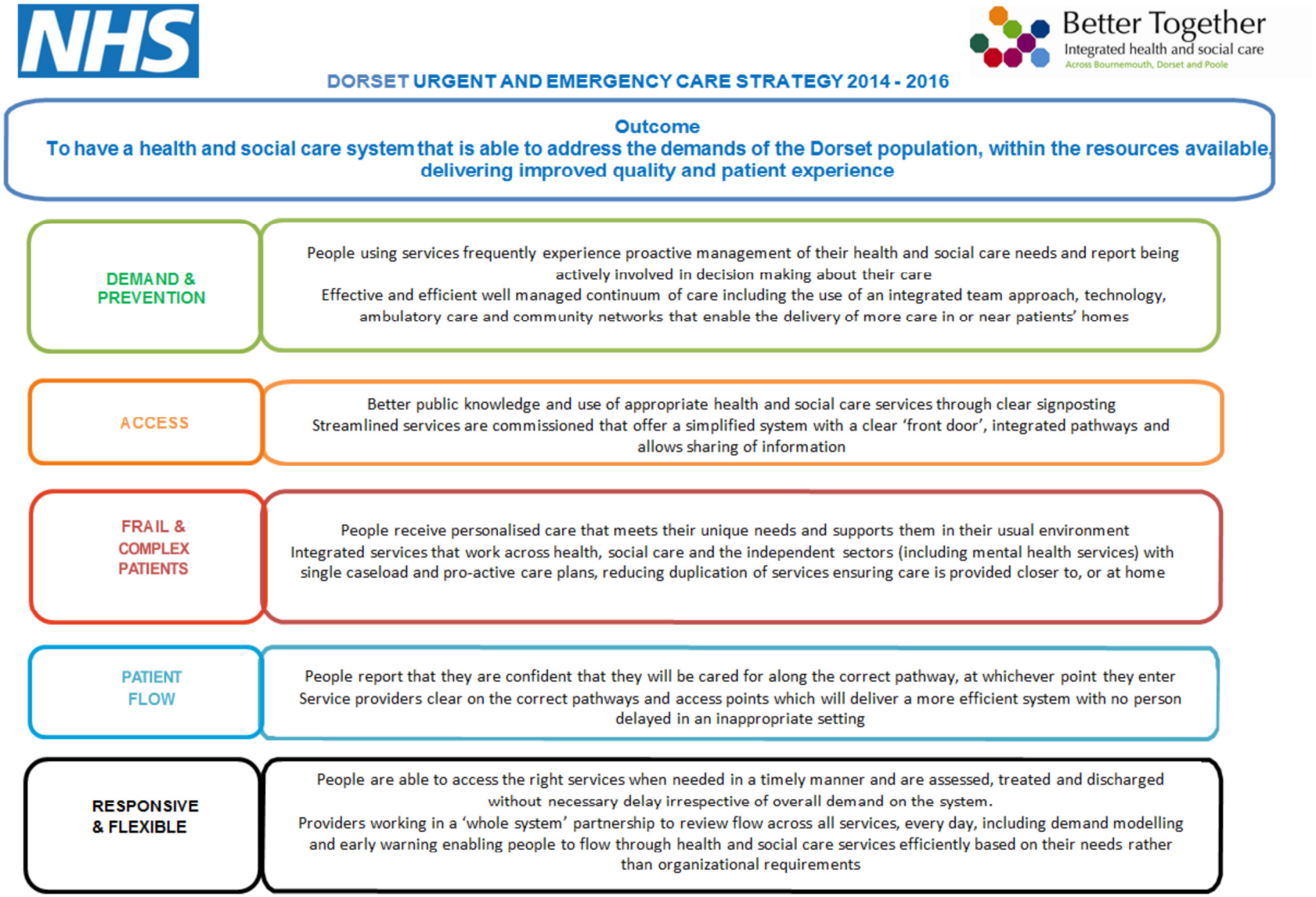
- The current system is not designed to cater for the current activity levels and is unsustainable in the longer term.
- There is no single indentifiable cause for the continuing increasing levels in demand activity (so there will be no single solution).
- Different services are available, depending on geographical location or provider, rather than patient need.
- The need to develop a 'proactive management of the frail elderly'

In 2013/14, the Dorset CCG invested in the region of £4M in service enhancements or developments that were anticipated to deliver in-year improvements and help alleviate seasonal pressures. Proposals were invited from all stakeholder organisations and encouraged partnership working. Projects were then agreed and established around four hubs – Poole, Bournemouth, Dorchester and South Western Ambulance NHS Foundation Trust. Each of these projects was subject to an evaluation to determine their effectiveness against key performance indicators. As a result of the evaluation of these projects has helped support the further development of the Urgent and Emergency Care Strategy work programmes and Better Care Fund schemes.


Better Together
Integrated health and social care
DORSET URGENT AND EMERGENCY CARE STRATEGY 2014-2016
OUR VISION
Patients with urgent care needs are seen and managed by the right health/social care professional, in the right setting and at the right time, quality and cost
OUR PATIENTS PRIORITIES
A positive experience
Please see me quickly
Provide a personal service
Explain my treatment or condition
Tell my story only once
Treat me close to my home
Friendly, helpful, skilled staff
More information about services available
Good Quality care
OBJECTIVES
1.Patients and the public are central to designing the right systems and are at the heart of decisions being made
2.The patient will experience a service that is working as one integrated and whole system although provided by multiple agencies
3.The patient will be seen at the right time, by the right person with the right skills to manage their needs in the right place
4.People are safeguarded and treated with dignity and respect by a skilled, capable, flexible, integrated workforce
5.The patient will be supported to self-care and get the right advice
6.To reduce avoidance emergency hospital admissions and re-admissions
7.To ensure resources are used efficiently and effectively
8.To ensure the workforce strategy and ways of working will meet the workforce capacity and skills challenges of the future
9.To complement other transformation programmes across the health and social care system
PROGRAMME
WORKSTREAMS
Demand
Review evidence of best practice to support new approaches to delivery, standards and guidance
Reduce overall demand on the system
Reduce numbers if under 5's attendances in A&E and admissions
Prevention
Expand night sitting service 'alternative offer' across Dorset
Expand early help services work to develop further community and voluntary sector services
Extend the use of telehealth/telemedicine
Extend falls prevention and support
Access
Establish an integrated model to manage the front door
Expand 7 day working from 8am-8pm across services
Review end of Life Pathway to reduce inappropriate admissions
NHS 111?
Frail and complex patients
A consistent pathway for frail elderly
Implement integrated locality teams to deliver a personalised approach and reduce reliance on services
Develop closed Mental Health Services/Hospital/Community interfaces
Extension of Nurse Practitioner model to?
Patient Flow
A specification and alignment of services
Enhance intermediate care/ reablement/ rehabilitation capacity
Shared information, advice and support on leaving hospital
Responsive and Flexible
Review commissioning approach and workforce issues in relation to Domiciliary Care
Improve information sharing capacity and integration of ICT systems
Ensure patient and public involvement informs service developments
Reduce the operating costs of the whole health and social care system without reducing the quality or scope of services
OUTCOME: To have an urgent and emergency care system that is able to meet the needs of the Dorset population, within the resources available, delivering improved quality and patient experience
PRINCIPLES FOR HIGH QUALITY
Access/ Availability
Needs Led
Continuous Improvement
Excellence
Cost Effectiveness

From a person-centred outcome focussed, co-ordinated service the areas of different include:

The Dorset Urgent and Emergency Care Strategy 2014-16 has also summarised outcomes in the following schematic:



4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Work is underway to implement the projects and initiatives to a point where benefits will be fully described, costed and then realised. This will enable us to reflect these assumptions in Part 2 of this template and mitigate the risks highlighted here and in the Business Plan.

The core components of the new system will be:

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) Developing whole-systems outcome-based commissioning to reflect best value.

c) Developing 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 diagram below summarises the 7 direct workstreams of the Better Together programme which sits alongside the work of the Urgent Care Board / Dorset System Resilience Group. The System Resilience Group will also oversee the implementation of the Dorset Operational and Resilience Capacity Plan and providers' ability to deliver required operational standards. Recently a whole system diagnostic is being undertaken by (ECIST) Emergency Care Intensive Support Team. The initiatives which this work will produce are:

- Development of a responsive dashboard that can be segmented by 'sector'
- Action focussed Emergency Admission Taskforce Cluster Groups
- West Midlands Regional Capacity Team presentation to System Partners
- Independent review of NHS 111

The key strands of work related to the BCF plan are:

Strand	Lead implementation body
i. Setting up the BCF pooled budget and development of further pooling of resources	Directors and Better Together Finance Group
ii. Implementing case finding and care co-ordination	System Resilience Group (short term scheme 1 areas) Better Together Programme (longer term establishment of integrated locality teams)
iii. Emergency department attendance initiatives scheme 2	System Resilience Group
iv. Ambulance conveyance reduction scheme 3	System Resilience Group
v. In-reach into care homes scheme 4 implementation	System Resilience Group
vi. Hospital at home service expansion	System Resilience Group
vii. Care overnight service coverage expansion	System Resilience Group (with support for Better Together Commissioning programme)
viii. Expansion and co-ordination of self- help and early help initiatives	Better Together Programme workstream
ix. Evaluation and monitoring of schemes impacts through shared dashboard reporting	System Resilience Group / Better Together Programme
x. Developing risk stratification and analytics through newly commissioned support	Better Together Programme
xi. Workforce planning to support BCF initiatives	Better Together Programme
xii. NHS number compliance and data sharing in preparation for an integrated health and social care summary record	Better Together ICT Workstream (ICT Development Fund bid)
xiii. Service reconfiguration impacts with providers and future commissioning approaches to secure financial and clinical viability.	Clinical Services Review (shared structures with Better Together

The System Resilience Group (previously Urgent Care board) will be supported by three cluster representatives across the agencies based around the 3 main acute hospitals for Dorset, namely Dorset County Hospital, Poole General and Royal Bournemouth & Christchurch. The cluster groups will be both responsible for improving local practice within existing services, plus implementing the new schemes identified in the BCF plan. They will have the expert help of ECIST to identify fast track changes.

The Better Together Finance Group is made up of Director level finance leads for each organisation and will be working closely with Commissioning Directors to implement the planned BCF pooled budget. The Better Together Programme as a whole will be looking to a more ambitious set of proposals including the addition of resources for integrated locality (multi-disciplinary) teams. The timeframes for the current BCF did not align with local plans to include for 19th September. The pooled budget work will also include exploring which commissioning arrangements best suit local partnerships and circumstances.

