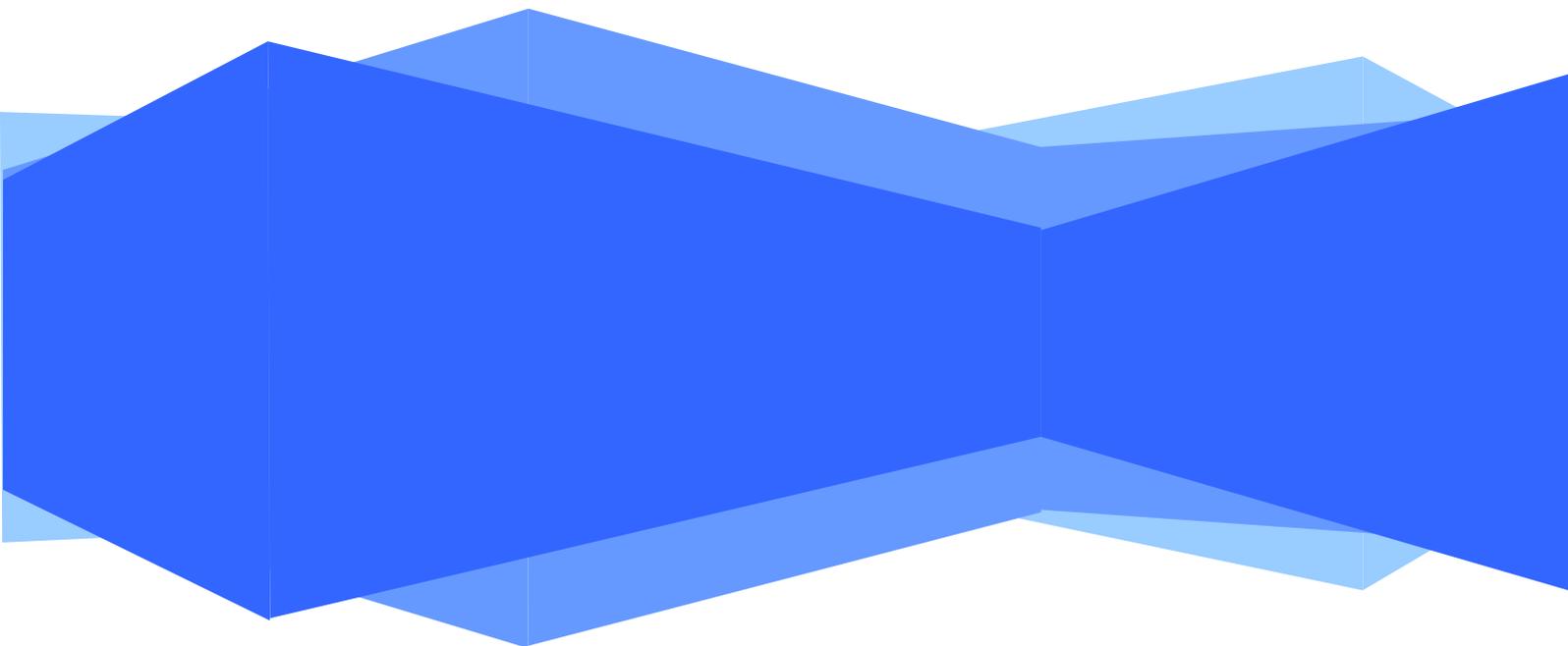
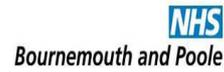


Bournemouth, Dorset & Poole Total Place Pilot

Final Report



This report is the product of the following organisations:



With thanks to:



Bournemouth



| Glossary

Avoidable admission:	An admission to secondary care that could have been avoided, e.g. an unplanned admission to hospital
B, D &P (or the sub-region):	Bournemouth, Dorset & Poole
Community services:	Includes all care in the community provided by local authorities and health services. This includes intermediate care provision such as reablement, domiciliary care and community healthcare provision. It also includes some elements of preventative services
Care Home placements:	Placements in Care Homes that can be funded by the service user, the local authority or PCT
Care Home placements (with nursing):	As above but a care home setting that provides nursing care
Community development:	A range of practices designed to increase the strength and effectiveness of community life, which will improve local conditions, enable participation and decision making and achieve greater control over circumstances
Early intervention:	Working proactively to identify people whose independence is at risk. Case finding and other tools

	for predicting risk are important here
Elective Care:	Secondary care that has been planned and arranged in advance
Intensive social care services:	Care home placements or very high cost domiciliary care
Non-Elective Care:	Secondary care that has not been planned, for example, an Accident and Emergency visit because of a fall
PCT:	Primary Care Trust
Prevention (including primary and secondary):	The term prevention can mean many things to different people. Within this report we are focusing on prevention which is aimed at minimising disability or detrition from established health conditions or complex social care needs. This differentiates it from primary prevention which is aimed at promoting well being and secondary prevention which concerns early intervention
Secondary care:	Acute hospital care
Spell:	The length of time that a patient spends in secondary care
Social Capital:	Social capital is an expansive concept, one that includes facets such as sociability, social networks, trust, reciprocity, and community and civic engagement

Tariff:

A nationally defined set of costs that the NHS uses to cost secondary care costs on a case by case basis

Third Sector:

A range of diverse organisations which have common characteristics:

- non governmental;
- value driven;
- principally reinvest any financial surpluses to further social, environmental or cultural objectives.

The term encompasses voluntary and community organisations, charities, social enterprises, co-operatives and mutual's both large and small

Well being:

A focus on maintaining independence and good physical, mental and social health and well being. Interventions include combating ageism, providing universal access to good quality information and advice, supporting safer neighbourhoods and promoting health and active life styles

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Please note this paper is complemented by a comprehensive set of annexes.

| Foreword

Our Total Place question was a clear one: “How can we secure improved outcomes for older people at less cost through improved collaboration between agencies, a deeper engagement with citizens and communities and a genuine focus on place?” This is a very important question, particularly across a sub-region involving two primary care trusts, a county council, two unitary councils, six district councils and the police and fire authorities.

As we move from testing a proposition to implementing it the next challenge will be to build on the ambition we have set and maintain the momentum for change. The Total Place perspective will be a vital one as we do this.

1 | Executive Summary

Public sector organisations in Bournemouth, Dorset and Poole currently face acute financial pressures and are preparing for further, deep reductions in public expenditure over at least the next four financial years. There is a broad consensus that, whatever the outcome of the forthcoming election, overall public expenditure will be cut by between 10% and 20% over the three years from April 2011. These financial pressures will be exacerbated in this sub-region by local demographic trends, particularly the large and growing proportion of older people.

This context highlights the importance of the question that has been at the heart of the Bournemouth, Dorset and Poole Total Place pilot:

“How can we secure improved outcomes for older people at less cost through improved collaboration between agencies, deeper engagement with citizens and communities and a genuine focus on place?”

We have explored this question in the context of our understanding that what older people want is to live independent lives for as long as possible and to receive care and support in their homes or as close to them as possible.

In our interim report we concluded that the key to securing improved services for older people at less cost is a shift in investment from the provision of “acute” care for older people (by health and local government) to community services and prevention. Our subsequent work has demonstrated the need for sustained, fundamental change if this shift is to be achieved within a reasonable timescale.

There is substantial evidence that a significant number of older people who are admitted to hospital in an un-planned way are “avoidably admitted”. Work is underway to develop a similar evidence base in relation to intensive social care.

The agencies that collaborated in this pilot share a commitment to achieving this shift through:

- reducing dependency on secondary health care and intensive social care;
- additional investment in community services and preventative activity;
- sustained investment in universal services and social capital.

Across the area there is a significant amount of work currently underway which is directly relevant to this question. This includes:

- The Transforming Community Services (TCS) Strategies being developed by the two PCTs;
- Work between the PCTs and councils to secure greater integration between health and social care;
- A number of initiatives across the area, including the POPP programmes in Dorset and Poole.

There is also scope for reducing dependency on and expenditure on intensive social care. The level of saving involved is less than that which can be achieved by diversion from secondary health care and the picture is complicated by factors such as the very different starting points of the three councils and the fact that they receive income for Care Home placements.¹

In our proposition we have set out the other actions that are needed in order to support the PCTs' ambition to achieve a 15% shift. They include:

- Local government's contribution to enhanced community services, including reablement;
- A targeted programme of preventative activity;
- The potential contribution of locality and neighbourhood working, involving a wider range of public services and the third sector. Elements of this have the potential to put GPs at the heart of a more integrated approach;
- The long term impact of the development of universal services and social capital.

¹ Income from service users assessed charges.

Taken together this would deliver the whole system change that we have concluded is necessary to secure the objective of improved services at less cost.

However, we are aware that if the agencies in the sub-region are to cope with the anticipated cuts in expenditure and meet the aspirations of their residents a higher level of diversion from “acute” care will be necessary. We have explored the scope for achieving a bigger and/or faster shift and have concluded that there are a number of key steps that could help achieve this, including:

- Closer investigation of how resources are used within the health and social care system, including a continuing review of the balance between secondary care and community services;
- Examination of the role of general practice as part of a revised and integrated health and social care delivery system, including addressing the variation between how GPs, as gatekeepers into secondary care, use the resources available to them;
- Longer term, a more ambitious shift will depend upon the extent to which the move to more prevention and the development of more low-level community support can help to create safer, healthier communities with a higher degree of resilience and capacity for self-care/self-management leading to less demand on traditional statutory services.

We have identified a significant number of challenges and barriers we face in implementing this approach. They are:

- Leadership and political challenges across organisational boundaries, including making the case for potentially sensitive changes to the shape of secondary care;
- Cultural and organisational change, including further integration between health and social care and building confidence and trust in alternatives to secondary care;
- The need for new forms of governance and financial management which transcend current boundaries and can oversee a process which is likely to involve expenditure by one organisation being necessary to secure savings by another;

- Government initiatives and requirements including the constraints of the current GP contracts and the perverse incentives that can be introduced by performance measures such as those applied to the Ambulance Trust;
- Capacity issues, both in relation to individual organisations and the partnership and governance structures that will be necessary to make our approach work.

In summary, the work we have carried out to date suggests that the approach we are proposing would secure improved outcomes for older people at less cost. But further work and financial analysis is required to develop and test the proposition before any definitive conclusions can be reached. The final section of the report sets out some next steps for the project board to consider.

In their TCS strategies NHS Dorset and NHS Bournemouth and Poole are planning to divert 15% of older people admitted to secondary care in an unplanned way and to meet the needs of those people through improved community services delivered by integrated health and social care teams. Our analysis suggests that this approach could form the core of a strategy which can indeed provide improved outcomes for older people at less cost. It is important to note, however, that our financial analysis is simply intended to develop and test this proposition, not to inform specific budgetary decisions.

2 | Introduction

“How can we secure improved outcomes for older people at less cost through improved collaboration between agencies, deeper engagement with citizens and communities and a genuine focus on place?”

This is the core question we have explored through the Total Place pilot in Bournemouth, Dorset and Poole. The question is crucially important locally given the high and growing proportion of older people in the sub-region, the performance and improvement issues facing local public agencies and the potential impact of a significant reduction in public expenditure. It is also highly relevant to the current national debate about policy in relation to older people.

Our proposition, which is set out in section five of this report, takes a system wide approach to addressing the question above, seeking to:

- reduce dependency on secondary health care and intensive social care;
- increase investment in community services and preventative activity;
- sustain investment in universal services and social capital.

Key to our approach is:

- Re-shaping secondary care and community services to secure a significant change to the overall system;
- Building confidence in the alternative, including ensuring that it is as responsive and accessible as possible.

Our approach draws on extensive previous engagement with older people which has been refreshed during the course of this work. It builds on the PCTs' Transforming Community Services strategies.

This report sets out:

- The context for this work, including how we have approached our task and the demographic and organisational context (section two);
- Our understanding of what older people want (section three);
- Why significant change is required (section four);
- Our core proposition (section five) supported by detailed annexes setting out our evidence base;
- Issues and barriers which need to be addressed if our approach is to be implemented (section six);
- A summary of the lessons we have learned during the course of doing this work (section seven);
- Recommended next steps (section eight).