The key high level milestones for the Better Care Fund plan are:

Locality teams

Business care approval	October 2014
Contracting framework and model for commissioning	November 2014
Provider proposals evaluated	April 2015
Contract award start of mobilisation	May 2015

Clinical Services Review

Procure external partner	October 2014
Needs analysis, care model research	March 2015
Develop blueprint	April 2015
Consultation	November 2015
Implementation	January 2016

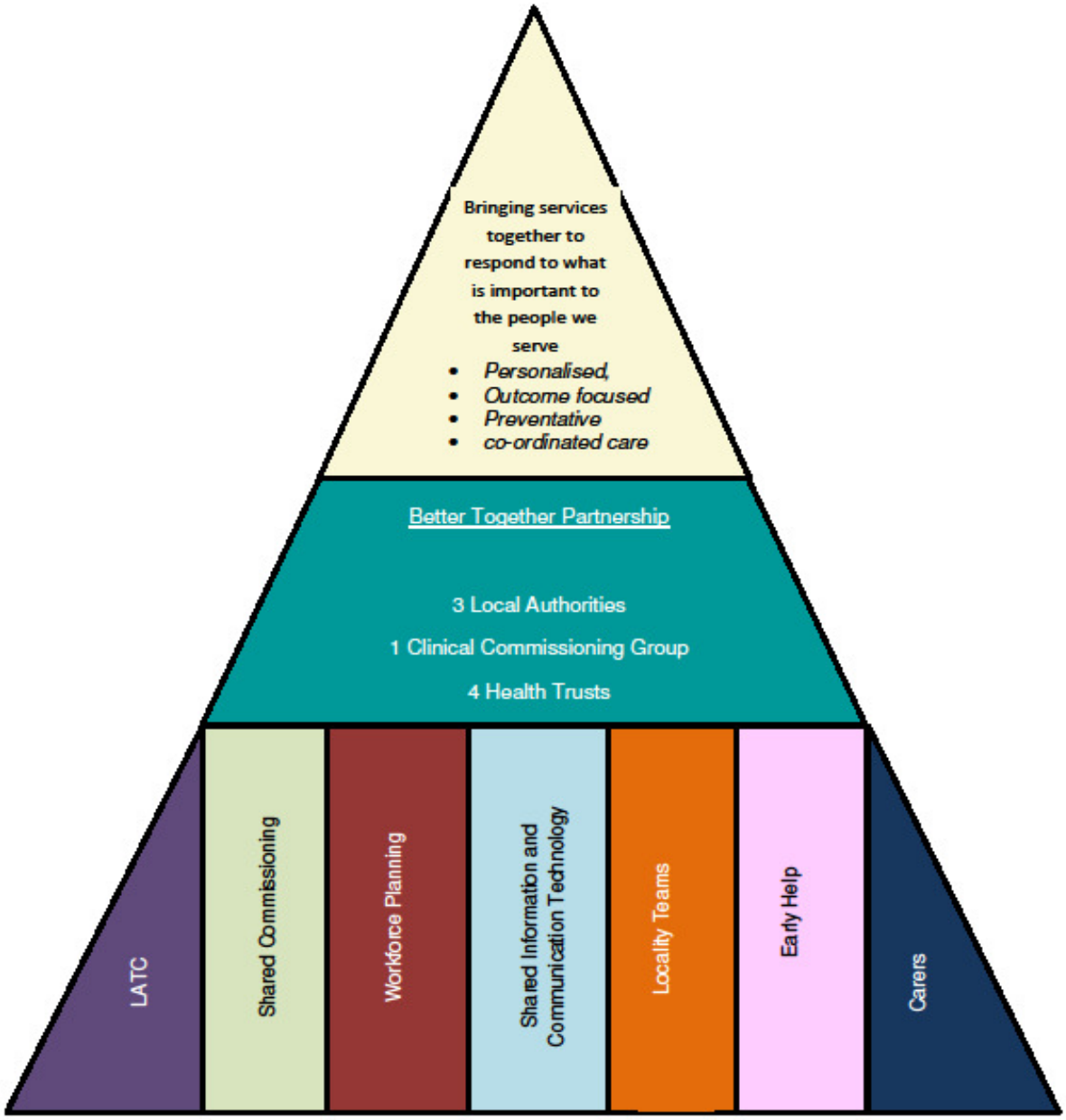
Urgent and Emergency Care

Emergency Care Intensive Support Team Review concluded	October 2014
Roll-out night sitting service (hospital at home)	March 2015
Expand Early Help Red Cross Services (assisted discharge)	December 2014

Information sharing and integrated ICT systems

ICT Development Fund bid (outcome)	October 2014
Information Sharing Protocols updated	February 2015
Integrated health and social care record roll-out starts	October 2015

Integrating Social Care in Bournemouth, Poole and Dorset



b) Please articulate the overarching governance arrangements for integrated care locally

The main governing body for the programme is the Better Together Programme board, comprised of senior representatives (normally direct reports to their respective CEOs) of the eight principal agencies. This board directs, co-ordinates and moderates the activities of a number of subsidiary boards (for example the Shared ICT project board) while controlling some larger projects directly. It has the following characteristics:

- The Better Together Programme Board is placed at the heart of the programme's governance structure.
- The board receives its authority from the Sponsoring Board which represents the partner organisations through their executives.
- Political leadership and influence exists through the Sponsor Board, the Health & Wellbeing Boards and Local Authority Cabinets, 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, the Finance Sub-Group, and the Workforce and Organisational Development Group.

A series of Project Boards oversee the development and implementation the projects that make up the Better Together Programme. Similar arrangements will apply to the Clinical Services Review and System Resilience Group. Shared boards and groups will be pursued to maximise capacity.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The oversight of the programme will include:

- Shared financial planning including pooling budgets to support whole system working.
- Use of 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.

- 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. The Finance Sub-Group to the Better Together Programme has a role in advising both the Programme Board and Sponsor Board, it is made up of director level Finance Leads for each agency.
- Investment in locality and community initiatives which seek to promote self help and divert demand.

Leadership across the new system will be developed to drive the cultural change that is needed within and across agencies. This work will be supported by the LGA Systems Leadership Programme. It 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.

Front-line cultural change for multi-agency teams will get change working at the leadership and front-line level based on putting the individual first and practising the principles in the vision. Front-line teams will identify barriers to progress which will be raised as issues for the leadership or sponsor group.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Case finding and care co-ordination
2	Emergency Department attendance avoidance
3	Ambulance service conveyance reduction
4	In-reach into care homes
5	Hospital at Home
6	Care Overnight

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

Severity	Likelihood					
	Impossible 0	Rare 1	Unlikely 2	Moderate 3	Likely 4	Certain 5
Prevented Harm – 0	0	1	2	3	4	5
No Harm (Near Miss) – 0	0	1	2	3	4	5
Minor -1	0	1	2	3	4	5
Serious – 2	0	2	4	6	8	10
Major – 3	0	3	6	9	12	15
Fatality – 4	0	4	8	12	16	20
Multiple Fatalities -5	0	5	10	15	20	25

KEY:

Low Risk Green 0-5	Moderate Risk Yellow 6-8	Significant Risk Orange 9-12	High Risk Red 15-25

	There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
1	Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector	2	4 3.5% reduction in admissions would result in a resource shift in the region of £4.1M.	Moderate	Our current plans are based on the agreed Better Together Strategy The development of our plans for 2014/15 and 2015/16 will be conducted from a whole system perspective
2	A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance	2	3	Moderate	The programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans.

	targets for 2015/16 onwards are unachievable.				
3	Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality	3	3	Significant	Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development Support from Health Education Wessex
4	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	4	4	High	We have modelled our assumptions using a range of available data including metrics from other localities and support from the National Collaborative. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.
5	Lack of engagement internally and externally, including with primary care	2	3	Moderate	Early engagement of representatives from relevant NHS and local authority bodies, including NHS England; securing effective patient representation by making use of local authority experts by experience, existing patient groups, foundation

					trust members and the council of governors; developing a comprehensive communication and engagement plan
6	Lack of agreement in relation to priorities and integration of services	2	3	Moderate	Provide a stable platform from which stakeholders can be fully informed; seek to reflect stakeholder views into design and implementation discussions
7	The savings and efficiencies needed to deliver transformational change may not materialise	4	4	High	Plans are fully costed and likely efficiencies estimated; close monitoring of progress post implementation
8	The absence of clear arrangements for under- or over-delivery	2	3	Moderate	Clear local processes set out in signed agreement, including that for disagreement resolution
9	Insufficiently detailed signed agreement	2	2	Low	Rules on data and performance management agreed up front
10	The speed of change required	4	3	Significant	Undertaking patient-based clinical audit providing detailed evidence to support plans; grasping a 'big bang' approach to changes in services, avoiding double-running costs
11	Clarity of roles and responsibilities	2	3	Low	Who is allowed to decide what and where delegated

					authority is best placed; defined process for decision-making with appropriate schemes of delegation
12	Failure to deliver change on a sustainable basis	3	3	Significant	Securing effective patient representation by making use of local authority experts by experience, existing patient groups, foundation trust members and the council of governors; development of detailed business cases and service specifications to support proposals; flexibility to move funds as needed
13	Financial failure of an NHS provider	2	5	Significant	Commitment of organisations to work together and understand whole-system spend and saving requirements and monitor change; plans developed as to how beds will be closed without destabilising local acute providers
14	Ineffective governance arrangements	1	3	Low	Thinking through: • The terms of reference of the HWB • The appropriateness of a formal committee to the HWB • Any amendments

					that might be needed to the business rules of the HWB, CCG and local authority
15	Failure to understand financial flows particularly in relation to savings, reinvestment, benefits and risks	3	4	High	Commitment of organisations to work together and understand whole-system spend and saving requirements; financial impact on individual organisations as well as for the health economy as a whole
16	Monitoring of work carried out under the fund will need to be resourced to be effective	1	3	Low	Resources discussed and jointly agreed/provided by health and social care
17	Existing workforce is unable to deliver the projects needed to make the vision a reality	3	4	High	Investment in infrastructure and workforce to support wider organisational development. Support of Health Education Wessex
18	Reputational damage of failure to deliver	2	2	Low	Development of proposals involves rigorous consultation and engagement, review and scrutiny
19	Impact of the Care Act 2014 results in significant cost pressures that cannot currently be quantified	4	4 Estimated costs significantly higher than BCF allocation	High	Plans developed for the introduction of the Care Act; senior officer appointed; impact monitored

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The CCG currently contracts £117m in Emergency Admissions across its key providers, with £107m represented by the 3 Dorset Acute providers. 3.5% reduction in cost would equate to circa £4.1m and therefore it is the CCGs intention to reduce the contract values with its key providers by this value, which will be held in a contingency fund, should the ambition identified within the Better Care Fund not be delivered this fund will be released back to the Acute's in direct proportion to the level of delivery, up to the maximum contingency value held.

It is the intention to hold this approach on an individual acute basis, which recognises the potential differences in delivery that could be experienced across areas, resulting from the different service change approaches being undertaken across the geographical area.

It is recognised that in order for the Acute providers to sign up to the Better Care Fund plan that consideration will need to be taken as to the actual costs that can be removed from the system as opposed to a pure payment by results basis and also recognises that the contracts in 2015/16 will need to reflect the growth in activity experienced in 2014/15, for this to work as only a marginal cost increase would have been incurred in relation to the 2014/15 activity level increases.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The BCF plan aligns with the following other initiatives:

- Better Together programme
- Primary care Direct enhanced services to reduce emergency admissions;
- Primary care Older people plan to reduce emergency admissions for people 75 and over;
- NHS Providers CQUINs to reduce reliance on urgent care services
- Urgent Care Board priority schemes and work programme including 7 day services.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The 2 year operating plan and 5 year strategic plan sets the ambition that in five years' time you will see:

- Integrated health and social care services designed around the individual;

- Financially and clinically sustainable services delivered in an innovative way;
- Focus on services not institutions.

This aligns with the BCF plan in the following ways:

- Delivering care closer to home and reducing reliance on hospital services;
- Delivering integrated health and social care services
- Establishing through the Better Together programme, the Urgent Care Board and the Clinical Services Reviews a blue print for NHS and Social Care Services in Dorset;
- Establishing a clinically and financially viable health and social care system;
- Person centred care.

c) Please describe how your BCF plans align with your plans for primary co-commissioning
    - For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG vision for co-commissioning primary care is to develop a primary care strategy to secure the future of primary care in Dorset as part of our plan to achieve a sustainable and effective care delivery system. To achieve this Dorset CCG seeks to work with NHS England to ensure co-commissioning can achieve local engagement of Member practices to achieve our commissioning intentions to support people in Dorset to lead healthier lives. We wish to work with NHS England to establish the right co-commissioning relationships to enable this.

There is strong alignment with the aspirations of co-commissioning plan and the BCF, eg;

Plans to co-commission primary care are being developed to support our 3 key transformation programmes of the CCG which are:

- Urgent care -working in partnership across primary, secondary and community care services, will deliver enhanced urgent care with an emphasis on prevention of avoidable admission.
- Clinical services review -designed to review clinical services across Dorset, with the aim of developing a modern model of clinically sustainable, high quality health services (including workforce) across Dorset.
- Better Together –which aims to transform health and social care across Dorset to enable and deliver a sustainable improvements in health and care outcomes through person centred, outcomes focussed, preventative, co-ordinated care.

These plans have already been endorsed by the CCG Governing Body.

Co-commissioning in Dorset will be used to support delivery of the ambitions set out in the Dorset Better Together Programme. Outcomes for patients, their carers and the health system resulting from this will include:

- total system costs reduction;
- people have independence, choice and control;
- resources are used efficiently and effectively;

- people are better able to help themselves;
- joint resource planning responds to need and local people's priorities;
- people experience better outcomes through safe, co-ordinated quality care;
- informal support maximised caring for people at home;
- a capable, sustainable motivated workforce.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Across the Dorset area we recognise that without change being made to the health and social care system, the increasing demands placed on our services as a result of financial pressure and demographic change will make those services unsustainable. Single agencies may be able to address waste in their own organisation through tactical re-design and continuous improvement initiatives, but to reduce the inefficiency and duplication that exists across organisations requires a transformational approach across the whole system. Our approach therefore to protecting social services is to utilise integration and early intervention to reshape activity and funding levels across the sector.

The plans outlined within the Better Care Fund are intrinsically linked to the Dorset-area Partnership's activity around transformation challenge "Better Together" and are focused towards expansion in the use of early intervention and reabling approaches to reduce on-going demand across the health and social care system. Activities within adult social care will become increasingly focused towards recovery, rehabilitation and reablement but with a clear recognition of the need for long term support for some customers in the most appropriate setting through the effective supply of residential and nursing provision.

The local health and social care agencies have worked collaboratively to respond to the need to protect social care services not only in their own right but to the benefit of the whole health and social care system.

For 2014/15 funding arrangements are in place as described within this template and business plan which can provide a high level of confidence in ensuring social care is protected. This reflects the arrangements previously in place using Section 256 Social Care Grant funding.

For 2015/16 the scale of change required across a significant number of services to release funds from health provision will prove challenging within the existing timeframe. This is set against significant budget reductions for Dorset, Bournemouth and Poole local authorities for this period. All three Councils have challenges in the 2015/16 budget and therefore funding in social care. Similar pressures apply to the District and Borough Councils of Dorset. Currently it is our intention that there would be more resourcing of adult social care initiatives from the pooled budgets in 2015/16 but this is dependent on achieving significant transformational change including the use of expenditure and on acute services. (see Section 2d). The unexpected level of pressure in secondary care has further exacerbated the financial challenge in the local health economy.

The impacts of the Care Act are yet to be fully assessed but will form part of the local preparations for change. The level of additional national resourcing for these changes raises the risk to these extra duties and demands being fully funded locally. Dorset, Bournemouth and Poole are likely to have a higher than national average, of people funding their own care which therefore increases this risk further.

In summary for 2015/16 the combination of these factors and reduced financial capacity to offset these, have increased the risk, since the April BCF submission, to the premise that social care can be protected. We are putting in place the governance and management mechanisms to manage the current risk and an additional mitigation has been provided by the CCG in recognition of these impacts. Further work will be undertaken transparently and jointly between partners as part of our financial planning. Given the range of risks identified above and the national uncertainties about Care Act funding, there is still a possibility that the local authorities may need to find further savings in social care which could have an impact on the social care and health system.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Eligibility criteria for social care services will remain unchanged at substantial.

Please see text in 7a(ii). The development of BCF scheme 1 and 2 are aiming to impact on demand that leads to hospital admissions. A potential secondary or indirect impact is to reduce the flow into long term health and social care intervention and call on social care high cost crisis interventions. However the increasing requirement for resourcing care at home will probably offset these benefits.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

For Dorset £1.065M, Bournemouth £0.471M, Poole £0.398M, which will be passported to the local authority towards the cost of Care Act 2014 implementation.

£15.842M across Bournemouth, Poole and Dorset from Section 256 Social Care funding grant has been passed to the local authorities and forms part of the pooled budget

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Local authorities have each set up Care Act Implementation Groups are working up detailed plans, utilising the non-recurring funding provided.

These groups are working collectively with ADASS and local groups (including and the CCN Care Bill Implementation Group (CBIG) and its Finance Group) to fully assess the impact of the Care Act and what implications there are for service delivery. Models such as the Lincolnshire model and Surrey Model have been utilised to arrive at possible financial consequences of this legislation.

The Local Authorities Care Act Implementation Groups will continue to evolve their working assumptions as national data and models improve (Surrey Model is now on its third iteration w/c 15th September 2014).

The areas being considered include:

- Costs of Care Act implementation (commissioning/provider resources).
- Costs associated with carers (to be funded through identified Carer Resources).
- Increased care/package costs as a result of implementing the national minimum eligibility threshold at substantial.

Specifically the Care Act Implementation Teams are targeting:

Personalisation
Create greater incentives for employment for local disabled adults in residential care

Carers
Putting carers on a par with users for assessment. Introduce the new duty to provide support for carers

Information advice and support
Linking LA information portals to national portal. Provision of advice and support to access and plan care, including rights to advocacy. Which links to the Pan Dorset 'My Life My Care' [https://www.mylifemycare.com] project.

Quality
Implementing Provider quality profiles

Safe-guarding
Implement statutory Safeguarding Adults Boards

Assessment & eligibility
Implement the national minimum eligibility threshold at substantial. Ensuring councils provide continuity of care for people moving into their areas until reassessment. Clarify responsibility for assessment and provision of social care in prisons. This will also include a review of the assessment and support planning tools and links to the Better Together – Integrated Locality Teams project

Veterans
Disregard of armed forces GIPs from financial assessment

Law reform
Training social care staff in the new legal framework, which should provide savings from staff time and reduced complaints and litigation

Detailed financial modelling and analysis is currently being undertaken to calculate the anticipated additional costs arising from implementation of the Care Act, both in relation to the social care reforms to be implemented from April 2015 and the funding reforms that are due to come into effect in April 2016.

Initial modelling suggests that the funding earmarked in the BCF for implementation of the Care Act may not be sufficient to meet the anticipated full costs of Part One of the Care Act, the social care reforms and the related new and extended duties.

v) Please specify the level of resource that will be dedicated to carer-specific support

The CCG has made an allocation of £1M for carer specific services across Bournemouth, Poole and Dorset. The Better Together Programme has a Carer workstream which will be co-ordinating the strategic cross-agency work. This includes developing a three local authority wide strategy for 2015/16 and to review priorities for this financial year from the existing plans. The review will need to include expenditure on respite or short-term breaks in community care and continuing health care. The carers funding will form part of the BCF pooled budget.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The costs of implementation however significantly exceeds the passported allocations.

The shortfall from the original plan is in excess of £6M. This reflects the shift in government policy and recent emerging financial pressures locally across all the agencies. The CCG has recognised these pressures and will be working with the Health and Wellbeing Boards to mitigate these impacts where possible.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The principle of developing seven day services is already supported by the partnership in order to ensure that the quality of medical advice in the community to support hospital discharge or avoid admission is consistent and of sufficiently high standard to be effective. This will also apply to out of hours arrangements. It is recognised that medical support to the health and social care community services is essential and proposals will explore consultant medical cover into the community. The national plan that GP working time will be extended in the revised GP contracts from April 2014 with a named GP for everyone over 75 years old, will also impact during this 2-3 year period. In the meantime we intend to review the current 24/7 medical support arrangements to community services which is provided through mixed arrangements with GPs contracted by NHS England through Local Area Terms for Monday-Friday 8:00am – 6:30pm, and at all other times contracted by Dorset CCG via South Western Ambulance Service Trust (SWAST).

The Urgent Care Board has a programme of work to increase seven day multidisciplinary working within the hospitals which includes weekend access to full diagnostics, consultant cover and clinical co-ordination as well as integrated care pathways into the community through virtual ward models. Specific social care capacity issues include increasing Social Work cover in hospital and at weekends linked to enhanced access to care packages across the Pan Dorset area. This will require further work with independent sector providers to develop the market for care at extended times. Redesigning assessment and care planning pathways will be part of this work. Dorset County Hospital has been chosen as one of 13 pilot sites nationally to become an early adopter for 7 day services to support discharge

In its review of services the Better Together Programme will consider and assess the benefits of jointly commissioning Integrated Health and Social Care teams which include 7 days a week coverage with an initial focus on older people who are frail and people with long term conditions. There is an intention to look at a business case for investment in 2015/16 with implementation following this.

Supporting work will be undertaken with HR leaders and staff partnership organisations to consider how staff will approach service delivery. A workforce and organisational development group has been formed to facilitate this work, including plans to commission work to identify the workplace cultural development needed to support leadership and front-line delivery teams in responding to personalised, customer focused care.

Health Education Wessex and the Sector Skills Agency are also partners in helping to support the wider workforce planning work of this programme.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Using the NHS number at the start of the care process is already business as usual for two LAs in Dorset. The third LA is developing its ability to use the NHS number, through the Better Together programme, Dorset and Poole LA have already pledged their full support to Bournemouth to enable population of the NHS number in their adult case management system, and create a consistent pan Dorset approach to sharing records using the NHS number as early as possible in the care process.

All three LA's are committed to working in an integrated way to be able to use the NHS number as part of their day to day business. The local authorities are in progress with the acquisition of a shared assessment and care management system: it is the intention to include ability to utilise NHS numbers within the specification for tender.

We are currently bidding for funds through NHS England to create and integrated health and social care record whereby the NHS Number will be the unique identifier with a requirement for all participating organisations to ensure the patients' records are correctly ascribed an NHS number before they can upload records to the system.

The NHS number has been mandated in Health for some years. All NHS provider organisations in Dorset have worked hard to ensure that the NHS number is traced and quoted on all correspondence between parties. GP's, Community and Mental Health use systems linked directly to the Spine. The Three Acute providers have processes in place to assign NHS numbers to patients when first seen at the earliest opportunity. For example, RBCHFT has a real-time lookup to the Patient Demographic System (PDS) from its Emergency Department system and was one of the first in the country to achieve this. .

Overall Dorset has a good track record of 95%+ use of NHS number with near time and real time tracing of records. Implementation of a shared record will cement the use of the NHS number as the primary identifier across Dorset providing better care and outcomes for patients.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open APIs and Open Standards from newly commissioned systems.

To enable cross-boundary working, we will improve interfaces between systems. We would like to create an ability to aggregate data from different sources into a shared format to allow interpretation and analysis. This will help with planning and monitoring of performance across the services. The intention to provide a whole system overview links to the work of the Health and Wellbeing boards and informing the Joint Strategic Needs Assessment. Improving data quality will help identify gaps or inconsistent or inaccurate records.