2.1 | Total Place in Bournemouth, Dorset and Poole

This Total Place pilot project covers the sub-region of Bournemouth, Dorset and Poole. The decision to focus on this geographical level, which was instigated by the government, has made our work richer, but more challenging.

The organisations involved are: NHS Dorset, NHS Bournemouth and Poole, Bournemouth Borough Council, Dorset County Council, Poole Borough Council, the six District Councils of Christchurch, East Dorset, North Dorset, Purbeck, West Dorset and Weymouth and Portland, Dorset Police and Dorset Fire and Rescue Service. There has, in addition, been active engagement from the third sector, older people themselves and a number of other organisations, including DWP/Job Centre Plus, Department of Health and other government departments.

The theme of the Bournemouth, Dorset & Poole pilot is services and support for older people. It is important to note that this choice reflects:

- The demography of the area, in terms of both the current population and forecasts;
- Current organisational performance, including a higher than average dependence on secondary care.

The choice also reflects the stated priorities of the county council and the two unitary councils and their strategic partnerships. Dorset's community strategy has identified "an ageing population with a falling proportion of young people" as a priority.² The Borough of Poole's priorities include "meeting the needs of our ageing population".³ Bournemouth is committed to "improving the health and community well-being for adults and older people."⁴ In addition, the pilot builds on the approach being adopted by the two PCTs in their Transforming Community Services Strategies.⁵

² Our Role In Dorset, Dorset County Council, 2009

³ Shaping Poole's Future: Sustainable Community Strategy 2006-2012, Borough of Poole, 2009

⁴ Bournemouth Vision 2026 – Sustainable Community Strategy 2007 - 2011, Bournemouth Borough Council, 2009

⁵ These strategies have yet to be published.

There are no formal partnership arrangements for health and social care matters at this sub-regional level. There is, however, a pan-Dorset Local Public Service Forum which brings together the chief executives of the key organisations. There are, however, extensive partnership arrangements at a more local level and joint commissioning arrangements are being put in place across the sub-region.

A Project Board has steered the pilot. Chaired by David Jenkins, Chief Executive of Dorset County Council, it includes the chief executives or equivalent of the partner organisations, including one representative from the district councils, third sector representation, two older people and, latterly, a trade union representative. A small project team has supported and managed the process.

In Bournemouth, Dorset & Poole we defined the task of Total Place as being to:

“secure better services and outcomes at lower cost through a focus on place, greater collaboration between agencies and greater involvement of customers/citizens.”

Improvement in services and less cost lies at the heart of what we are seeking to achieve.

We have also seen Total Place as providing:

- A space for radical and creative thinking, but with a focus on implementation, delivery and efficiencies;
- An opportunity for systemic and organisational learning and development;
- A “hotline” to Whitehall and an opportunity to influence national thinking.

Although the Department of Health generally uses 50 as the definition of an older person, in this pilot we are focussing on services and support for people aged over 65.

There are three main elements to our work:

- Detailed work with colleagues from across the sub region in a number of working and task groups;
- A series of facilitated working events which have sought to engage a wider group of people locally and input from elsewhere, including government departments;
- Commissioning and responding to research and other studies to inform our proposition.

The main events included:

- Two Bournemouth, Dorset and Poole Total Place assemblies;
- A simulation day;
- An external challenge event;
- Meetings with the Department of Health and Treasury;
- A number of discussions with councillors, non-executive directors, older people and the third sector.



The tight timetable for this pilot has meant that a number of critically important players have not been involved in the work, particularly the acute hospitals, GPs and housing providers. An important next step if significant system-wide change is to be implemented successfully will be to involve them in the work.

2.2 | Bournemouth, Dorset and Poole: the context

In this section we set out the context for our work in terms of:

- The demographics of the area;
- The financial position;
- Performance issues.

Demographics

The Office of National Statistics, 2008, mid year estimates show the population of the sub-region to be approximately 710,500.⁶ The Dorset county area with a population of approximately 407,000 people, is predominantly rural but with urban areas. It has an ageing population and relatively low density. House prices are among the highest in England. Average earnings are low and businesses small but unemployment is also low. Tourism comprises a significant section of the local economy and the local authority expects this to rise during the 2012 Olympics.⁷

Bournemouth Borough Council has approximately 163,900 residents. Bournemouth's working age population is growing more quickly than other age groups. Though still a dominant sector, tourism is declining in significance for the diversifying local economy. Unemployment (1.7 per cent) is higher than the regional average but lower than the national average. Like its neighbours, average earnings are low but house prices high. Although overall the town has average levels of deprivation, there exist significant pockets of deprivation.⁸

Poole lies west of Bournemouth with a population of approximately 138,800. The population is similarly ageing. Housing is predominately owner-occupied and house prices are among the highest in the country. Unemployment is low but, like Dorset, wages are also low. The local economy is diverse. Although generally affluent, some

⁶ Office for National Statistics, Population Statistics, 2008

⁷ Corporate Assessment Report: Dorset County Council, Audit Commission, 2007

⁸ Corporate Assessment Report: Bournemouth Borough Council, Audit Commission, 2005

areas of Poole are more deprived and 9.8 per cent of the population live in low-income households.⁹

BME populations across the sub-region vary. According to ONS and Census data just over 3% of the population of the Dorset County area are from a BME background with this figure rising to around 6% of the population in Poole and 8% in Bournemouth.¹⁰

As reported by the Audit Commission, England's population is ageing. In 2009, 17.7 million people will be aged 50 or over.¹¹ This represents close to 33% of the total population. By 2029 this total will increase by more than 25% to 22.9 million, which represents about 39% of the population as a whole.

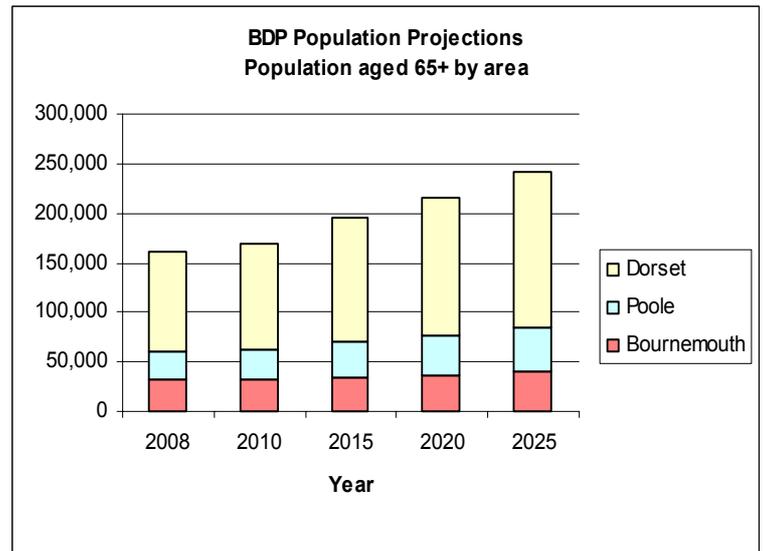
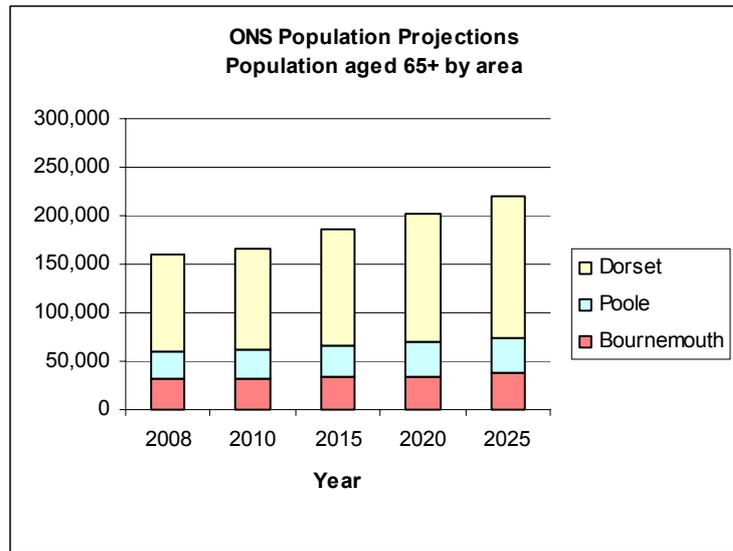
Trend-based projections assume that changes that have been observed in the past are likely to continue and these are produced biennially by Office of National Statistics. Approaches to population projections produced in-house by Bournemouth, Dorset & Poole local authorities are policy-led and linked to estimated levels of housing supply in response to the recognition that population growth is largely dependent upon inward migration. Subsequently the quantity of available housing that is provided will, to some extent, influence the amount of migration that will be seen. The B, D & P projections therefore assumes that if new houses are to be built they will be occupied.

The charts below illustrate the different projected population statistics for over 65's and over 85's from both the Office of National Statistics and from Bournemouth, Dorset and Poole local authorities.

⁹ Corporate Assessment Report: Borough of Poole Council, Audit Commission, 2008

¹⁰ It is important to note that these figures are 2006 estimates using the 2001 census data as a base line, population growth and changes to the BME makeup of the sub-region since 2006 may mean some of these figures have changed. Office for National Statistics, 2006.

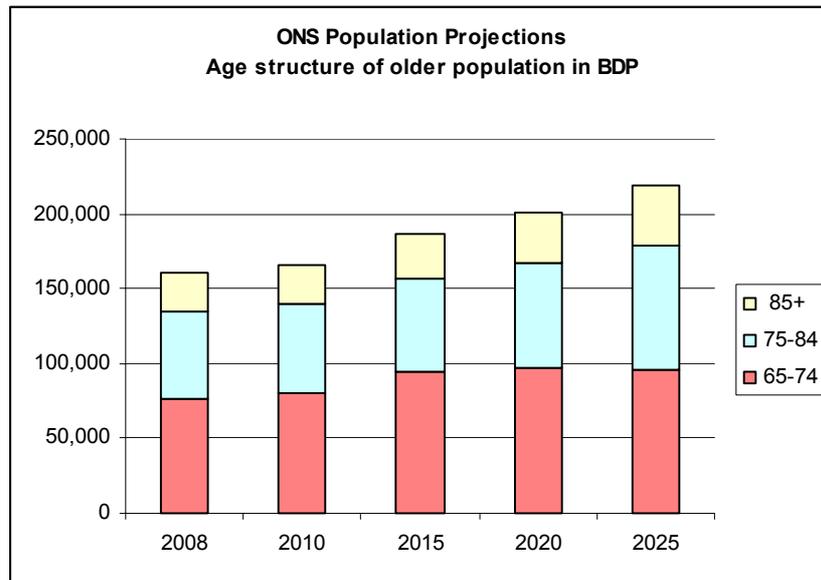
¹¹ The Guardian Care for Older People Conference Presentation, Audit Commission, 2008



The charts show that the ONS and Bournemouth, Dorset & Poole projections differ in terms of absolute numbers of older people, with the latter projections showing the largest increases. This is due to these projections being linked to housing supply and therefore inward migration. As the greatest gains in inward migration are from the pre-retirement age group (45-59 year olds) this further leads to increases in the future older population of the sub-region.¹²

In both projections it appears that a major issue for the sub-region in the near future will be meeting the needs of an increasingly older population, and particularly critical will be the growing number of people living to an advanced old age, largely due to continuing gains in life expectancy.

¹² Office for National Statistics, Population Statistics, 2008



The chart above, which is based upon projections provided by the Office of National Statistics, shows that all three of the age bands of older people are expected to increase over the next fifteen years.

Currently it is estimated that 22.4% of Bournemouth’s population is above retirement age, and 24.3% in Poole. Both are higher than the national average of 19.2%. However, Dorset has a significantly higher proportion at 28.6%, with the highest proportion of population above retirement age in the country.¹³

By 2025, this proportion is projected to have increased further to 37% of Dorset’s population, and 27.1% and 32.4% in Bournemouth and Poole respectively. The largest increases are predicted to be in the 85+ age group. Particularly startling is that by 2031 it is projected that the number of adults aged 85+ will have doubled across Bournemouth, Dorset and Poole.

There are also a range of national research and trend based projections regarding long term conditions including:

- The number of people aged 65 and over with some disability will increase by 40% to 3.3 million;

¹³ Office for National Statistics, Population Statistics, 2008

- The numbers of disabled older people receiving informal care will rise by 39% to 2.4 million;
- Numbers of people in long term care home placements (with and without nursing) will rise by 40-42% to 450,000.¹⁴

On a local level this means that the Joint Strategic Needs Assessment, (JSNA) for Bournemouth, Dorset & Poole shows the numbers of people living with long term conditions to be broadly in line with the national average.¹⁵ However, it predicts a notable increase in the number of older people with long term conditions, including obesity, in line with the increase in numbers of older people generally. The JSNA also points to the benefits to be derived from effective investment by health and social care agencies in effective management of conditions.

In short the key factor is that the sub-region and Dorset and Poole in particular, have a significant and increasingly large number and proportion of older people.

Finances

As part of the Total Place project process a high level count on public expenditure across Bournemouth, Dorset and Poole was conducted. This count revealed that the total spend by public agencies - both local and national - in Bournemouth, Dorset and Poole in 2008-09 was at least £5.7bn (which excludes most MoD expenditure in the area) of which:

- 66% was spent on health (21%) and social protection (45%)¹⁶;
- Local bodies spent £2.9bn.

¹⁴ Use of Resources in Adult Social Care, Department of Health, 2009,

¹⁵ Joint Strategic Needs Assessment (JSNA), NHS Bournemouth & Poole, Bournemouth Borough Council & Borough of Poole Council, 2008

¹⁶ Social protection is a COFOG definition and covers a range of areas such as benefits such as attendance allowance, disability allowance, housing benefit and pensions.

Local authority financial position

National grant funding arrangements are not favourable to the sub-region. Bournemouth, Dorset and Poole local authorities' budgets have been severely constrained for some years and efficiency programmes are being pursued in order to manage within available funding and address the most urgent pressures. A major part of the funding that it has been possible to direct towards adult social care has been required to deal with the strong pressure on Learning Disability and Physical Disability services, including transition cases from Children's Services and the Campus Reprovision project.

The Government's intention that, from October 2010, free personal care at home will be provided to those with critical needs, partly paid for from efficiency savings found by the local authorities, places further pressure on budgets and pre-empted the use of any divertible spending.

Local Authorities Older People Spend

The high level count suggested that in 2008/09 the three councils with responsibility for adult social care spent a total of £132m on older people, of which around £61m was spent on care home placements (without nursing) (Gross).¹⁷ The pattern of spend across the three councils is very varied and is summarised in figure 1 below.

- Bournemouth Borough Council spending significantly more on care home placements (with and without nursing);
- Dorset County Council has historically been a low spender on both care home placements (with and without nursing) and community services for older people;
- Poole spends proportionately less than either Bournemouth or Dorset on care home placements (with and without nursing).¹⁸

¹⁷ See Annex 6

¹⁸ See Annex 1

Whilst each of the three councils is following a broadly similar pattern of service developments in line with national policy, as set out in Transforming Social Care, it is also the case that there are differences in the speed and specifics of these.

Figure 1 shows differences in the level of spending on older people between the three authorities. These reflect the variations between the authorities need to spend on older people as assessed by the governments Relative Needs Formula, which underpins the national grant distribution.

Figure 1

	<u>Bournemouth</u>	<u>Dorset</u>	<u>Poole</u>
	Net	Net	Net
	Spend	Spend	Spend
	£000	£000	£000
OLDER PEOPLE (AGED 65 OR OVER) INCLUDING OLDER PEOPLE WITH MENTAL HEALTH NEEDS			
Assessment and care management	6,219	8,107	2,762
Nursing care placements	2,845	7,435	2,802
Residential care placements	10,802	27,198	6,222
Nursing and residential care placements total	13,647	34,633	9,024
Supported and other accommodation	38	7	28
Home care	6,494	9,847	5,457
Day Care / Day Services	2,102	5,009	1,682
Direct Payments	536	1,238	282
Equipment and adaptations	510	1,511	741
Meals	9	72	258
Other services to older people	828	2,778	-1
TOTAL OLDER PEOPLE (excluding Supporting People)	30,383	63,202	20,233
Spending per member of the population aged over 65	£947	£649	£708

Source: Expenditure from PSSEX1 returns. Population per Registrar General's mid-2007 estimates. All costs include a share of management and support overheads.

While this report was being finalised, the Audit Commission published its latest report on provision for older people: *Under Pressure – Tackling the financial challenge for councils*

of an ageing population. The Audit Commission's findings provide welcome support for the direction of travel set out in this report.

Health Services

Further details of the count are included in the Bournemouth, Dorset and Poole Total Place Interim Report but the PWC analysis suggests that £1,052m was spent on health by local bodies, the vast majority of which was accounted for by NHS Dorset (£565.8m) and NHS Bournemouth and Poole (£482m).¹⁹ Expenditure on care and support for older people by the two PCTs is dominated by the cost of unplanned admissions to secondary care. In 2008-09 the two organisations funded a total of 43,025 spells at a total cost of £122m.²⁰ Both PCTs are experiencing an increase in the number of admissions.

There are differences between the health services provided for older people across the two PCT areas. For example, NHS Dorset provides a number of community hospitals where as NHS Bournemouth and Poole provide far fewer community hospital beds. It is also important to note that the PCT's are in a significant period of change with the implementation of their Transforming Community Services strategies and are also under pressure to find efficiencies on a local and regional basis to address anticipated funding shortfalls.

In common with other health and social care communities across the South West and indeed nationally the PCTs are being challenged to improve quality of services whilst making significant productivity gains. Their forward financial planning assumes future funding allocations will be made on a flat cash basis.

The overall picture

All public sector organisations in the area currently face acute financial pressures. We are mindful of the comments of David Nicholson, NHS Chief Executive, when he announced that the next spending review period from 2011 to 2014 would demand

¹⁹ Bournemouth, Dorset and Poole Total Place Pilot Interim Report, Total Place Partners, 2009

²⁰ See Annex 6

between £15 and £20 billion of efficiency savings.²¹ This equates to a savings target of over 5% every year. We are also aware of estimates by organisations such as the Institute for Fiscal Studies that public expenditure cuts of between 10-20% may be required over the three year period from 2011-14.²²

It is important to emphasise that the figures presented in the report represent a set of aspirations rather than a budgetary commitment. It is also important to recognise that all the agencies with which we have worked are reviewing their expenditure plans and seeking savings and efficiencies. In our financial analysis we have not set a particular savings or efficiency target; nor have we taken into account the need for any upfront investment. Rather we have sought to estimate what contribution our proposition could make to helping the agencies in Bournemouth, Dorset and Poole to cope with the anticipated public expenditure position.

Performance

Performance issues were an important factor in the choice of older people as the theme for the Total Place pilot. National benchmarking tools, such as the NHS Better Care, Better Value Indicators; NHS Comparators; NHS Opportunity locator and Dr Foster indicate that NHS Bournemouth and Poole and NHS Dorset have significant potential to realise financial savings resulting from reduced use of secondary care services for areas such as non-elective admissions, excess bed days and length of hospital stays.²³

Since the publication of the Interim report in mid-September, Local Authorities and PCT's have each received their one place (comprehensive area) assessments.²⁴ Each of the local authorities was assessed as performing well and, within this, the Adult Services in Bournemouth and Dorset are judged to be performing well (Dorset previously adequate) and those in Poole are judged to be performing adequately. NHS

²¹ David Nicholson speech to the Healthcare Financial Management Association, reported in the Daily Telegraph, 2009,

²² Britain's Fiscal Squeeze; the choices ahead, Institute of Fiscal Studies, 2009

²³ See Annex 6

²⁴ Bournemouth, Dorset and Poole Total Place Pilot Interim Report, Total Place Partners, 2009

Bournemouth and Poole is rated as excellent and NHS Dorset is rated as good. Dorset Fire and Rescue Service is performing well, as is Dorset Police.²⁵

The organisations in the area aspire to be in the upper quartile of performance. The challenge involved in achieving this is illustrated by the position in relation to dementia. A review of approaches to dealing with dementia in the South West has highlighted differences between the two Bournemouth/Poole and Dorset communities, not only in terms of having urban and rural characteristics but also in terms of population growth and diagnosis rates and the success of current working arrangements.²⁶

There are currently around 5,400 people with dementia in the area covered by NHS Bournemouth and Poole. This will increase by 18% to around 6300 by 2020. It is achieving a reasonable diagnosis rate of 43.6%, ranking it 38th nationally.

Conversely there are around 6,700 people with dementia in Dorset, set to rise by 44% by 2020 to above 9,600. The diagnosis rate is low at 29.3%, ranking the PCT 147th nationally.²⁷ This indicates there is considerable scope to improve diagnosis and early intervention to reduce the impact on secondary care.

The local area agreement sets annual targets for three year periods and these arrangements need to be aligned with other health targets e.g. vital signs, “health ambitions” and across organisations. The area should have an over riding performance measure relating to the wellness of its citizens.

²⁵ Dorset One Place Assessment / Poole One Place Assessment / Bournemouth One Place Assessment, Audit Commission, 2009

²⁶ South West Dementia Review, South West Health Authority, 2009

²⁷ South West Dementia Review, South West Health Authority, 2009

3 | What older people want

An important starting point for our work has been extensive evidence nationally and locally that older people want to live independent lives for as long as possible, and to receive care and support in their homes or as close to them as possible. We have also had at the centre of our thinking the understanding that older people are worried about being lonely and perceptions that they “need to go into a care home.”

The main source for our understanding of what older people want is the output from a comprehensive consultation exercise which was conducted in Dorset during 2008 when over 4,000 older people took part in *Ageing Well*.²⁸ This consultation asked older people to reflect on what they wanted and expected from their public services and what outcomes they felt would need to be realised to make a real difference to their day-to-day lives.

Eight main outcomes were highlighted as the most important factors that would help improve the lives of older people. At the start of our work these outcomes were adopted by the organisations involved in the Total Place project as the key indicators of what older people across B, D & P want and what the organisations involved in Total Place should strive to achieve. These eight outcomes are:

- Having housing suitable for your needs;
- Being socially integrated;
- Making a positive fulfilling contribution;
- Feeling safe and secure;
- Feeling free from discrimination;
- Feeling financially secure;
- Being in good health in mind and body;
- Having dignity, choice and control.

We have refreshed this understanding of what older people want through a number of smaller scale discussions, including visits to existing groups across the place such as

²⁸ Ageing Well, Dorset County Council, 2008

the Dorset Age Partnership (DAP) and Partnership for Older Peoples Project (POPSS) forums, as well as Total Place specific consultation events.

Two small scale consultation events were held where older people and their carers were updated on the progress of the project and given the opportunity to influence the work. A range of questions were also asked at the events in an informal, flip-chart exercise. Some of the responses can be seen on the following page and in Annex 2.



As well as using existing data and original Total Place specific insight, a range of national research and policy was also used to inform the project. Research such as *Don't Stop Me Now* and *Just Ageing; Fairness, Equality and the Life Course* were two such documents of a range of national customer insight research utilised by the project.²⁹

We have also been conscious that although the forecast increase in the number and proportion of older people in the area is a challenge, it also provides a significant opportunity to involve older people in the provision and improvement of services. It is important to capitalise on the contribution that older people can make to the care of other older people, of themselves and to the wider community.

An important feature in our Total Place question is the hypothesis that engagement with older people can help to secure improved outcomes at less cost. We have sought to reflect this in the inclusion of older people on our project board and our main working group. It will be important this engagement continues as the work develops.