We have experience since 2010 in using the Mirth Open Source Integration engine **http://www.mirthcorp.com/products/mirth-connect** to queue and transform messages between parts of the health community in Dorset, based around two hubs.

This is currently being used by Dorset HealthCare to send admission/discharge and ED/MIU notifications between the Acute and community hospitals out to GP practices and community based staff, and to receive and transform pathology results for the RiO Mental Health system.
A separate Mirth TIE is being used internally at Poole Hospital, having replaced a commercial product to meet their internal integration needs. (Dorchester and the Royal Bournemouth both have existing commercial TIEs).

We anticipate building on the experience with Mirth, and using these tools as part of the solution linking existing systems to the shared Dorsetwide record.

In addition, because we have not yet procured the shared record, we plan to consider an open source option for the portal alongside commercial solutions, and we would welcome any collaboration in assessing that option, and assistance in ensuring we achieve a robust assessment between the two. We have been in active dialogue with personnel from the Leeds project (especially comparing notes on patient consent issues), and a significant part of our community already use the same technology as the Hampshire Health Record (commercial from Graphnet).

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Our local NHS Information Governance group now includes social care and links with national best practice solutions/guidance. Membership includes key IG and Data sharing staff across all the partner agencies and will focus upon the key drivers such as the IG Toolkit and Caldicott2. Reviewing current information sharing policy, the consent approach in Dorset, and developing detailed information sharing protocols are a priority for the programme. Workshops are underway to agree a priority plan for the way forward which will include consultation with front line staff. The group directly reports through the existing Better Together governance structure to ensure alignment with the overall programme and needs of the Better Care Fund.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Risk stratification approaches are being used to identify the proportion of the population who will receive case management, have a lead accountable professional and personalised care plans, this is a key design principle of the integrated community teams.

The proportion of those at high risk of hospital admission, and those who will need to have a joint care plan and an accountable lead professional will form part of the Cost

Benefit Analysis model being applied to the future specification of the integrated locality teams.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Risk stratification approaches are being used to identify the proportion of the population who will receive case management, have a lead accountable professional and personalised care plans, this is a key design principle of the integrated community teams. These principles will help improve safeguarding practice with multi-disciplinary teams along with better information sharing through an integrated health and social care record.

The proportion of those at high risk of hospital admission, and those who will need to have a joint care plan and an accountable lead professional will form part of the Cost Benefit Analysis model being applied to the future specification of the integrated locality teams.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

A joint care plan is not in place currently for all individuals at high risk as this will be a key feature for the proposed multi-disciplinary locality teams as part of scheme 1 (care finding / care co-ordination).

2% of anticipatory care care plans have a named GP. Comprehensive coverage is in place in mental health and learning disability integrated teams.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Our vision is to bring services together to respond to what people have told us is most important to them.

The launch event included user and carer representatives to identify the high impact areas of the programme and offer commitments or pledges to contribute as well as identifying potential barriers.

The programme is developing a combined communications and engagement strategy supported by specific engagement and communications plans. Dedicated posts will support this work.

Local workshop events will be used based on the outcomes for the programme with a number of projects being assessed or re-designed to maximise their contributions.

The overall programme will be collating existing feedback across the agencies from the public to test out the proposed benefits and outcomes. Healthwatch will be assisting and will provide baseline data and feedback.

Some of the projects will commission user-led organisations to assist with engagement and design work. Secondary consultation will then take place on proposals for change once they have been formulated.

The programme has a dedicated website on dorsetforyou. The programme includes the development of a new information and advice website which has been developed with Stakeholders and will have a soft launch to provide an opportunity for further review.

The additional elements of the programme arising out of the Better Care Fund requirements will be incorporated into the arrangements above.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The Better Together partnership is made up of 8 agencies including Dorset Healthcare University Foundation Trust, Poole Hospital Foundation Trust, Dorset County Hospital Foundation Trust and Royal Bournemouth and Christchurch Hospitals Foundation Trust. The health providers form part of the Programme Board and Sponsor Board.

ii) primary care providers

Primary care representation is included on the key strategic bodies. These include Health and Wellbeing boards, Better together Sponsors and Programme Board, Urgent care Board and the Clinical Services Review will be CCG led.

The three Emergency Admissions Task Groups have GP representation and the Older Peoples Plan aligns with the BCF proprieties including reference to emergency admissions reductions

iii) social care and providers from the voluntary and community sector

A launch event for the transformation programme was held on 22nd November attended by 150 individuals from a wide range of provider agencies, voluntary sector organisations and carer and user groups. Ongoing engagement with this e-group forms part of the transformation implementation.

Bournemouth, Poole and Dorset local authorities have developed a Market Position

Statement where commissioning intentions and outcomes are described. Provider Forums are in place and will be briefed on the Better Care Fund implications on commissioning and workforce. There is a plan to review the Market Position Statement after the final BCF plan has been developed.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Dorset CCG is the Lead Commissioner for Dorset County Hospital, Royal Bournemouth and Christchurch Hospitals and Poole Hospital. Other main hospitals include Yeovil District Hospital and Salisbury District Hospital.

In recent years projected changes in activity patterns have been detailed in Quality Productivity and prevention Programmes (QIPP) produced by the CCG, however these will need to be revised to take account of latest demographic and activity trends evidenced in the JSNA and hospital performance data. The assumptions of the BCF intentions will need to be projected into activity and service modelling for the hospitals. For example the intention through this plan is that activity within the Acute sector will see a reduction in total emergency admissions by 3.5%. This is based on the metrics for the 13/14 baseline year. There is also a planned reduction in the length of stay for older people who are frail or have multiple long term conditions. This is reflected in the Delayed Transfer of Care targets. Set against these intentions we need to recognise and assess the impact of increasing frailty and complexity of treatment interventions which extend rather than reduce lengths of stay.

The planned reduction in activity will need to be manageable for the Acute hospitals both in terms of clinical and financial viability and provide sufficient capacity to deliver good performance. The financial assumption is that reducing activity in the hospitals will release the funding necessary to invest in integrated service provision to prevent, re-able and allow pro-active case management of service users, enabling users to avoid admissions, speed up discharge and enable people to be cared for in their own homes. If the investment in the high impact areas of the programme is not achieved or in part, this will create additional pressure within the Acute sector, especially in the winter months.

It is recognised that cash savings will need to take account provider fixed costs, and the deficit position of some providers in recent years. In the short term the BCF plan will need to assess closely the benefits and savings for schemes as part of the investment analysis. There will be a Clinical Services Review with Acute and Community providers to assess the changes required in the next few years. This work will build on an assessment already carried out by the King's Fund and Oak Group on the three main Acute Hospitals. The scope of the Clinical Services Review is being consulted upon with key stakeholders including the NHS providers and Health and Wellbeing Boards. This will be a large scale programme supported by an external consultancy with programme support from Monitor. The CSR will need to develop a new model for sustainable health

services in the future this will inevitably involve significant public consultation as proposals are developed.

Work is underway to model the impacts of the 6 schemes identified in this plan to contribute to the 3.5% reduction target in emergency admissions. An aggregated model has been produced to assess the potential impact for each trust. It is also recognised that projected demand needs to be factored into the assumptions. Please see contingency statement.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Case Finding and Care Co-ordination
What is the strategic objective of this scheme?
Systematic case finding through MDT's to identify and target high risk groups, improving anticipatory care and therefore reduce emergency admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model of Care - maximising the use of incentives for providers through the primary care DES, older people's plan, NHS providers urgent care CQUINs and investment in district nursing to undertake risk stratification, (including systematic case finding, with intelligence from all sectors primary/community/secondary care, domiciliary care and SWAST); MDT meetings, targeting case management/care co-ordinators for high risk patients/ frailty assessments/ implementing anticipatory care plans for over 75's and sharing of these across sectors. **Target Patients** – High Risk patients, specifically older people with complex needs and those with a long term condition.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
All partners have been fully engaged in the development of the Locality MDT's, key partners include: • NHS Dorset Clinical Commissioning Group • General Practitioners • Borough of Poole • Bournemouth Council • Dorset County Council • Dorset Healthcare NHS Foundation Trust • South Western Ambulance Service Foundation Trust • Royal Bournemouth and Christchurch Hospital NHS Foundation Trust • Dorset County Hospital NHS Foundation Trust • Poole Hospital NHS Foundation Trust Further work is required to involve the secondary care hospitals and SWAST.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Integrated care value case toolkit (LGA)
- Making best use of the Better Care Fund (The King's Fund), **http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf**
- Co-ordinated care for people with complex long term conditions Oct 13
- Providing Integrated care for older people with complex needs Jan 2014
- Making Integrated care happen at scale and pace March 13
- Holland et al, Heart, 2005, 91, 899-906
- Proactive care partnership **http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf**
- Case study examples: NHS North West London, Torbay, Tower Hamlets
- 'Case management: what it is and how it can be best implemented'
- 'South Devon & Torbay: Proactive case management using the community virtual ward and the Devon predictive model'
- Goodwin N, Sonala L, Thiel V, Kodner D (2013). Co-ordinated care for people with complex chronic conditions. London: The King's Fund.
- Ross S, Curry N, Goodwin N (2011). Case management: what it is and how it can best be implemented. London: The King's Fund.
- Challis D, Hughes J (2011) Intensive care/case management, PSSRU, Manchester
- Graffy J, Grande M, Campbell J (2008). 'Case management for elderly patients at risk of hospital admission: a team approach'. Primary Health Care Research and Development, vol 9, no 1, pp7-13.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Through current new investment streams of the Direct Enhanced Service and the Older peoples plan investment in primary, NHS Providers, CQUIN and investment into District Nursing.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Contribute, along with the other high impact schemes, to 3.5% reduction in emergency admissions.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Multi-agency emergency admission taskforce groups
- Better Together Programme Board
- System Resilience Group
- Cluster urgent care dashboard to measure admission and readmission rates

What are the key success factors for implementation of this scheme?
• Improved service user experience-person centred care; • Reductions in avoidable emergency admissions and readmissions; • Reduction in long term care home placements.

Scheme ref no.

2

Scheme name

Emergency Department attendance avoidance programme (minor injuries and illness)

What is the strategic objective of this scheme?

The strategic objective of this scheme is to reduce the current rise in attendances at Dorset's three emergency departments, and the subsequent reduction in conversion from attendances to admissions.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of Care – there are a number of different schemes linked to this objective, including those listed below. If a scheme is targeted to a specific area of Dorset this has been identified in brackets:

- Advanced Nurse Practitioner (ANP) Scheme – ANP based in the emergency department to proactively manage patients attending with a primary care complaint;
- Emergency Care Intensive Support Team (ECIST) review of the local system in order to ascertain why there has been an increase in demand across the urgent care system in Dorset;
- Alcohol Nurse helps to manage patients with alcohol related conditions through alternative pathways (Poole);
- Rapid Response – an additional two Emergency Care Practitioners in Rapid Response Vehicles are made available in areas of high demand (East Dorset) between 08:00 and 18:00 hours daily, this service is accessed via the local Single Point of Access Service (East Dorset).

The next steps in this work programme is to improve the systematic delivery model which integrates the primary and secondary care workforce at the front door, maximises the use of community alternatives to manage minor illness and injuries and to the review the OOH's service offer.