²⁹ Don't Stop me now, Audit Commission, 2008 and Just Ageing; Fairness, equality and the life course, Equality and Human Rights Commission, 2009

Extracts from consultation responses

What disadvantages older people?

Housing
Living in private ...
Health inequalities
Lack of mobility
The attitudes to ageing
Lack of good public transport
People don't always listen
Lack of voice and not knowing our legal rights
Negative attitudes towards old age

Where would you prefer to be treated if you needed help?

As near to my home as possible
As locally as possible in a small unit
As locally as possible – near family
At the best equipped / staffed location – not too far from home
At home
Close to home
At home or in my local area

What services do you feel add most to your quality of life?

Local shops and regular buses
Local communities
Day centres
Community groups
Friends; people to do things with on a day to day basis
I want to know in advance what to expect from retirement
Leisure interest groups
Local shops and post offices
Locally based older peoples meeting places, lunch clubs, coffee morning
Community groups, the post office, lunch clubs
Lunch clubs, support groups (for communicating)

Who or where would you go if you needed support or help?

“Depends on the issue and if you are able to understand where to go”

“Its all according to what the problem or issue is...”

“The library”

“Charities or local POPP’s wayfinders”

“Family”

“GP’s or nurses”

How do you think ‘care’ and ‘health’ services could be improved?

A ‘can do’ attitude from caring services and agencies

By talking to each other

Home visits

More investment in staff development and support

By becoming more localised

Provide better respite care for carers across county

Find more use for day centres and look at the activities that could be provided in the day, night and weekends

Better cooperation between social health, NHS and the community

Find more paid / voluntary carers for rural areas

Forming more carers support groups at local level

Make getting to the services i.e. hospitals, easier

Listen

Person centred approach

Earlier diagnosis of dementia and identification of respite facilities

Be brave: reinstate ‘moderate’ levels of eligibility criteria

Occasional visits of GP’s to engage with people at lunch clubs

4 | Why things need to change

In our interim report we concluded that a determined drive to “invert the triangle of care” was the key to securing improved services for older people at less cost. In short this requires a shift in investment from the provision of secondary care and intensive social care services for older people to community services which will include some prevention and early intervention services.³⁰ Universal services and the development of social capital will need the active engagement of older people themselves and a sustainable strategy that can offer long term benefits. In summary the shift required must be wide ranging and cannot just be limited to those who meet FAC (fair access to care) eligibility criteria. There is a need for interventions which address the whole population of older people – not just the 11.6% who come into contact with social services in the sub-region.

In our subsequent work we have collected more evidence on the nature of the challenge and the need for sustained, fundamental change is needed if this shift is to be achieved within a reasonable timescale. This section summarises the scale of the problem and explains why fundamental, whole system change is required.

The Challenge to Improve – Case Study

After five weeks in hospital Miss C was provided with the intensive home care support her daughter had previously and unsuccessfully requested.

Miss C, aged 86, had been admitted to hospital from home where she lived alone. She had been found wandering and was in poor physical condition, with partial sight and Alzheimer’s. Hospital staff were very concerned about Miss C’s condition when she was admitted. The minimum cost per day of Miss C’s stay in hospital, before treatment and staff costs, is £365.

Miss C received no community services and was not known to the community mental health team. Her daughter had contacted the access team, but was told she did not meet the criteria for support despite her poor condition and tendency to wander.

Following intensive input from the hospital social worker, Miss C is now back at home receiving the intensive home care her daughter had been seeking. The home care that Miss C receives costs £299 per week.

³⁰ Bournemouth, Dorset and Poole Total Place Pilot Interim Report, Total Place Partners, 2009

As we have reported in section two there is a significant over-reliance across the pilot area on secondary care and intensive social care services for older people. This is wasteful of resources and does not produce best outcomes for service users. NHS Bournemouth and Poole has the second highest emergency hospital admission rates in the South West region (even after age standardisation). The chances of an older person who presents to A&E being admitted to Poole Hospital are 23%, to Royal Bournemouth Hospital 30% and 50% at Dorset County Hospital in Dorchester.³¹ 60% of older people responded to by the South West Ambulance Service are taken to hospital. This is below the national level but still significantly above the level considered desirable or achievable.³²

In the longer term two factors are likely to exacerbate the pressures facing agencies in the area. They are:

- Demographic change: The demographic profile suggests that there will be a 31% increase across the sub region in people over the age of 85 in the next 10 years. 57% of those aged over 85 years are in contact with a district nurse.³³
- The predominance of chronic health conditions, which mean that more people require long-term, complex care and support. Long term health problems already account for 80% of GP consultations, a pressure which is bound to increase as the effects of an ageing population take hold.³⁴

A priority in these circumstances is for an enhanced range of community services and preventative work. The menu of options is huge – from telecare and telemedicine, through the Expert Patient Programme and other self care approaches. Community based initiatives and patient centred care are crucial. Yet despite moves to put the commissioning role of PCTs at the centre of the system the overwhelming majority of the spending and activity still takes place in secondary care.

Across Bournemouth, Dorset and Poole schemes designed to prevent admissions to hospital are operating on a limited basis in different localities but not yet on a comprehensive basis. Annex four contains a pilot study conducted in the Dorset area

³² See Annex 6

³³ Use of Resources in Adult Social Care, Department of Health, 2009

³⁴ Use of Resources in Adult Social Care, Department of Health, 2009

that found that 15% of all admissions to secondary care of older people (to Dorset County Hospital) were assessed as avoidable or preventable. 15% were also for stays of two days or less. Just fewer than 50% of those “avoidably admitted” were also known to social care services.

NHS Bournemouth and Poole, the Borough of Poole and Bournemouth Borough Council have been working in partnership since September 2009 in one of the Department of Health national integrated pilots. It is testing a new model of GP locality integrated dementia services. The ambition is to integrate not only health and social care but to become established within the wider community. One of the key performance indicators is a reduction in inappropriate admission to hospital and long term care.

Similarly, the introduction of reablement services in the sub-region is in urgent need of further development. The aim of reablement is to reduce (or indeed eliminate) the need for long-term care by individuals by building skills and confidence (over a maximum period of six weeks). Initial findings show that within a pilot site in Ferndown it was possible to reduce the weekly amount of care in nearly 75 of 100 cases.³⁵ The Transforming Social Care strategies direct local authorities to develop preventative and early intervention services. The initial indications are that reablement services will substantially reduce costs in the short, medium and long term.



Further evidence about why change is needed to improve efficiency and cost effectiveness derives from the evaluation of the POPP programme which involved both Dorset and Poole.³⁶ This report suggests that pilot sites continue to have a demonstrable effect on reducing hospital emergency bed-day use when compared with non-POPP sites. A number of other initiatives have been identified which could contribute to a

³⁵ Report not yet published

³⁶ The National Evaluation of Partnerships for Older People Projects, Personal Social Service Research Unit, 2010

reduction in hospital bed-days, such as the Improving Self Efficiency, Self Esteem and Confidence in Children and Adults pilot in East Dorset (ISSECA) which have yet to be fully tested. The initial results are very encouraging.³⁷

In summary, despite increased investment in community services and some well-being, early intervention and preventative activity, the numbers of older people being admitted to hospital and other forms of “acute” care has continued to increase.

In reviewing the reasons for this we have adopted a transport analogy. We have concluded that secondary care capacity is like motorway capacity: for as long as it exists it will be filled. What is required, therefore, is a whole system change which involves:

- Reconfiguring secondary care and community services to secure a shift in capacity to the provision of care and support in and near people’s homes;
- More sustained investment in truly integrated, responsive and easily accessible community services and intermediate care;
- More sustained, comprehensive and targeted investment in preventative activity;
- Action to address issues around culture and expectations to build confidence in the new system.

The Challenge to Improve - Case Study

Mr F spent six weeks in hospital having been found collapsed at home in a very confused condition. Simply to keep Mr F in a hospital bed cost a minimum of £365 per day before staff and treatment costs are considered.

Mr F, who is 86 years old, lived alone in warden-controlled accommodation. On many occasions he was found wandering by the police. Despite concerns having been expressed by his warden and brief contact with the community mental health team, he did not receive any community services.

Hospital staff could not get a clear picture from Mr F about how he shopped, cooked or paid bills. A subsequent visit revealed that there was no food in his flat and that there were a number of unpaid bills. While in hospital Mr F required intensive input from the hospital social worker and subsequently a care home placement had to be funded at a cost of £500.85 per week.

The next section sets out in detail our proposition for securing this shift.

³⁷ See Annex 5

5 | The Propositions

Introduction

The agencies that collaborated in this Total Place pilot share a commitment to improving outcomes for older people across Bournemouth, Dorset and Poole at less cost by:

- reducing dependency on secondary care and intensive social care;
- additional investment in community services and preventative activity;
- sustained investment in universal services and social capital.

This is not a new commitment, and this proposition takes full account of the PCTs' Transforming Community Services strategies and work being done across the sub-region to better integrate health and social care. The key elements that the Total Place approach brings are:

- Our recognition of the collaborative nature of the action required to achieve it, possibly including action at a sub-regional level and the involvement of a wide range of bodies beyond health and social care;
- Our focus on acting in relation to the system as a whole, from the commissioning of secondary care through to community development and steps to nurture neighbourliness at the very local level;
- Our belief that fundamental change is required to the shape of health and social care delivery in the sub-region if a sustained shift in the balance of expenditure and care is to be achieved.

Our overall vision is one in which older people are able to live independent lives longer and where possible receive care and support at home or in the community. To build that picture we have focused on three jigsaw pieces. These are about opportunities to:

- Reduce the number of older people avoidably admitted to secondary health care or unnecessarily receiving intensive social care services;

- Enhance the range of community services to: meet the health and social care needs of older people in or as close as possible to their homes; and prevent them from becoming dependent on secondary or intensive social care;
- Develop universal services and social capital so that older people can meet their needs with the least recourse to statutory services and maintain their independence and well-being.

In order to retain a focus on the “at less cost” element of our commitment we have used the following formula:

$$\mathbf{A - (B+C) = Y}$$

Where:

A is the saving secured by reducing the number of older people avoidably admitted to secondary health care or unnecessarily receiving intensive social care services;

B is the increased investment necessary to develop enhanced community services in order to:

- Meet the requirements of those diverted from secondary care and intensive social care services;
- Prevent unnecessary use of intensive social care and secondary health services in the future.

C The cost of sustained provision in universal services and the development of social capital to help older people maintain their independence; and

Y is the contribution to responding to a significant reduction in public expenditure.

This proposition has been explored at a Bournemouth, Dorset and Poole level, but as the following sections make clear, we believe that different elements of the task can be discharged at different levels, while maintaining an essential focus on the system as a whole.

5.1 | Diversion from “acute” care

The starting point for our proposition is to reduce significantly the numbers of older people who are avoidably admitted to secondary care or who are avoidably receiving intensive social care. The analysis and evidence on which this section is based is attached in Annex Six.

Diversion from secondary health care

Our exploration of this proposition through the Total Place pilot helpfully coincided with the preparation by the two PCTs of their Transforming Community Services strategies. This section of our report draws heavily on that work.

A substantial body of national and local evidence shows that there is significant potential to reduce the dependency of older people in Bournemouth Dorset and Poole on secondary care services.³⁸ This includes national benchmarking tools such as the NHS Better Care, Better Value Indicators; NHS Comparators; NHS Opportunity locator and Dr Foster.

Locally, a study of emergency admissions (See annex four) has identified the potential for significant reductions in unplanned admissions of older people, a conclusion confirmed in a more recent local study.³⁹ In 2008/09 NHS Dorset accounted for 49,006 unplanned admissions and NHS Bournemouth and Poole for 50,664. Of these 48.9% were over the age of 65 in Dorset and 37.5% in Bournemouth and Poole. In both areas the number of unplanned admissions is increasing.