Target Groups:

- Those attending the emergency department who could be managed elsewhere;

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Dorset CCG are the lead commissioner of these services, working in partnership with all key partners listed below through the System Resilience Group (previously Urgent Care Board):

- NHS Dorset Clinical Commissioning Group

- Dorset Healthcare NHS Foundation Trust
- South Western Ambulance Service Foundation Trust
- Royal Bournemouth and Christchurch Hospital NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Dorset Urgent Care Board commissioned the Kings Fund to review the current urgent and emergency care system during 2013/14, which included the following elements:

- Examining the routine data for the health economy and comparing this with other similar systems in the South of England and elsewhere;
- Commissioned the Oak Group to undertake a large pint of prevalence study of admissions across acute medicine, older people's medicine and the community hospitals;
- Reviewing existing urgent and emergency projects and initiatives;
- Facilitating the development of a frail and elderly pathway.

Alongside this reference has also been made to the following key National Documents:

- Transforming Urgent and Emergency Care Services in England;
- The Francis Report (2013);
- Operational Resilience and Capacity Plan.
- **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf**
- Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' Quality Watch, The Health Foundation, Nuffield Trust.
- Purdy S (2010). Avoiding hospital admissions: what does the research evidence say? London: The King's Fund. Available at: **www.kingsfund.org.uk/publications/avoiding-hospital-admissions** (accessed on 19 December 2013).
- Poteliakhoff E, Thompson J (2011). Emergency bed use: what the numbers tell us. London: The King's Fund.
- Shepperd S, Doll H, Angus RM, Clarke MJ, Iliffe S, Kalra L, Ricauda NA, Tibaldi V, Wilson AD (2009). 'Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data'. Canadian Medical Association Journal, vol 180, no 2, pp175.82.
- Oliver D, Foot C, Humphries R (forthcoming). Making our health and care services fit for an ageing population. London: The King's Fund

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
A number of these schemes are funded through the urgent care hub non recurrent fund and some are in mainstream contracts.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribute, along with the other high impact schemes, to 3.5% reduction in emergency admissions.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Key performance indicators have been agreed for each of the projects listed above; performance is submitted by the providers and collated by Dorset CCG. The impact on schemes on the overall system is monitored through the monthly Urgent Care Dashboard which has been agreed by the System Resilience Group.
What are the key success factors for implementation of this scheme?
• Improved service user experience-person centred care; • Reductions in emergency attendances; • Reductions in avoidable emergency admissions and readmissions; • Agreed Organisational Resilience Capacity Plan through the System Resilience Group.

Scheme ref no.
3
Scheme name
Ambulance service conveyances reduction
What is the strategic objective of this scheme?
To identify high impact changes to increase see and treat and reduce conveyances, also outcome of 111 review.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Work with SWAST through the Right Care 2 programme to develop initiatives which will support patients being seen and treated at an alternative setting to the Emergency Department, including: • Work with minor injury units in order to establish a protocol to enable suitable patients to be conveyed to a minor-injury unit; • Explore the potential benefits of routing GP admission calls via single point of access rather than bed bureau to enable all alternative options to an acute admission be explored. Review of the 111 service currently underway to ascertain any improvements / issues related to the current performance issues. Implementation of any actions Delivery of two specific projects funded via the System Resilience Group (previously the urgent care board): • Rapid Response – as additional two Emergency Care Practitioners in rapid response vehicles are made available in areas of high demand (East Dorset) between 08:00 – 18:00 hours daily, this service is accessed via the single point of access; • Advanced Nurse Practitioner is available within each of the three acute trusts to see and treat patients, in particular those presenting with a primary care complaint.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
• NHS Dorset Clinical Commissioning Group • Dorset Healthcare NHS Foundation Trust • South Western Ambulance Service Foundation Trust • Royal Bournemouth and Christchurch Hospital NHS Foundation Trust • Dorset County Hospital NHS Foundation Trust • Poole Hospital NHS Foundation Trust

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Dorset Urgent Care Board commissioned the Kings Fund to review the current urgent and emergency care system during 2013/14.

Alongside this a review of key National Documents has taken place, including:

- Transforming Urgent and Emergency Care Services in England;
- The Francis Report (2013);
- Local evidence;
- Operational Resilience and Capacity Plan.
- Emergency Care Intensive Support Team Report

The Dorset Urgent Care Board commissioned the Kings Fund to review the current urgent and emergency care system during 2013/14, which included the following elements:

- Examining the routine data for the health economy and comparing this with other similar systems in the South of England and elsewhere;
- Commissioned the Oak Group to undertake a large point of prevalence study of admissions across acute medicine, older people's medicine and the community hospitals;
- Reviewing existing urgent and emergency projects and initiatives;
- Facilitating the development of a frail and elderly pathway.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

No additional investment requirements

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Contribute, along with the other high impact schemes, to 3.5% reduction in emergency admissions.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators have been agreed for each of the projects funded via the System Resilience Group; performance is submitted by the providers and collated by Dorset CCG.

The impact on schemes on the overall system is monitored through the monthly Urgent Care Dashboard which has been agreed by the System Resilience Group, including the percentage of patients who are seen and treated rather than conveyed to the Emergency Department.

What are the key success factors for implementation of this scheme?
• Increase in patients seen and treated outside of the emergency department; • Improved service user experience-person centred care; • Reductions in emergency attendances.

Scheme ref no.
4
Scheme name
In-reach into Care Homes
What is the strategic objective of this scheme?
To reduce the number of attendances and admissions from care homes.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model of Care – Develop a focused and co-ordinated approach to systemic support and in reach into care homes. This links to the locality MDT key impact priority area. **Target Patients** – High Risk patients in care home settings, specifically older people with complex needs and those with a long term condition. For example those at risk of falls, history of stroke or in need of end of life care.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
All partners have been fully engaged in the development of the Locality MDT's, key partners include: • NHS Dorset Clinical Commissioning Group • General Practitioners • Borough of Poole • Bournemouth Council • Dorset County Council • Dorset Healthcare NHS Foundation Trust • South Western Ambulance Service Foundation Trust • Royal Bournemouth and Christchurch Hospital NHS Foundation Trust • Dorset County Hospital NHS Foundation Trust • Poole Hospital NHS Foundation Trust
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• NICE clinical guideline NICE (2013). Falls: assessment and prevention of falls in older people. NICE clinical guideline 161. London: NICE. Available at www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf (accessed on 17 December 2013). • For the economic case for investing in falls prevention, see 'Fracture prevention services: an economic evaluation'. (Department of Health, 2009).

- For a recent independent evaluation of a working falls prevention service, see Campbell et al (2013), which evaluated the impact of Northamptonshire Crisis response service
- Page 65 of the LGA Evidence Review: 'Integrated care evidence review, November 2013'
- Department of Health (2009). Fracture prevention services: An economic evaluation. London: The Stationery Office.
- Centre for disease control compendium of effective fall interventions: **http://www.cdc.gov/HomeandRecreationalSafety/pdf/CDC_Falls_Compendium_lowres.pdf**
- **http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf**
- SCIE Research briefing 36: Reablement: a cost-effective route to better outcomes
- **http://www.scie.org.uk/publications/briefings/briefing36/**
- NICE Local Practice Examples:
  - Management of patients with stroke: REDS (Reach Early Discharge Scheme)
  - Rapid Response Services: intermediate tier, multi-disciplinary health and social care service
  - Enhanced home-based palliative care for adults
  - Early discharge and intensive community rehabilitation for stroke patients
- **www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Auditof-Intermediate-Care/year-two.php**
- Kings Fund;
- Making best use of the Better Care Fund Jan 2014
- Co-ordinated care for people with complex long term conditions Oct 13
- Providing Integrated care for older people with complex needs Jan 2014
- Making Integrated care happen at scale and pace March 13

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Through current new investment streams of the Direct Enhanced Service and the Older peoples plan investment in primary, NHS Providers CQUIN and investment into District Nursing.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribute, along with the other high impact schemes, to 3.5% reduction in emergency admissions
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Multi-agency emergency admission taskforce groups Better Together Programme Board System Resilience Group

Cluster urgent care dashboard to measure admission and readmission rates.
What are the key success factors for implementation of this scheme?
• Improved service user experience-person centred care; • Reductions in avoidable emergency admissions and readmissions; • Reduction in long term care home placements.

Scheme ref no.
5
Scheme name
Hospital at Home
What is the strategic objective of this scheme?
To enable the management of patients in the community to prevent admission and support discharge.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Shared care service between outreach secondary care advanced practitioners and community intermediate care service to support higher acuity patients in crisis e.g. comprehensive geriatric assessment, management of UTI / chest infections – hydration and IV antibiotics therapies early discharge of patients with stroke and people with falls who have mild cognitive impairment.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
NHS Dorset Clinical Commissioning Group are the lead commissioner of this services, working in partnership with all key partners listed below: • Dorset Healthcare NHS Foundation Trust • Dorset County Hospital NHS Foundation Trust • Poole Hospital NHS Foundation Trust
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The Dorset Urgent Care Board commissioned the Kings Fund to review the current urgent and emergency care system during 2013/14, which included commissioning the Oak Group to undertake a large point of prevalence study of admissions across acute medicine, older people's medicine and the community hospitals. The review found that: • 284 non-qualified* days could have been provided at the sub-acute level of care. This accounts for 179 patients; • 72 acute care admissions could have been diverted to sub-acute level of care. • 'Non-qualified' - patient could be treated at a lower level of care to meet medical needs. • NICE clinical guideline NICE (2013). Falls: assessment and prevention of falls in older people. NICE clinical guideline 161. London: NICE. Available at **www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf (accessed on 17 December 2013).**

- For the economic case for investing in falls prevention, see 'Fracture prevention services: an economic evaluation' (Department of Health, 2009).
- For a recent independent evaluation of a working falls prevention service, see Campbell et al (2013), which evaluated the impact of Northamptonshire Crisis response service
- Page 65 of the LGA Evidence Review: 'Integrated care evidence review, November 2013'
- Department of Health (2009). Fracture prevention services: An economic evaluation. London: The Stationery Office.
- Centre for disease control compendium of effective fall interventions: **http://www.cdc.gov/HomeandRecreationalSafety/pdf/CDC_Falls_Compendium_lowres.pdf**
- **http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf**
- SCIE Research briefing 36: Reablement: a cost-effective route to better outcomes
- **http://www.scie.org.uk/publications/briefings/briefing36/**
- NICE Local Practice Examples:
  - Management of patients with stroke: REDS (Reach Early Discharge Scheme)
  - Rapid Response Services: intermediate tier, multi-disciplinary health and social care service
  - Enhanced home-based palliative care for adults
  - Early discharge and intensive community rehabilitation for stroke patients
- **www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Auditof-Intermediate-Care/year-two.php**

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment proposals are being considered from the urgent care hub investment fund.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Contribute, along with the other high impact schemes, to 3.5% reduction in emergency admissions.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators have been agreed and are submitted by the provider.

The impact of schemes on the overall system is monitored via the monthly Urgent Care Dashboard which has been agreed by the System Resilience Group.

What are the key success factors for implementation of this scheme?

- Improved service user experience-person centred care (target 75%);
- Reductions in emergency attendances (target 10 admissions, 4 beds per month).