On the basis of this national and local evidence we have identified a target of reducing unplanned admissions of older people by 15% over three years as being challenging but achievable. This is the assumption on which the PCTs are developing their Transforming Community Services strategies. They expect this could be achieved over a three year

³⁸ See Annex 6

³⁹ Review of inappropriate hospital admissions and discharges and support for older people at home, Dorset health scrutiny committee, 2008

period, as demonstrated in figure 2 which sets out avoidable episodes of care, percentage diversion and the level of resources released over a three year period (using figures for 2008-09 as a base):

Figure 2⁴⁰

NHS Dorset (no productivity) ⁴¹			
15% of over 65's non-elective -			
At the end of:	Year 1	Year 2	Year 3
	40%	80%	100%
Spells	1,439	2,878	3598
Savings	£4,412,881	£8,285,762	£10,359,650
Cost to make savings	£1,510,950	£3,021,900	£3,777,900
Net Savings	£2,901,931	£5,263,862	£6,581,750

NHS B&P (no productivity)			
15% of over 65's non-elective -			
At the end of:	Year 1	Year 2	Year 3
	40%	80%	100%
Spells	1142	2284	2855
Savings	£3,197,600	£6,395,200	7,994,000
Cost to make savings	£1,142,000	£2,284,000	£2,855,000
Net Savings	£2,055,600	£4,111,200	£5,139,000

Reducing the number of unplanned admissions by around 15% would bring the position in the sub-region to around the national average. It is consistent with the PCTs' draft Transforming Community Services strategies. The Total Place pilot project has, however, been keen to explore what it would take to achieve a greater reduction and/or to increase the speed at which a greater level of diversion could be achieved. This will be necessary if the agencies in the area are to reach to top quartile of performance. Later in the report we refer to ways this might be achieved, but for the purposes of our core proposition we are adopting a goal of 15%.

Diversion from intensive social care

⁴⁰ See Annex six for more information about this calculation.

⁴¹ These figures exclude any planned productivity gain to be made in delivering community services.

Bournemouth, Dorset and Poole local authorities share the commitment of the PCTs to providing improved services at less cost. To this end they have and will continue to address the potential for avoiding unnecessary admissions to care homes and the provision of high cost domiciliary care. To illustrate this Poole have over the last two years significantly reduced funded care home placements. Dorset reduced the funded placement target numbers from 1106 in 2008-09 to 1040 in 2009-10.

It is important to note the different referral and decision making processes that exist between provision of social care services and health services as well as the significant differences between the three councils with responsibility for social care. For example, Bournemouth Borough Council has a proportionately higher level of spend on Care Home placements than the other two local authorities. Additionally, there are a number of considerable differences between the financial impact of diversion from social care as opposed to secondary health care, these include:

- Local authorities receive a financial contribution towards the cost of Care Home placements which reduces the financial benefits of diversion which accrue to them;
- Councils are required to pick up the costs of “self funders” who opt for Care Homes but present to the local authority when they run out of capital and can no longer afford to pay for their placement;
- For many people the difference in cost between intensive social care and the alternative is significantly less than that between secondary health care and the alternative.

It should also be noted that some services which may produce significant efficiencies, particularly reablement are in the early stages of implementation. Therefore, and inevitably, predictions of savings and relative reductions in costs are still tentative.

As is shown in annex six the level of expenditure on care home placements in Poole is relatively low. Poole has concluded that there is limited scope for significant further diversion from care home placements, but is actively exploring the scope for avoiding inappropriate long term domiciliary care. Initial results from a scoping exercise are due in March.

Dorset County Council is, historically, a relatively low spender on both Care Home placements and domiciliary care services for older people. Consequently the opportunities available for savings and efficiencies are considered to be limited. Dorset has estimated that a 10% reduction in funding Care Home placements would equate to about 140 places. At an average cost of £585 per week, the gross saving would be approximately £3.7m, reduced to £2.7m when the loss of service user contributions is taken into account.⁴² Since March 2005 the number of residential care places purchased in the independent sector has reduced by 20%. The significant reduction in care home placements already made in recent years and the relatively intensive level of need of those who now reside in care homes means that domiciliary care packages would also be relatively high cost. The county council is, however, vigorously piloting policies to reduce avoidable longer term care home placements principally through reablement services and reviewing block contract arrangements to drive down void costs.

Bournemouth is in a different position, the detail of which is set out in annex nine. In short, the council currently admits a relatively higher proportion of older people to Care Homes than the other two councils. For Bournemouth, a 10% reduction in funding care home services would equate to 80 places. This would save roughly £1.9m gross in a full year, on a median cost of £461 per place per week. The loss in client contributions is estimated at £110 per person per week, i.e. £457k a year, leaving a net saving of about £1.4m. It is difficult to be definite about costs for alternative services to support these 80 people to remain in their own home, but these are best guess figures. The conclusion for Bournemouth would seem to be that the net savings made in reducing residential places is almost entirely offset by the costs of providing reablement and domiciliary care and day care (see section 5.3 for detailed information on alternative services). Total savings could add up to only £100k a year.

The Use of Resources in Adult Social Care guide recommends that, as a useful local target, 40% of social care expenditure is on long term care home placements.⁴³ The respective position for older people in 2008/09 using PSS EX1 figures is Bournemouth 50%, Dorset 57% and Poole 48%.⁴⁴ The current relative funding position for older

⁴² See Annex 6

⁴³ Use of Resources in Adult Social Care, Department of Health, 2009

⁴⁴ See Annex 1

people's services in each of the three authorities will impact on their ability to reach the 40% target figure. Each of the local authorities are aware of this target but are equally clear that real medium and long term savings are also dependant on the development of community services which are referred to in section 5.2 below.

The table below illustrates the scope for diversion from intensive social care provision by the Local Authorities. This level of diversion is broadly self-financing for Local Government but will also assist and support the PCT's commitments to reduce dependency on secondary care services. The Local Authorities recognise that further investment in the services and others is necessary if the ambition to achieve 15% reductions and above is to be realised. There is also a need for considerably more work between the PCT's and the Local Authorities to address areas of mutual concern and where joint working can be most effective.

Illustrative Picture of potential diversion from long term care home placements and long term domiciliary care

over 65's receiving long term care home placements and long term domiciliary care			
Local Authority	Bournemouth	Dorset	Poole
Total Care Home placements supported by the LA's (08-09)	810	1550	445
Proposed diversion from care homes	80	140	14
Projected reduction in expenditure	£1,400,000	£2,670,700	£308,000
Current numbers receiving domiciliary care (hours per week)			6,500
15% assumed saving (hours per week)			975
15% assumed net saving			£690,000
Projected reduction in expenditure			£998,000
Alternative Provision type	Reablement, OT, equipment, day care and domiciliary care	Reablement, OT and equipment and domiciliary care	Reablement
Cost of alternative provision (@£1000per person for Poole)	£1,300,000	£2,221,700	£986,000

Conclusions

This analysis would suggest that while there is scope for a significant reduction in the number of older people avoidably admitted to hospital, there is not an easy parallel with reductions in intensive social care services provided by the local authorities, in particular Dorset and Poole will find difficulty in making reductions in the short term in care home

placements given their recent measures. All three councils are positively and urgently exploring a number of ways of significantly reducing avoidable expenditure and increasing efficiencies. The results of their work will be shared with partners over the next few months. Some early information on the anticipated savings from the introduction of reablement services is set out in the next sub section.

The summary position therefore is:

$$\text{£18.3m} - (\text{B} + \text{C}) = \text{Y}$$

Where:

B is the increased investment necessary to develop enhanced community services in order to:

- Meet the requirements of those diverted from secondary care and intensive social care services;
- Prevent unnecessary use of intensive social care and secondary health services in the future.

C The cost of sustained provision in universal services and the development of social capital to help older people maintain their independence; and

Y is the reduction in overall expenditure that could be secured.

It should be noted that:

- This figure draws on the PCTs' Transforming Community Services Strategies and excludes any local authority contribution. However, an illustrative table of a potential reduction in care home placements can be seen above. Further local authority commitments to efficiencies and cost reductions are indicated against each of the service areas described in the following sub section;
- It is based on average tariff;
- It excludes the cost of any alternative provision;
- It is an annual figure but current assumption is that it would take three years before the full rate of diversion was achieved.

It is also clear from discussion during this exercise that action on this issue at a Bournemouth, Dorset and Poole level may be necessary, because:

- Acute hospital catchment areas do not reflect PCT or local authority boundaries and people from different parts of the sub-region often attend a secondary care setting outside the area covered by their PCT or local authority;
- A concerted sub-regional approach by the relevant local authorities, PCTs and their leaders could help address the contentious issues this approach may raise and secure the necessary support needed to carry this work forward.

5.2 | Re-shaping and expanding community services

The second element of our proposition concerns additional investment in community services and preventative activity. This is important in order to both meet the needs of people who would otherwise be admitted to secondary care and intensive social care, and to reduce the dependency on “acute” care in the medium and long term. This section of the report outlines the nature of that provision (set out in the table), summarises a number of issues which need to be addressed in putting enhanced provision in place, and provides some information on examples of good practice.

Community services

The core of this element is being developed by the PCTs (in conjunction with the county and borough councils) through their Transforming Community Services Strategies. At the heart of these strategies is the provision of acute care and redesigned intermediate care in people’s homes or in designated care settings (see annex 6). They envisage the provision of integrated services with local authorities, including close liaison with GPs, A&E departments and the South Western Ambulance Trust to build confidence in the new system.

The services provided will include: acute assessment and diagnosis; crisis support and intensive rehabilitation and reablement. The vision includes integrated community teams and care services. The PCTs are also planning to redesign services for people with long term conditions to enable them to continue to live independently for as long as possible.

Types of community service provision:

- Reablement and focused intermediate care;
- Early diagnosis of, and intervention for, people with dementia;
- Health and social care crisis response services;
- Extra care housing and other supported housing models;
- Telecare and Telehealth;
- Intravenous therapies;
- Virtual Wards;
- Support for carers;
- Falls prevention and management;
- Direct access Community Hospital beds;
- Self care and peer support;
- Case finding and case management, using predictive risk and screening tools;
- End of life care;
- Clinical triaging;
- Joint working in relation to long term conditions / complex needs;
- Integrated community equipment services;
- Some elements of preventative services.
- **See annexes 6, 7&8 for specific references to approaches in B, D &P.**

This approach builds on “Putting People First” and the Transforming Social Care programme which recognise the importance of timely support in maintaining individual independence, at a time when local authority resources are increasingly targeted at those with greatest need. Intermediate care services form an important part of the care continuum for people whose care needs exceeds those offered “routine” primary health and social care support, yet whose management does not require admission to an “acute” hospital or to a long term institutional care setting. Department of Health guidance recommends that intermediate care services should be targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to secondary care or care home services.⁴⁵

⁴⁵ Putting People First, Department of Health. 2007

Prevention

The role of prevention and early intervention is a crucially important part of the picture we are painting. Our overall proposition is that a comprehensive and sustained range of community services can be supplemented by preventative and early intervention activities which have the potential to both contribute directly to reducing pressure on secondary care in the short term and to making a longer term contribution to a fundamental shift in the balance of care and support for older people.

National policy direction is increasingly geared toward prevention and early intervention services. Putting People First and the Local Authority Circular *Transforming Social Care* are both focused on local public services making “a strategic shift towards early intervention and prevention, the cornerstone of public services.”⁴⁶ Effective prevention is also at the heart of the 2010-11 NHS Operating Framework, “prevention work can help people to stay healthy, support those most at risk of ill health and provide a rapid diagnosis when symptoms of ill health present”.⁴⁷ Our proposition envisages early intervention and prevention services playing a key part in the shift that, in conjunction with enhanced community service provision, can help to reduce unplanned admissions to secondary care and improve older people’s lives in the sub-region. In developing our thinking we have drawn on lessons from early intervention and prevention approaches currently underway across the place and elsewhere. These include:

- Mid-Dorset admissions prevention initiative. This localised project has offered low level monitoring, befriending and practical support in an effort to prevent avoidable admissions to hospital;
- Poole and Bournemouth Councils jointly fund a Handyvan service that aims to provide a service to older people (over 60 and in receipt of benefits) to enable them to maintain their tenancy and/or owner/occupiers to remain in a safe and secure home. For the period April 2008 to February 2009 the Handyvan Service received over 1,200 enquiries and over 1,500 jobs were carried out. An enhanced service, in partnership with Dorset Police and with CLG funding, is

⁴⁶ See Annex 13

⁴⁷ NHS Operating Framework

- currently being developed which will secure properties and will initially target the over 80s;
- Specific housing adaptations are provided by West Dorset Care & Repair Agency which helps elderly people and those with a disability lead independent lives;
 - Borough of Poole provide a range of floating support services for older people with dementia and other specific health and social care needs.