Scheme ref no.
6
Scheme name
Care Overnight
What is the strategic objective of this scheme?
To provide support to patients on discharge overnight in order to facilitate timely discharge and reduce re-admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model of Care – Expansion of the Dorset County Council Pilot which provides a roaming night sitting service. Patients / Carers are able to contact the service for support following discharge. **Target Patients** – High Risk patients, specifically older people with complex needs and those with a long term condition.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
All partners have been fully engaged in the development of the Locality MDT's, key partners include: • NHS Dorset Clinical Commissioning Group • General Practitioners • Dorset County Council • Dorset Healthcare NHS Foundation Trust • Dorset County Hospital NHS Foundation Trust Further work is required to roll the service out to Poole and Bournemouth Hospitals.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• Kings Fund; • Making best use of the Better Care Fund Jan 2014 • Co-ordinated care for people with complex long term conditions Oct 13 • Providing Integrated care for older people with complex needs Jan 2014 • Making Integrated care happen at scale and pace March 13 • Innovative local scheme shortlisted for HsJ award

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Investment considered through the urgent care hub investment fund.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribute, along with the other high impact schemes, to 3.5% reduction in emergency admissions.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
• Multi-agency emergency admission taskforce groups • Better Together Programme Board • System Resilience Group • Cluster urgent care dashboard to measure admission and readmission rates.
What are the key success factors for implementation of this scheme?
• Improved service user experience-person centred care; • Reductions in avoidable emergency admissions and readmissions;

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	**Bournemouth and Poole**
Name of Provider organisation	**Poole Hospital NHS Foundation Trust**
Name of Provider CEO	**Debbie Fleming**
Signature (electronic or typed)	Paul Miller, Director of Finance on behalf of Debbie Fleming

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,114
	2014/15 Plan	12,655
	2015/16 Plan	12,212
	14/15 Change compared to 13/14 outturn	(3.5%)
	15/16 Change compared to planned 14/15 outturn	(3.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	459
	How many non-elective admissions is the BCF planned to prevent in 15-16?	443

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes we agree with the data that has been produced by Dorset CCG. We also fully support the strategic ambition of the Dorset BCF programme (Better Together) and the principles of whole systems working to move this strategy forward. In doing so we appreciate the acceptance of the Better Together programme that the significant increase in activity being experienced in 14/15 (10% increase in activity above plan) needs to be addressed in addition to the assumed 7% reduction (3.5% + 3.5%) outlined above.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not applicable. However please note the comment above, relating to the 10% increase in forecast activity against the 14/15 plan. Finally we would also highlight that this currently represents an assumed reduction in activity

		during 15/16 of a minimum of 17%. However if activity trends continued to increase further during 15/16, then the actual reduction required could be 20% plus.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes we have considered the implications of the current plans and target reductions as currently presented. However the position of the Trust is that we are still not totally assured that the planned 15/16 activity levels will not be exceeded. This uncertainty means we will require separate contract discussions for 15/16 to ensure that the correct capacity is actually commissioned to manage the system risks, should increasing numbers of patients still require hospital treatment in 15/16. Failure to commission appropriate capacity during 15/16 will lead to unacceptable patient experiences and the missing of relevant hospital targets. Finally we are assured that the need for these separate 15/16 contract negotiations, are recognised by the CCG.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	**Dorset**
Name of Provider organisation	**Poole Hospital NHS Foundation Trust**
Name of Provider CEO	**Debbie Fleming**
Signature (electronic or typed)	Paul Miller, Director of Finance on behalf of Debbie Fleming

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16,006
	2014/15 Plan	15,446
	2015/16 Plan	14,905
	14/15 Change compared to 13/14 outturn	(3.5%)
	15/16 Change compared to planned 14/15 outturn	(3.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	560
	How many non-elective admissions is the BCF planned to prevent in 15-16?	541

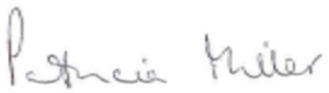
For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes we agree with the data that has been produced by Dorset CCG. We also fully support the strategic ambition of the Dorset BCF programme (Better Together) and the principles of whole systems working to move this strategy forward. In doing so we appreciate the acceptance of the Better Together programme that the significant increase in activity being experienced in 14/15 (10% increase in activity above plan) needs to be addressed in addition to the assumed 7% reduction (3.5% + 3.5%) outlined above.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not applicable. However please note the comment above, relating to the 10% increase in forecast activity against the 14/15 plan. Finally we would also highlight that this currently

		represents an assumed reduction in activity during 15/16 of a minimum of 17%. However if activity trends continued to increase further during 15/16, then the actual reduction required could be 20% plus.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes we have considered the implications of the current plans and target reductions as currently presented. However the position of the Trust is that we are still not totally assured that the planned 15/16 activity levels will not be exceeded. This uncertainty means we will require separate contract discussions for 15/16 to ensure that the correct capacity is actually commissioned to manage the system risks, should increasing numbers of patients still require hospital treatment in 15/16. Failure to commission appropriate capacity during 15/16 will lead to unacceptable patient experiences and the missing of relevant hospital targets. Finally we are assured that the need for these separate 15/16 contract negotiations, are recognised by the CCG.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Bournemouth and Poole
Name of Provider organisation	Dorset County Hospital
Name of Provider CEO	Patricia Miller
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	7,491
	2014/15 Plan	7,229
	2015/16 Plan	6,976
	14/15 Change compared to 13/14 outturn	(3.5%)
	15/16 Change compared to planned 14/15 outturn	(3.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	262
	How many non-elective admissions is the BCF planned to prevent in 15-16?	253

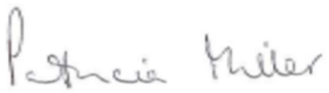
For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes we agree with the data that has been produced by Dorset CCG. We support the strategic ambition of the Dorset BCF programme and the whole system working together to move this forward. The significant increase in activity experienced in 14/15 (14% increase in activity above 13/14) needs to be addressed in addition to the assumed 7% reduction (3.5% + 3.5%) outlined above
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust has considered the implications on services and is concerned that any funding transferred from it should reflect the cost savings achievable rather than the tariff.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Dorset
Name of Provider organisation	Dorset County Hospital
Name of Provider CEO	Patricia Miller
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	9,144
	2014/15 Plan	8,824
	2015/16 Plan	8,515
	14/15 Change compared to 13/14 outturn	(3.5%)
	15/16 Change compared to planned 14/15 outturn	(3.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	320
	How many non-elective admissions is the BCF planned to prevent in 15-16?	309

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes we agree with the data that has been produced by Dorset CCG. We support the strategic ambition of the Dorset BCF programme and the whole system working together to move this forward. The significant increase in activity experienced in 14/15 (14% increase in activity above 13/14) needs to be addressed in addition to the assumed 7% reduction (3.5% + 3.5%) outlined above
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust has considered the implications on services and is concerned that any funding transferred from it should reflect the cost savings achievable rather than the tariff.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	**Bournemouth and Poole**
Name of Provider organisation	**Royal Bournemouth Hospital**
Name of Provider CEO	**Tony Spotswood**
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	11,075
	2014/15 Plan	10,687
	2015/16 Plan	10,313
	14/15 Change compared to 13/14 outturn	(3.5%)
	15/16 Change compared to planned 14/15 outturn	(3.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	388
	How many non-elective admissions is the BCF planned to prevent in 15-16?	374

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes we agree with the data that has been produced by Dorset CCG. We support the strategic ambition of the Dorset BCF programme and the whole system working together to move this forward. The significant increase in activity experienced in 14/15 (14% increase in activity above 13/14) needs to be addressed in addition to the assumed 7% reduction (3.5% + 3.5%) outlined above
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not applicable. However please note the comment above, relating to the 14% increase in forecast activity against 13/14 levels. This represents an assumed reduction in activity during 15/16 of a minimum of 21% (ie a total reduction in admissions of 2,423). However if activity trends continued to increase further

		during 15/16, then the actual reduction required could be greater.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have considered the resultant implications of the current plans and target reductions as currently presented. However the Trust is still not totally assured the planned 15/16 activity levels will not be exceeded. This will need to be addressed separately within the 15/16 contract discussions to ensure the correct capacity is commissioned to manage the system risks. Failure to commission appropriate capacity during 15/16 could lead to unacceptable patient experiences and the missing of relevant hospital targets. We are assured the need for these separate 15/16 contract negotiations, are recognised by the CCG.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	**Dorset**
Name of Provider organisation	**Royal Bournemouth Hospital**
Name of Provider CEO	**Tony Spotswood**
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,518
	2014/15 Plan	13,045
	2015/16 Plan	12,588
	14/15 Change compared to 13/14 outturn	(3.5%)
	15/16 Change compared to planned 14/15 outturn	(3.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	473
	How many non-elective admissions is the BCF planned to prevent in 15-16?	457

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes we agree with the data that has been produced by Dorset CCG. We support the strategic ambition of the Dorset BCF programme and the whole system working together to move this forward. The significant increase in activity experienced in 14/15 (14% increase in activity above 13/14) needs to be addressed in addition to the assumed 7% reduction (3.5% + 3.5%) outlined above
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not applicable. However please note the comment above, relating to the 14% increase in forecast activity against 13/14 levels. This represents an assumed reduction in activity during 15/16 of a minimum of 21% (ie a total reduction in admissions of 2,973). However if activity trends continued to increase further

		during 15/16, then the actual reduction required could be greater.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have considered the resultant implications of the current plans and target reductions as currently presented. However the Trust is still not totally assured the planned 15/16 activity levels will not be exceeded. This will need to be addressed separately within the 15/16 contract discussions to ensure the correct capacity is commissioned to manage the system risks. Failure to commission appropriate capacity during 15/16 could lead to unacceptable patient experiences and the missing of relevant hospital targets. We are assured the need for these separate 15/16 contract negotiations, are recognised by the CCG.

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Bournemouth & Poole

Please provide:

Harry Capron
h.capron@dorsetcc.gov.uk

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Bournemouth & Poole

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	36,528
Change in Non Elective Activity	-1,293
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	1,926,570
Combined total of Performance and Ringfenced Funds	6,373,988
Ringfenced Fund	4,447,418
Value of NHS Commissioned Services	22,054,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	9,627	18,392	27,300	36,528
Cumulative Change in Non Elective Activity	-17	348	-25	-1,293
Cumulative % Change in Non Elective Activity	-0.0%	1.0%	-0.1%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	25,330	0	11,920	1,889,320

Health and Wellbeing Funding Sources

Bournemouth & Poole

Please complete white cells

	Gross Contribution (£000)	
	2014/15	2015/16
Local Authority Social Services		
Bournemouth		533
Poole		495
Bournemouth		1,238
Poole		862
Total Local Authority Contribution	**-**	**3,128**
CCG Minimum Contribution		
NHS Dorset CCG - Bournemouth element		12,223
NHS Dorset CCG - Poole element		9,831
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**22,054**
Additional CCG Contribution		
NHS Dorset CCG	**6,974**	
Total Additional CCG Contribution	**6,974**	**-**
Total Contribution	**6,974**	**25,182**

Summary of Health and Wellbeing Board Schemes

Bournemouth & Poole

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	-	-			
Community Health	-	14,220			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	6,974	10,962	6,974	6,974	
Other	-	-			
Total	**6,974**	**25,182**	**6,974**	**6,974**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		-
Community Health		14,220
Continuing Care		-
Primary Care		-
Social Care		7,834
Other		-
Total		**22,054**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	-	-	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	-	1,927	1,927
Other	-	-	
Total	**-**	**1,927**	**1,927**