Falls prevention is an effective example of how action at this level can make a difference. Each year, 35% of over-65s experience one or more falls. About 45% of people aged over 80 who live in the community fall each year. Between 10 and 25% of such fallers will sustain a serious injury. Published evidence shows that:

- The numbers are large. A local authority and PCT population of 300,000 may currently include 45,000 people aged over 65. As things stand it can reliably be assumed that of these:⁴⁸
 - 15,500 will fall each year;
 - 6,700 will fall twice or more;
 - 2,200 fallers will attend an accident and emergency (A&E) department or minor injuries unit (MIU);
 - a similar number will call the ambulance service;
 - 1,100 will sustain a fracture, 360 to the hip.
- The cost to the public purse is high: the additional direct cost to the NHS for hip fractures is estimated to be £10,000 per incident (excluding any additional local authority social care costs).⁴⁹

A number of important issues will need to be addressed in enhancing community services and preventative activity, including:

- The role of integrated teams;
- The importance of targeting;

⁴⁸ Falls and Fractures: Effective interventions in health and social care, Department of Health, July 2009.

⁴⁹ Falls and Fractures: Effective interventions in health and social care, Department of Health, July 2009.

- Issues of confidence and trust.

The next sections address each of these issues in turn.

Integrated Teams

Work is underway in both parts of the sub-region on deeper integration between health and social care, and our proposition would involve building on that work, including the development of integrated health and social care community teams. This reflects the fact that the majority of people with long term conditions or complex needs require support from various professional staff within both health and social care. At an individual level this is likely to result in joint case management of a person's needs. As well as providing better outcomes for adults and older people, when health and social care operate in a joined up way, there are also efficiencies on offer to both the health service and local government.

We are aware that there are different models across the country; the unifying characteristics of most of these are that they involve:

- multi-disciplinary and multi-agency team working and joint responsibility for a shared case load - in other words there is a degree of joint case management;
- working alongside GP practices undertaking case management and associated treatment and rehabilitation interventions for individuals who may have a combination of complex single or multiple conditions and intensive needs, and whose care requires coordination;
- seeking alternatives to hospital admission in order to avoid inappropriate use of hospital beds, prolonged and unnecessary stay in hospital or inappropriate admission to long-term care facilities;
- making use of every opportunity for joint visits between disciplines and other organisations' for the benefit of the patients;
- being proactive in case finding and intervening early through the use of:
 - predictive risk tools to stratify the local population;
 - The adoption of a case finding model with local hospitals utilising information used by ward staff but previously not accessed by social care professionals. Thus rather than maintaining the historic referral and

allocation model, older people admitted to hospitals will be reviewed by a member of the team within 24 hours;

- Paramedics will have direct access to team leaders in order to avert admissions to hospital;
 - GPs will use mechanisms (e.g. whiteboard systems) whereby they will identify people known to be at risk to the locality team in advance of a crisis occurring.
- Having direct access to appropriate social care services and health services and adopting 'pro-active case co-ordination'. This will target people not deemed to be eligible for ongoing social care, but who nevertheless could benefit from time limited assessment with a view to co-ordinating and facilitating their access to community sector or other mainstream services.

Work is being undertaken between Dorset County Council and NHS Dorset on a Connecting Health and Social Care project. Reporting in March 2010 this is expected to show that a more integrated approach between the sectors will lead to the County Council being able to meet savings targets for 2010/11 on staffing of around £1m. There are other opportunities to achieve savings through joint commissioning.

Case Study: Integration of Health and Social Care services

The Poole POPP project had a specific on reducing avoidable admissions and length of stays within Poole Hospital. In annex six a table summarises the goals set for the project and outcomes achieved by March 2008. The success of the project as compared with other areas of Poole which were not within the pilot directly led to:

- The investment by NHS Bournemouth & Poole of £680,000 in an intermediate care service which replicated the Poole POPP pilot model;
- The reconfiguration of £535,000 of Borough of Poole services through the redesign of the existing hospital social work team and the in house rapid response team to form a new joint intermediate care service;
- The project was nationally recognised and won the regional and national health and social care award in 2008 for partnership working.

Targeting

An important lesson we have drawn from the national POPP programme highlights the effectiveness of targeting interventions on those whose independence is at risk.⁵⁰ The learning also suggests that there are effective alternatives for some people to standard ongoing social care support. Targeting is therefore important as a way of:

- Finding and supporting those people who are at risk of deterioration;
- Diverting some people away from a social services response to have their needs better met through community support.

Ways in which this could be taken forward include:

- Developing a proactive care co-ordination function focussed explicitly on case finding people at risk as well as being part of a managed pathway into alternatives means of support for this who are not eligible for ongoing support from social services;
- Using small area mapping and comprehensive data analysis to identify 'hotspots' for neighbourhood team intervention.

⁵⁰ Making a Strategic Shift to Prevention and Early Intervention, Dept of Health, 2009

Intervening before the point of crisis is at the heart of preventative approaches. One of the most significant developments in recent years has been initiatives which enable councils to proactively identify people who could benefit from early support, and then to work with them over a relatively short period of time to address the range of factors in their lives which appear to be hastening their deterioration or which could potentially result in a crisis episode.

Proactive care co-ordination is the term used to describe an approach to working with people to undertake a holistic assessment of their needs and make arrangements for them to access the support they require from third sector organisations or local community capacity. The people worked with are mostly not yet deemed eligible for mainstream social services care management - i.e. they are below 'FACS' eligibility criteria.

The evidence suggests that this kind of function can:^{51,52,53}

- Reduce the use of emergency bed days in secondary care, A&E attendance;
- Reduce GP appointments;
- Reduce falls;
- Produce better outcomes for older people;
- Act as an alternative pathway away from social care.

This kind of intervention is an important part of the 'infrastructure' of a social care and health system. It is estimated that the cost of implementing a comprehensive model of this type of intervention across the sub-region would be around £2.3m (but an element of this could be off-set by using existing capacity).

A study of a sample of service users by the POPP National Evaluation found that following involvement with proactive care coordination services:⁵⁴

- Visits to A&E departments fell by 60%

⁵¹ Knowsley Mental Health Services (2008) Knowsley IKAN service end of year report. Knowsley PCT.

⁵² National Evaluation of the POPP Programme, PSSRU, 2010

⁵³ Cass Business School (2008) The economic, health and social benefits of care co-ordination for older people: the Brent Integrated Care Co-ordination Service. Cass Business School.

⁵⁴ Personal Social Services Research Unit (2009) The national evaluation of the POPP Programme. Department of Health.

- Hospital overnight stays were reduced by 48%
- Visits to practice nurses reduced by 25%
- GP appointments fell by 10%.

Trust and confidence

There are a number of critically important organisational and cultural issues which must be addressed in putting this alternative provision in place, including:

- The importance of community services being as responsive as possible, including 24/7 cover;
- The importance of building trust in this alternative provision throughout the system, including GPs, paramedics, A&E clinicians, older people, their carers and families.

This will take time and effort, but is a critically important part of implementing the new approach.

The next sections deal in more details with a number of important aspects of community services and preventative activity.

Dementia

We are aware that improving community services for older people with dementia will be critically important if we are to significantly reduce demand on “acute” services. Within the overarching framework outlined by the National Dementia Strategy improvements will need to be made in community and intermediate care services for this group of people. Whilst many people with dementia will have their needs appropriately met within the generic model, there will be a need for a degree of specialist provision in order to meet the admission avoidance targets. Options to be considered include:

- Crisis Response and Intensive Support Service - providing time limited enabling support to facilitate older people with dementia or a mental illness to remain in their own homes and/or to support hospital discharge. It provides domiciliary enabling support at a point of crisis or significant risk to loss of independence. The aim is to seek to establish an appropriate and sustainable level of support to

enable the older person to remain at home rather than being admitted to hospital as an emergency or a care home. One of the innovative features of the model is that it undertakes a reablement approach which older people with mental health needs are often excluded from;

- Dementia out of hours support service – to offer short-term support, advice, assessment and onward referral to people with dementia, and to support carers. In essence the service model involves including a specialist dementia element within mainstream out of hours response services;
- Reconnect Service - provides housing related floating support to older people with memory problems or dementia. The essential purpose of the service is to assist people to develop or maintain their independence within the community, so preventing the loss of their home or tenancy and/or avoid the unnecessary use of more institutional forms of care. The service is a long term non-chargeable Supporting People service. It is currently commissioned in part of the Total Place area and could be extended throughout.

Reablement

Reablement has a central role to play in reducing the need for long term intensive domiciliary care and there is emerging evidence that it may assist in preventions of admissions to secondary care and Care Homes. Evidence from a number of councils suggests that the average cost per client for a complete episode of reablement is somewhere between £1,600 and £2,100.⁵⁵

The average performance range is that around 50% of people who start reablement require no subsequent domiciliary care, and that the evidence suggests this remains true for the majority of these people even two years later.

With regard to hours of domiciliary care used, it is thought possible that in the first year of operation it might be possible to see a reduction (compared to conventional domiciliary care packages) of approximately 45%, which might reduce even further to 56% in the second year of operation.

⁵⁵ Based on work with a number of councils by the Care Services Efficiency Delivery (CSED) programme

All this data comprises averages and it is recognised that it will be important to better understand the current position before basing firm cost reductions on these figures. Nevertheless they do indicate the scale of what is possible.

Reablement programmes are underway across the sub-region and details are included in annex 6.

Extra care housing

Extra care housing models are generally lower in cost to local authorities than care home placements. This form of provision is particularly important in the Total Place area, particularly in the context of the care home placement profile. Plans are in place for the expansion of extra care housing in the area and this will enable the substitution, at lower cost, of some of the future placements in care homes which might otherwise have taken place.

Within Bournemouth there is an extra care housing scheme already in place which has health facilities available on site. Two more schemes are currently being built, with finance and planning permission agreed; these are likely to be completed during 2011. There is a range of sheltered housing, both council owned and in the private and voluntary sector with either warden or floating support. A Housing Officer works within adult social care that focuses on independent living for older people and fast tracks housing to facilitate hospital discharge and avoid admission to residential care.

Dorset has invested heavily in extra care housing provision in recent years and continues to do so. Major schemes have been developed in Weymouth, Portland and Christchurch and building is now taking place on a scheme in Blandford Forum.

Telecare

Local Authorities generally are beginning to make wider use of assistive technologies to support people to remain in their own homes. This varies from simple call systems to

alert a central point when a person has had an emergency to using sensors to track key activities that may trigger alarm. In Bournemouth, a “Bleep” service and access to equipment to monitor movement and falls, are available via Housing Landlord Services and are widely advertised and demonstrated at day centres etc. In Dorset, a pilot project began in October 2006 and is ongoing. Evaluation shows there have been some quantifiable savings made by both the County Council and the NHS, tentatively amounting to a saving of £155,000 (£104,000 to Dorset CC and £51,000 to the health service). In the first 12 months of the pilot 250 service users were assessed and by projection there may have been net savings in the region of £847,000. Identifiable savings have definitely accrued to both the County Council and the health service – 10 of the sample were able to delay or prevent their admissions to care homes and a number of instances identified where telecare support facilitated an early hospital discharge. National data confirms and reflects projected figures for Dorset.