<Please explain discrepancy between D44 and E44 if applicable>

Health and Wellbeing Board Expenditure Plan

Bournemouth & Poole

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
1 - 6 Schemes	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		9,387
Protecting Social Care	Social Care		CCG			Private Sector	CCG Minimum Contribution	6,974	6,974
ICES	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,028
ICES	Community Health		CCG			Private Sector	CCG Minimum Contribution		2,051
DFG	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,253
Social Care Capital Grant	Social Care		Local Authority			Private Sector	Local Authority Social Services		847
Carers	Community Health		CCG			Private Sector	CCG Minimum Contribution		824
Reablement	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		1,958
Care Act duties	Social Care		CCG			Local Authority	CCG Minimum Contribution		860
Total								**6,974**	**25,182**

Health and Wellbeing Board Financial Benefits Plan

Bournemouth & Poole

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
						-		
						-		
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Total						**-**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
						-		
Reduction in non-elective (general + acute only)		1 - 6 Schemes		1,293	1,490	1,926,570		
						-		
						-		
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Total						**1,926,570**		

Bournemouth & Poole

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,820**	**2,567**	**2,609**	**2,703**	**2,791**	**2,652**	**2,479**	**2,312**	**2,223**
	Numerator	9,627	8,765	8,908	9,228	9,610	9,130	8,535	7,960	7,720
	Denominator	341,424	341,424	341,424	341,424	344,329	344,329	344,329	344,329	347,354

Rationale for red/amber ratings

P4P annual change in admissions *-1293*
P4P annual change in admissions (%) *-3.5%*
P4P annual saving *£1,926,570*

Please enter the average cost of a non-elective admission[1]: **£1,490**

Rationale for change from £1,490

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans) Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	% CCG registered population that has resident population in Bournemouth & Poole	% Bournemouth & Poole resident population that is in CCG registered population	Contributing CCG activity Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Dorset CCG	21,156	19,263	19,576	20,281	45.5%	100.0%	9,627	8,765	8,908	9,228
Total						100%	9,627	8,765	8,908	9,228

References

1 The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Bournemouth & Poole

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**873.4**	**824.1**	**788.3**
	Numerator	565	555	540
	Denominator	64,805	67,344	68,501
	Annual change in admissions		*-10*	*-15*
	Annual change in admissions %		*-1.8%*	*-2.7%*

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**81.0**	**84.8**	**85.5**
	Numerator	410	1,820	1,835
	Denominator	505	2,147	2,147
	Annual change in proportion		*3.7*	*0.7*
	Annual change in proportion %		*4.6%*	*0.8%*

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**502.2**	**465.1**	**597.2**	**903.1**	**878.0**	**845.6**	**811.7**	**772.7**	**742.3**	**713.8**	**685.2**	**653.0**
	Numerator	1,380	1,278	1,641	2,510	2,440	2,350	2,256	2,165	2,080	2,000	1,920	1,845
	Denominator	274,775	274,775	274,775	277,919	277,919	277,919	277,919	280,199	280,199	280,199	280,199	282,548
						Annual change in admissions		*2402*				*Annual change in admissions*	*-1366*
						Annual change in admissions %		*35.3%*				*Annual change in admissions %*	*-14.8%*

Rationale for red ratings

Patient / Service User Experience Metric

Metric		Baseline [enter time period]	Planned 14/15 (if available)	Planned 15/16
[please insert metric description]	*Metric Value*	N/A	N/A	N/A
	Numerator	N/A	N/A	N/A
	Denominator	N/A	N/A	N/A
Improvement indicated by:	<Please select>			

Local Metric

Metric		Baseline 2012/13	Planned 14/15 (if available)	Planned 15/16
Estimated diagnosis rate for people with dementia	*Metric Value*	0.5	0.7	0.7
	Numerator	3099.0	3,650	3,855
	Denominator	5,656	5,363	5,524
Improvement indicated by:	Increase			

References/notes

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014)[1]

1. Based on "Personal Social Services: Expenditure and Unit Costs, England 2012-13" (HSCIC) http://www.hscic.gov.uk/catalogue/PUB13085/pss-exp-eng-12-13-fin-rpt.pd
2. There is no robust national source for the average annual saving due to being at home 91 days after discharge from hospital in to reablement / rehabilitation services. Therefore HWBs should provide the estimate that underpins their planned financial savings, which it is assumed will include the impact of reduction admissions to hospital and to residential ca
3. Based on 12-13 Reference Costs: average cost of an excess bed day. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

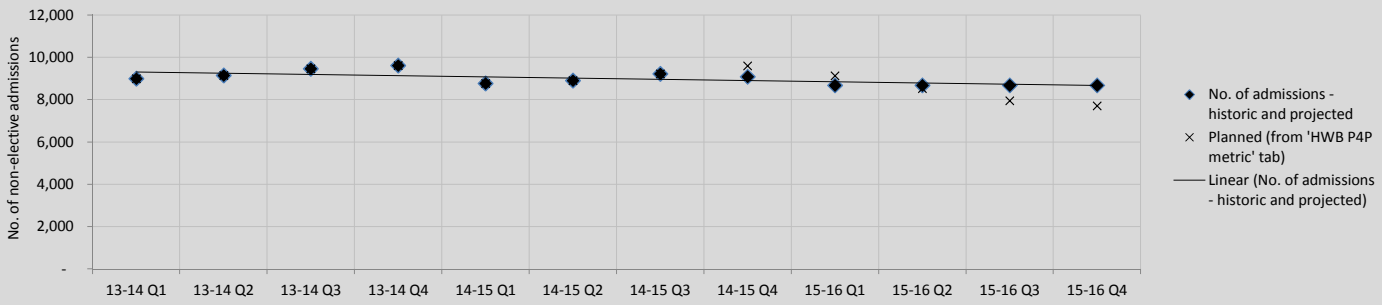
Bournemouth & Poole

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection			
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	8,995	9,152	9,464	9,627	8,765	8,908	9,228	9,093	8,684	8,684	8,684

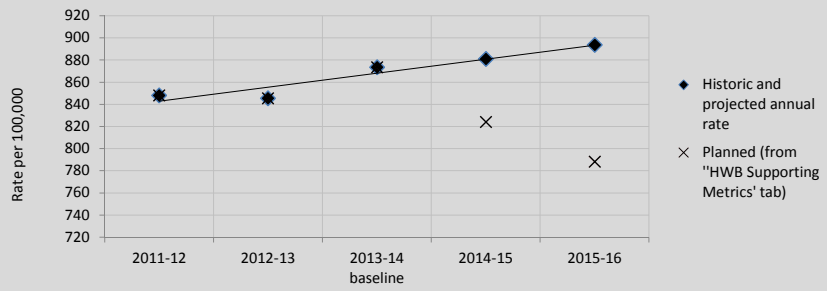


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,663.3*	*2,521.9*	*2,521.9*	*2,521.9*	*2,499.9*
	Numerator	*9,093*	*8,684*	*8,684*	*8,684*	*8,684*
	Denominator	*341,424*	*344,329*	*344,329*	*344,329*	*347,354*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	848	846	873	*881*	*894*
	Numerator	535	545	565	*555*	*540*
	Denominator	62,965	64,805	64,805	*67,344*	*68,501*



This is based on a simple projection of the metric proportion.

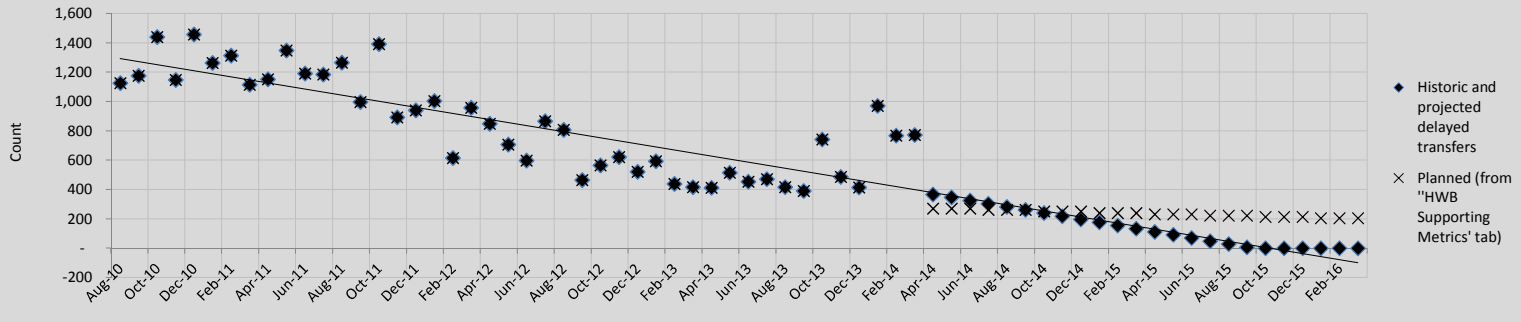
Reablement

Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	79.9052632	75.1545455	81.0237624	*79.8*	*80.4*
	Numerator	700	385	410	*1,820*	*1,835*
	Denominator	885	515	505	*2147*	*2147*

This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic										
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	1,125	1,175	1,440	1,147	1,457	1,263	1,313	1,115	1,151	1,347	1,191



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*373.9*	*305.1*	*236.3*	*166.1*	*97.8*	*29.5*	-	-
	Numerator	*1,039*	*848*	*657*	*465*	*274*	*83*	-	-
	Denominator	*277,919*	*277,919*	*277,919*	*280,199*	*280,199*	*280,199*	*280,199*	*282,548*

* The projected rates are based on annual population projections and therefore will not change linearly

15-16 Q4
8,684

																				Baseline				
Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
1,184	1,264	997	1,392	893	940	1,003	615	957	848	706	597	865	807	465	564	621	521	593	438	416	412	515	453	472	416

							Linear projection* (set so cannot fall below zero)																
Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
390	741	486	414	970	768	772	*368*	*346*	*325*	*304*	*283*	*261*	*240*	*219*	*198*	*176*	*155*	*134*	*113*	*91*	*70*	*49*	*28*	*6*	-

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
	-	-	-	-	-

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Dorset

Please provide:

Harry Capron
h.capron@dorsetcc.gov.uk

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Dorset

1. Reduction in non elective activity	
Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	44,104
Change in Non Elective Activity	-1,554
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds	
Figures in £	
Financial Value of Non Elective Saving/ Performance Fund	2,315,460
Combined total of Performance and Ringfenced Funds	7,909,827
Ringfenced Fund	5,594,367
Value of NHS Commissioned Services	27,368,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	11,594	22,189	32,952	44,104
Cumulative Change in Non Elective Activity	-84	371	-62	-1,554
Cumulative % Change in Non Elective Activity	-0.2%	0.8%	-0.1%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	125,160	0	0	2,190,300

Health and Wellbeing Funding Sources

Dorset

Please complete white cells

	Gross Contribution (£000)	
	2014/15	2015/16
Local Authority Social Services		
Dorset		1,072
Dorset		3,041
Total Local Authority Contribution	**-**	**4,113**
CCG Minimum Contribution		
NHS Dorset CCG		27,368
-		-
-		-
-		-
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**27,368**
Additional CCG Contribution		
NHS Dorset CCG	**8,869**	
Total Additional CCG Contribution	**8,869**	**-**
Total Contribution	**8,869**	**31,481**