Case Study: MR AG

This is a case study from a local project conducted by a GP (see annex five for more information)

We had little contact with Mr AG until March 2005 when he presented with anxiety and depression, nausea and lethargy. Investigations revealed a hiatus hernia and gallstones, but following treatment for both over the next few months plus antidepressant medication, he felt no better. In February 2006, he took to his bed with persistent nausea, shortness of breath, tiredness, malaise and generalised weakness and “felt he was going to die”.

Between March 2005 and October 2007, in spite of:

- 51 GP consultations;
- 16 days in hospital;
- 10 Consultant outpatients appointments (Medical and Psychiatric);
- Weekly input from an occupational therapist and 2-weekly input from a Community Psychiatric Nurse for 6 months;
- Numerous blood test, endoscopies, X-Rays and scans.

He made little progress. Apart from the early findings of gallstones and a hiatus hernia (both treated), there were no other positive investigations and the conclusion was that all unexplained symptoms were due to anxiety and depression. Between October and November 2007, MR AG and his wife agreed to take part in an ISECCA course.

The results were that from October 2007 to August 2008, MR AG attended the surgery on 3 occasions only at my request. Progress was maintained and in May 2008 he achieved the goal that he set during ISECCA to visit his favourite area of Northumberland – Bamburgh. He thoroughly enjoyed his week’s holiday, which he had not been able to achieve for 4 years. I now see AG on a monthly basis for 20-minute appointments. He continues to have occasional panic attacks, but is able to manage them more successfully. He has had no further referral for investigation or secondary care.

Conclusions

Our estimate of the cost of alternative provision to meet the needs of a 15% diversion of unplanned admissions to hospital is £6.6m. The details of how this figure was estimated are set out in annex six, but it is based on average spell costs for integrated health and social care community services. It does **not** include the cost of reablement services.

There are major challenges for both commissioners and providers in this approach, which explain why achieving the shift we are seeking is so difficult.

For commissioners the challenge is to have the confidence that investing additional funds in alternative care pathways will reduce unplanned admissions to hospital, freeing up the resource to continue investment in the alternatives, including well-being, early intervention and prevention.

For the providers of secondary care the challenge is to have confidence that the alternative provision will actually reduce the demand on their service enabling them to reconfigure provision. There also needs to be reassurance that funding which is invested in early intervention and preventative services is secure and will not be summarily withdrawn if other priorities appear more pressing.

Finally, it is important to note that the proposal to increase the level of diversion from secondary care over three years would provide opportunities to:

- Put alternative provision in place;
- Reconfigure secondary care in a planned way, including the transfer of staff where appropriate;
- Build trust and confidence in the alternative.

So the next iteration of our formula is:

$$\mathbf{£18,3m - (£6,6m + C) = Y}$$

5.3 | Universal services and social capital

The third element of our proposition is the development of universal services and social capital so that older people can meet their needs with the least recourse to specialist services and maintain their independence and well-being. These activities often have a longer term impact than the other elements of our proposition, but they are potentially important in sustaining a long term reduction in dependency on secondary health care and intensive social care.

Types of universal services and social capital:

- Community development schemes;
- Libraries;
- Assisted bin collections;
- Transport schemes;
- The link age plus pilots;
- Social networks (neighbourhood network schemes);
- Older peoples forums and groups;
- Lunch clubs;
- Free swimming and other assisted leisure activities;
- Concessionary travel passes;
- Home safety checks;
- Befriending schemes;
- Inter-generational activities and events;
- Advocacy, information and advice;
- Healthy eating and other health and well being promotion services;
- Promoting volunteering;
- Community safety initiatives;
- Peer health mentoring;
- Tackling ageism;
- Involving older people;

It is in relation to universal services that the full scope of the Total Place approach – the engagement of all organisations in an area – can be brought to bear in improving outcomes for older people. Examples of initiatives currently underway across Bournemouth, Dorset and Poole include:

- Dorset Fire and Rescue offers free home safety checks to identify vulnerable groups (including older people) and in areas of Dorset where risk profiling indicates that there is a greater risk of fire;
- West Dorset District Council offers assisted waste & recycling collections for older people. This is a free assisted collection service for anyone with a physical difficulty that prevents them from putting their waste or recycling out for collection;
- Dorset Police organise their community services into 78 Safer Neighbourhood teams that focus on engagement and problem solving to make older people safe and feel safe. The teams aim to integrate with partners and also with home watch community networks. Home watch covers 20% of the sub-region and they are predominantly served by older people.
- East Dorset District Council supports community initiatives such as the Pedal Back the Years Events where people can learn to cycle again, helping them regain independence and create social networks⁵⁶;

Neighbourliness, the contribution of volunteers and the ability of older people to help each other can make a significant contribution to helping people to live independent lives for longer. This encompasses the rich tapestry of activity and initiatives which is probably best described as “social capital”. One of the roles for public bodies and organisations such as councils for voluntary service is to help to create the conditions in which social capital can flourish.

In developing our thinking about this element of our proposition we have drawn on lessons from community-led initiatives currently underway across the place (see annex 13). These include, for example:

- 18 lunch clubs in Bournemouth supported by funding from Bournemouth Borough Council. These clubs provide opportunities for older people to socialise and discuss topics relevant to them such as health, leisure, housing and finances with

⁵⁶ Health improvement statement, East Dorset District Council, 2009

- their contemporaries and the organisers/volunteers of the service. Going out to a club encourages older people to leave their house and can help them maintain mobility, memory and dignity;
- Estimated figures by Dorset Community Action suggested that there are 1039 third sector organisations, groups or clubs that principally benefit older people in the Dorset County area (see annex 15). Estimates are of smaller but still substantial number of these groups in Bournemouth and Poole.
 - Project Purple is a Poole based initiative that provides activities for over 55's in Poole. Funded by the NHS Bournemouth & Poole Innovations Fund, the aim is to set up a range of social and health improving activities for over 55's across the Borough;
 - Poole Borough Council support six social clubs for older people who also recruit local volunteers at annual events;
 - ROOTS is a gardening service provided by people with mental health issues to assist older people to maintain their properties, it is organised by the charity Help and Care on behalf of Bournemouth Borough Council;
 - Dorset POPPS is a project jointly funded by Dorset County Council and NHS Dorset. It is designed to help build supportive communities to enable older people to remain living in their own homes for as long as they wish by developing responsive, appropriate, services and activities at a localised level. There are a number of facets to this approach including a "wayfinder" service (volunteers who signpost information) and a community development fund for small, sustainable projects that older people or volunteers can apply for help to fund services. Since April 2008, 58,748 people have contacted POPP services and have received a service, activity or information, 2,848 activities or sessions have been funded and 433 new volunteers have been engaged in delivering the POPP funded projects;
 - In Bournemouth, a Community Connections Service provides support for older people living in their own home that are isolated or at risk of becoming isolated. The service provides an opportunity to access locally based activities of the client's choice, which will prevent deterioration in their ability to remain independent in the community, and to reduce their sense of isolation. This service currently has 45 older people allocated to two support workers and 23 befrienders (volunteers) who visit a client each;

- There is a number of smaller scale, similar services provided by District Councils. West Dorset District Council offers support to older people's forums and disability forums within the district through a community support team. The forums provide an opportunity for people to get information on services, campaign on local issues and meet socially. West Dorset DC also provides regular operational support to Age Concern and offers a range of community enabling and cultural grants to third sector organisations to develop their operations.⁵⁷

The developmental nature of some of these programmes and the fact that in many cases the benefits will only be realised over the medium to long term means that financial evidence base for this approach is still insufficient to reliably scale up the potential contribution across the system. However, local and national research has highlighted areas where the early intervention, well-being and preventative approach has resulted in savings further “upstream”, i.e. for secondary care providers.

Dorset POPPS has identified some early evidence of cost savings, with Housing Options for Older People Case Workers and Dorset Blind Association Case Workers who work with individuals to address housing and support in the home issues, having reduced the need for care home placements and home care packages by 60, a cost saving of over £1m.⁵⁸ Alongside the potential financial benefits of the community development approach there are a range of additional non-financial benefits such as performance benefits, strategic benefits and improvements in outcomes for older people themselves.

We have not attempted to put a figure on the ‘C’ element of our formula. This reflects the difficulty referred to above in “scaling up” the costs of rolling out pilot initiatives. It also reflects the different starting points of different agencies across the sub-region and the part that this type of activity is likely to play in their strategy. It is important to retain this element in the formula, however, because it is important to sustain expenditure on this activity and there may be scope for expenditure to be increased in those parts of the area that consider it appropriate to do so as part of “Total Place” approach to using resources saved by reducing dependency on acute care.

⁵⁷ See Annex 14

⁵⁸ See Annex 13

5.4 | Information, advice and support

Our work on this issue has confirmed that the availability of high quality information, advice and low level support is crucially important to helping older people to live independent lives (see annex twelve). It has a contribution to make to all three of our jigsaw pieces. We have also concluded that a segmented approach to targeted marketing recognises the different needs of individuals and communities is more appropriate than one which focuses on the particular interests of individual agencies. The timeliness and accessibility of information is critically important.

Wellbeing, prevention and early intervention in action

“NHS Bournemouth and Poole fund a “silver swimmers project”, offering older people aged 60 and over the chance to swim for free at Rossmore Leisure Centre and Lodge Hill Swimming Pool”

Specifically there may be an opportunity to give effective advice and guidance to people who are considering taking up a care home placement, funded from their own resources. Helping people decide if they could remain in their own home for longer with the application of practical support and assistance may well be beneficial to them. Social care commissioners would also benefit in the long run. Any decision by older people who self fund long term care home placements to defer admission will mean that local authorities, who may still be responsible for picking up costs once individuals capital has depleted, will not have to meet them as quickly or for as long.

Providing information, advice and support in a way in which people need it, when they want it, clearly mitigates against the notion that any sort of single provider solutions will be effective. The multiple, diverse contact points which individuals access clearly means there is value in having cross sector principles for the provision of relevant information, advice and support for older people. This means that there is an important role for commissioners to ensure comprehensive provision across a variety of different providers.

5.5 | Neighbourhood/locality working

The pilot project has generated considerable discussion about opportunities for improved efficiency in service delivery (see annex 16). This reflects our recognition of the value of cross agency working and the need for effective information sharing about people in high risk circumstances. To achieve efficiency, improve targeting of resources and deliver better outcomes for more people, front line staff in the public agencies need to more closely address their mutual agendas as well as their separate ones. This approach clearly engages a wide range of public agencies and citizens and not just the health and social care system for older people. We envisage locality and neighbourhood working playing a crucial role in delivering these efficiencies and providing an enhanced service for older people and their families and carers. In organisational terms this means facilitating the active participation of the police service, fire and rescue service, neighbourhood and community groups, third sector organisations and older people themselves. We have concluded that neighbourhood and locality working has a potentially substantial contribution to make to the delivery of community services, preventative activity, universal services and the development of social capital.

To date, there has not been a conclusion about the optimum size of a “locality” or “neighbourhood” and different approaches are likely to be appropriate in different areas. Annex 16 sets out one potential set of proposals. The key elements which need to operate seamlessly are:

Level 1 – Neighbourhood based, specific and generic services, including infrastructure for volunteers and Police Community Support Officers (PCSOs) (Neighbourhood area)

Level 2 – Cluster based, specialist and generic services, including GP’s, District Nurses, care assistants and fire prevention officers (Cluster area)

Level 3 – Organisation based and specialist, including blue light services, long term care home placements and hospitals

We envisage that action at a neighbourhood/locality level is crucially important to the delivery of community services and well-being and preventative programmes. This level could potentially provide an integrated framework for:

- The integrated teams referred to in the previous section;
- Putting GPs at the heart of a new approach;
- Assessing risk and priorities;
- Building social capital;
- Integrated assessment processes;
- Delivering well-being, early intervention and preventative activities;
- Delivering some aspect of community services;
- Gathering local intelligence to inform commissioning.