Summary of Health and Wellbeing Board Schemes

Dorset

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	-	-			
Community Health	-	17,431			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	8,869	14,050	8,869	8,869	
Other	-	-			
Total	**8,869**	**31,481**	**8,869**	**8,869**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		-
Community Health		17,431
Continuing Care		-
Primary Care		-
Social Care		9,937
Other		-
Total		**27,368**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	-	-	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	-	2,315	2,315
Other	-	-	
Total	**-**	**2,315**	**2,315**

<Please explain discrepancy between D44 and E44 if applicable>

Health and Wellbeing Board Expenditure Plan

Dorset

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
1 - 6 Schemes	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		11,823
Protecting Social Care	Social Care		CCG			Private Sector	CCG Minimum Contribution	8,869	8,869
ICES	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,072
ICES	Community Health		CCG			Private Sector	CCG Minimum Contribution		2,118
DFG	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,963
Social Care Capital Grant	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,078
Carers	Community Health		CCG			Private Sector	CCG Minimum Contribution		1,048
Reablement	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		2,442
Care Act duties	Social Care		CCG			Local Authority	CCG Minimum Contribution		1,068
Total								**8,869**	**31,481**

Health and Wellbeing Board Financial Benefits Plan

Dorset

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
						-		
						-		
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Total						**-**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
						-		
Reduction in non-elective (general + acute only)		1 - 6 Schemes		1,554	1,490	2,315,460		
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Total						**2,315,460**		

Dorset

Red triangles indicate comments

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,782**	**2,542**	**2,583**	**2,676**	**2,753**	**2,643**	**2,471**	**2,311**	**2,233**
	Numerator	11,594	10,595	10,763	11,152	11,510	11,050	10,330	9,660	9,370
	Denominator	416,730	416,730	416,730	416,730	418,055	418,055	418,055	418,055	419,551

Rationale for red/amber ratings

P4P annual change in admissions *-1554*
P4P annual change in admissions (%) *-3.5%*
P4P annual saving *£2,315,460*

Please enter the average cost of a non-elective admission[1] **£1,490**

Rationale for change from £1,490

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Dorset	% Dorset resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Dorset CCG	21,156	19,263	19,576	20,281	52.8%	95.9%	11,171	10,172	10,337	10,709
NHS Somerset CCG	14,655	16,641	16,654	17,370	0.6%	0.7%	85	96	96	100
NHS West Hampshire CCG	13,023	12,852	12,931	13,409	2.0%	2.5%	259	255	257	266
NHS Wiltshire CCG	10,159	9,250	9,373	9,716	0.8%	0.9%	79	72	73	76
Total						**100%**	**11,594**	**10,595**	**10,763**	**11,152**

References

1 The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Dorset

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned □14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**531.0**	**501.3**	**469.9**
	Numerator	580	575	551
	Denominator	109,035	114,706	117,269
	Annual change in admissions		*-5*	*-24*
	Annual change in admissions %		*-0.9%*	*-4.2%*

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**89.9**	**90.3**	**91.0**
	Numerator	600	605	610
	Denominator	670	670	670
	Annual change in proportion		*0.4*	*0.7*
	Annual change in proportion %		*0.4%*	*0.8%*

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**916.0**	**1,383.3**	**1,338.8**	**1,443.0**	**1,301.0**	**1,296.5**	**1,267.1**	**1,203.2**	**1,188.5**	**1,173.9**	**1,159.2**	**1,139.9**
	Numerator	3,109	4,695	4,544	4,897	4,415	4,400	4,300	4,100	4,050	4,000	3,950	3,900
	Denominator	339,403	339,403	339,403	339,363	339,363	339,363	339,363	340,756	340,756	340,756	340,756	342,140
								Annual change in admissions	*-30*			*Annual change in admissions*	*-1315*
								Annual change in admissions %	*-0.2%*			*Annual change in admissions %*	*-7.6%*

Rationale for red ratings

Patient / Service User Experience Metric

Metric		Baseline [enter time period]	Planned 14/15 (if available)	Planned 15/16
[please insert metric description]	*Metric Value*	N/A	N/A	N/A
	Numerator	N/A	N/A	N/A
	Denominator	N/A	N/A	N/A
Improvement indicated by:	<Please select>			

Local Metric

Metric		Baseline 2012/13	Planned 14/15 (if available)	Planned 15/16
Estimated diagnosis rate for people with dementia	*Metric Value*	0.4	0.6	0.7
	Numerator	3,106	4,835	5,150
	Denominator	8,104	7,686	7,916
Improvement indicated by:	Increase			

References/notes

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014)

1. Based on "Personal Social Services: Expenditure and Unit Costs, England 2012-13" (HSCIC) http://www.hscic.gov.uk/catalogue/PUB13085/pss-exp-eng-12-13-fin-rpt.pdf
2. There is no robust national source for the average annual saving due to being at home 91 days after discharge from hospital in to reablement / rehabilitation services. Therefore HWBs should provide the estimate that underpins their planned financial savings, which it is assumed will include the impact of reduction admissions to hospital and to residential care
3. Based on 12-13 Reference Costs: average cost of an excess bed day. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

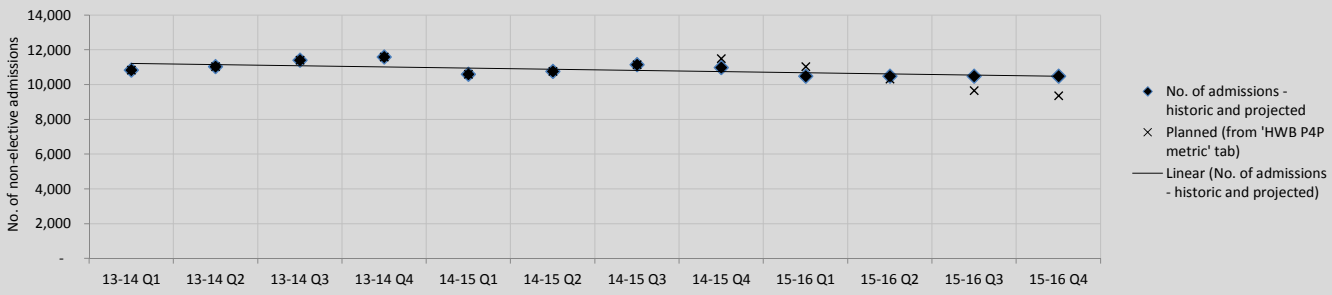
Dorset

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	10,847	11,036	11,406	11,594	10,595	10,763	11,152	10,993	10,495	10,495	10,495	10,495

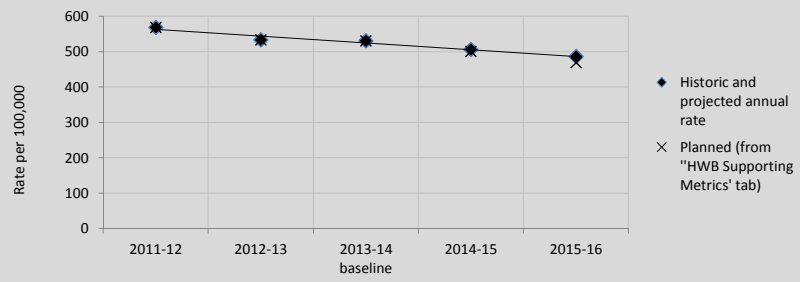


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,637.9*	*2,510.4*	*2,510.4*	*2,510.4*	*2,501.5*
	Numerator	*10,993*	*10,495*	*10,495*	*10,495*	*10,495*
	Denominator	*416,730*	*418,055*	*418,055*	*418,055*	*419,551*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

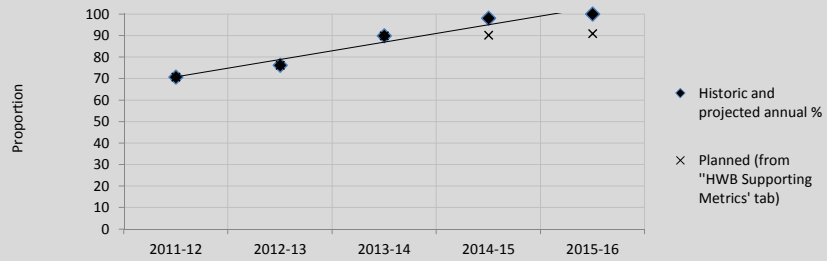
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	570	534	531	*506*	*487*
	Numerator	600	580	580	*575*	*551*
	Denominator	105,000	109,035	109,035	*114,706*	*117,269*



This is based on a simple projection of the metric proportion.

Reablement

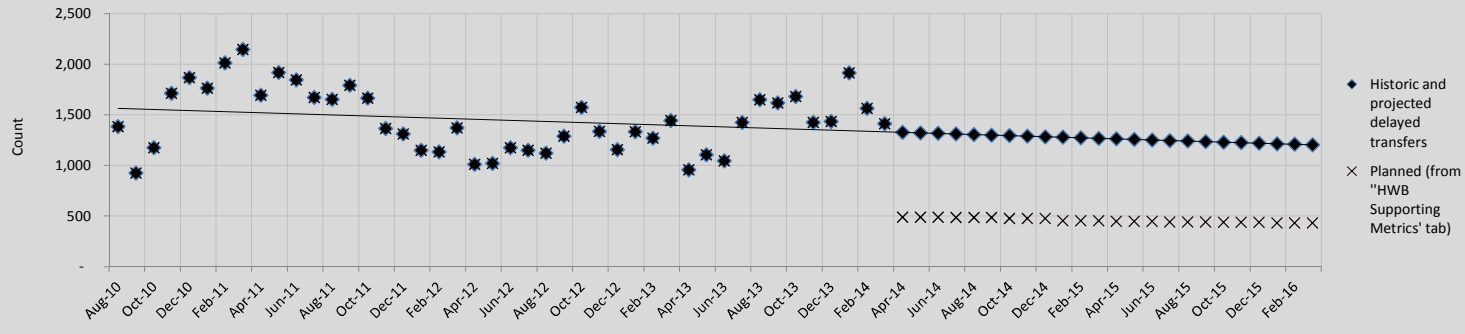
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	70.7	76.3	89.9	*98.2*	*100.0*
	Numerator	500	495	600	*605*	*610*
	Denominator	710	650	670	*670*	*670*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	1,385	926	1,177	1,714	1,868	1,765	2,014	2,147	1,694	1,919	1,847	1,674



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*1,169.1*	*1,154.9*	*1,140.7*	*1,121.9*	*1,107.7*	*1,093.6*	*1,079.4*	*1,061.0*
	Numerator	*3,967*	*3,919*	*3,871*	*3,823*	*3,775*	*3,726*	*3,678*	*3,630*
	Denominator	*339,363*	*339,363*	*339,363*	*340,756*	*340,756*	*340,756*	*340,756*	*342,140*

* The projected rates are based on annual population projections and therefore will not change linearly

																				Baseline						
Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
1,655	1,792	1,666	1,365	1,313	1,151	1,134	1,371	1,013	1,023	1,178	1,151	1,124	1,290	1,576	1,339	1,158	1,333	1,272	1,444	957	1,106	1,046	1,425	1,651	1,619	1,682

					Linear projection* (set so cannot fall below zero)																			
Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
1,427	1,435	1,917	1,565	1,415	*1,328*	*1,322*	*1,317*	*1,312*	*1,306*	*1,301*	*1,296*	*1,290*	*1,285*	*1,280*	*1,274*	*1,269*	*1,264*	*1,258*	*1,253*	*1,248*	*1,242*	*1,237*	*1,231*	*1,226*	*1,221*	*1,215*

Feb-16	Mar-16
1,210	*1,205*