We have also explored the contribution that neighbourhood management could make to our proposition. Where this approach is introduced, for example in recognition of the relative deprivation, high risk or demand indicators of a particular neighbourhood, it could play an important role in helping to meet the needs of older people in that area.

5.6 | More or quicker?

The view which has emerged from detailed discussions and from recent discussion at our project board is that the immediate ambition will be to achieve the 15% goals already referred to. The range of service transformation required to deliver this goal is anticipated to be challenging. However, it is equally understood that reaching the goal would still only mean we achieve the national average.⁵⁹

Recent national policy discussions have considered that up to 30% of unplanned admissions of older people to secondary care are avoidable. Further, the expectations set for health communities through the national QIPP programme (improving quality through innovation, productivity and prevention), and its interpretation at local level, suggest further efficiencies are desirable and achievable.

⁵⁹ See Annex 6

The extent to which a reduction of more than 15% of unplanned admissions for older people can be delivered locally will depend firstly on how effectively alternative services can meet the specific needs of individuals, and the extent to which they can be established across the whole sub-region. This challenges the willingness and ability of providers (and commissioners) to adopt and adapt examples of good practice already evident elsewhere in the country, particularly if they demonstrate deeper integration of health and social care and a different degree of trust and cooperation than has been evident locally between partners.

For some patient groups the service redesign will contribute more in terms of improvement in quality and patient experience, and in future cost avoidance as the demand increases as a result of demographic change, than it will in absolute cost reduction. The developments in dementia care are a case in point, where although there is considerable scope for developing improved community based services, only a low percentage of people with dementia are currently diagnosed. The degree to which the length of stay in secondary care for people who have a subsidiary diagnosis or undiagnosed dementia which can be translated into reduced cost is uncertain.

It will also be necessary to look more closely at how resources are used within the health and social care system, and to develop an approach which facilitates the sharing of risk and benefits in an explicit and transparent way. For example, it could be argued that high bed occupancy in “acute” and (particularly) community hospitals in Dorset is driven by low Social Services investment in care home placements. Viewed as a system, there would be a net benefit if the number of community hospital beds was reduced and funds channelled into supporting people at home. In this case the savings would accrue to NHS budgets but the significant additional expenditure would be incurred in social care, and the current system conditions mitigate against this type of shift in expenditure. It may be that the closure of hospital beds is exactly the sort of “shock to the system” that would drive the required change. But it would also raise serious issues of public and political expectations, organisational responsibilities and system resilience.

A further opportunity is to continue to review the balance between secondary care and community services, and in particular to address the variation between how General Practitioners, as gatekeepers into secondary care, use the resources available to them.

In Dorset, analysis shows significant variation in unplanned hospital care by weighted practice population. If all above average practices performed at the average level there would be a £5million reduction in expenditure. The figures for Bournemouth and Poole are likely to be similar.

Examination of the role of general practice as part of a revised and integrated health and social care delivery system also warrants further investigation. Managing increasing numbers of people at home or in community settings requires that GPs rethink how their skills might best be used – in this context they are pivotal in directly providing and coordinating the delivery of care rather than acting principally as the source of referral for people entering community-based services. This requires a re-evaluation of what we expect GPs to do and perhaps re-defining the expectations of their current contractual position to place more emphasis on:

- risk-profiling the practice population;
- identifying (case finding) people at risk of serious health deterioration;
- managing, or contributing to, their proactive care coordination.

Longer term, further additional benefit will depend upon the extent to which the move to more prevention and the development of more low-level community support can help to create safer, healthier communities with a higher degree of resilience and capacity for self-care/self-management leading to less demand on traditional statutory services.

Case Study: Wellbeing and early intervention in action.

Project: Morecombelake luncheon club – monthly lunch club, cost £920 to set up and run.

“An almost blind, older lady now has monthly contact with a group of people of similar age and interests. At the age of over 80 she is expanding her group of friends and acquaintances and looks forward to her monthly lunch”

This case study is important as it illustrates a relatively small, straightforward project leading to the inclusion of a potentially isolated person in a rural area. This inclusion is not limited by her identified ‘needs’ (e.g. joining a group for visually impaired people), but by expanding her wider, everyday support network.

During our work we have begin to explore a number of wider policy issues. Those which we consider may warrant further exploration locally are:

- The development of personalised commissioning and truly integrated personal budgets;
- Consideration about whether to fund long term care home placements. This needs to be set alongside the need for a comprehensive set of services;
- An examination of the potential for more radical to collaboration with other services such as shared housing, family placements, neighbourhood and community care;
- Exploration of the possibility of free personal care for older people in their homes.

To some extent these ideas sit in the context of policy development by the government and opposition parties. Annex 17 refers to local consideration of some of the points above.

5.7 | Conclusion

The final iteration of our formula, assuming a 15% diversion from secondary care is:

$$\mathbf{£18,3m - (£6,6m + C) = Y}$$

On this basis we have concluded that it is possible to secure improved services for older people at less cost through a shift in expenditure from acute and intensive care to community services and preventative activity.

It is important to note, however, that our financial analysis is simply intended to develop and test the proposition, not to inform specific budgetary decisions. It does not take account of the extent to which the measures outlined are already being assumed by the relevant organisations in their financial planning and budget commitments.

6 | Issues and Barriers

This section of the report discusses a number of significant challenges and barriers we envisage would be faced in implementing the approach we are proposing, including ways in which they might be addressed. They raise implications for local organisations and for government. They are:

- The leadership and political challenges across organisational and area boundaries;
- Cultural and organisational change;
- Governance and financial management which transcends current boundaries;
- Commissioning practices;
- Government initiatives, programmes and reporting and other requirements;
- Capacity Issues and the administrative, management and leadership burden of partnership working.

In short, our overall conclusion is that there are no fundamental barriers to the local agencies organising themselves in order to pursue this approach so long as there is the will. But, as we set out below, there are things government could do which would make the task significantly more difficult – for example in how the financial challenge is presented nationally; and there are a number of actions government could take which would help the local agencies to make progress, which are outlined in more detail below.

The leadership and political challenges

Our work and evidence from elsewhere suggests that secondary care capacity is like the M25: as much capacity as is available will be filled. This means that initiatives that prevent people from requiring hospital care, while benefiting the individuals concerned do not translate into a reduction in acute provision. The prevention “cheque” is never cashed. Our proposition is based on the hypothesis that the way to secure significant change is to actually reduce and reconfigure secondary care capacity.

Changes such as this will be controversial locally, despite the availability of evidence to show that the result will be improved services for older people. Local politicians will come under considerable pressure to oppose such proposals and “defend” local institutions. The national political context will also be important. The current national political debate in which commitments have been made to “protect spending on hospitals” is not helpful. The attitude of Ministers and local MPs could well be important in creating the conditions in which this approach can be implemented (or not).



A leadership challenge for commissioners is to invest the additional funds necessary in alternative care pathways with the confidence that emergency admissions will fall. Similarly the leaders within providers of secondary care will need to develop the confidence that demand on their services will indeed fall.

The PCT's have a relatively low level of investment in early intervention, well-being and prevention services. It will require strong leadership, clear lines of accountability for budget management and a strong partnership approach to ensure the value of disinvestment in secondary services is understood and translates into funding for community based provision. Dorset Fire and Rescue have been highlighted as a local public service which has made strides in shifting their organisational approach from reactive to a proactive, preventative approach and there may well be lessons from their experience which could be of value to other agencies.

The nature of the governance arrangements put in place to oversee the implementation of this approach will be critically important in creating the conditions in which the leadership required can be deployed (see below). An action learning approach could also usefully be put in place to enable leaders across all the organisations involved to develop their collective leadership capacity as the proposed approach is developed and

implemented. Issues arising could be fed into individual agencies' leadership development programmes and there may be scope for commissioning a pan-Dorset programme.

Organisational and cultural change

Implementing this approach will require whole system redesign involving major organisational and cultural change. In terms of organisational change this means:

- Reconfiguring secondary care provision as a result of a significant reduction in the capacity required for avoidable, unplanned admissions of older people. Further, in the longer term there may be a case for reviewing the level of capacity required for planned admissions of older people. The direction and speed of these changes means that the impact on the financial viability on providers must be planned and managed;
- A much more integrated approach across health, social care, housing and other agencies/sectors to provide services such as home adaptations, equipment and telecare/telemedicine products to enhance community services and intermediate care. Potentially there may be a pivotal role for GP practices and a wider role for paramedic services and changes to working practices including the need for a 24/7 response to match that provided by paramedics and A&E services;
- New forms of collaboration – and possibly organisational change – to support the commissioning and delivery of a sustainable programme to develop social capital;
- The development of a neighbourhood/locality focus for the provision of some community services and the delivery of early intervention, well-being and preventative activity. This will require more partnership working with the voluntary and community sector, capitalising on its ability to attract external funding and mobilise voluntary effort.

Given the system-wide nature of our approaches these changes will need to be planned and implemented in an integrated way.

The range of cultural issues to be addressed is also significant. They include:

- Expectations and assumptions throughout the system about what is “best” for older people – the default position often being to admit to some form of institutional care;
- The tendency of the system to “medicalise” what are often social or psychological needs. There is evidence, for example, from a small scale project at a GP surgery in Dorset suggesting that targeting patients with either long term conditions, medically unexplained symptoms, placing high demands on GP time, or very costly to the PCT through specific interventions reduced unplanned admissions to secondary care and saved money throughout the system (See Annex five);
- The need to create the conditions in which different groups of professionals can collaborate more effectively in the interests of older people;
- The need to develop trust and confidence in alternatives to hospital provision among clinicians, other professionals, older people, their carers and families;
- The need to reduce the perceived risk in using alternatives to secondary care and improve confidence of junior staff to refer to local alternatives;
- A focus on how the ‘gate-keeping’ system to secondary care works especially during times when alternatives are not readily available, i.e. Friday through Sunday.

Addressing these issues is likely to require work with particular professional groups, and it will be critically important to secure effective engagement with relevant agencies and groups – such as GPs, the ambulance trust and acute trusts – in the next stages of work.

Governance and financial management

The governance and financial management arrangements necessary to support the implementation of this approach are necessarily complex. There are issues of financial management, geography and inter-agency working to be taken into account.

At the core of our proposition is a proposed shift in resources from secondary care and intensive social care to community services and preventative activity. This will mean

investment by one agency to enable reduced expenditure by another; it may require an actual shift in resource and budgetary provision between agencies; it will certainly require closer alignment of budgetary decisions and processes between agencies, including governance and financial management issues.

It is clear from discussions with partner agencies across the place that shifting resources across agencies is not a simple process and sometimes involves more work than simply 'going it alone.' Aligned or pooled budgeting processes need to become more flexible and easier to implement to allow agencies greater scope to bring together significant budgets to address local issues in a more joined up way. This is a multi-faceted issue; central government need to reduce the bureaucracy attached to implementing and running aligned or pooled budgets and local organisations need to become more transparent and trustworthy when working together in this way.

As we explained earlier, at present there are no formal partnership arrangements in place to support joint working on health and social care issues across Bournemouth, Dorset and Poole. There is, however, a Multi Area Agreement covering the sub-region and a local public service forum which brings together chief executives at a pan-Dorset level.

The level at which different elements of our proposals are implemented is an important issue that will require further work and on which there is a range of views:

- It is a clear that the primary impetus for change must be at local authority/PCT level, building on the Transforming Community Services Strategies;
- But it must be born in mind that the nature of the catchment areas for the acute hospitals serving the sub-region do not match local authority or PCT boundaries;
- Other elements of the approach, for example, the development of social capital and locality working, may be best taken forward at a more local level.
- There needs to be an understanding that a move away from single agency "silo funding" is essential to achieve the whole system and service delivery requirements that are an essential requirement of the Total Place approach.
- It is a challenge for statutory public organisations to fully appreciate the benefits of many Whitehall funded initiatives. Consideration needs to be given to the potential problems facing local statutory agencies faced with the consequences

of having to pick up the funding and expectations of initiatives previously funded with short term, central government money. More coherency between local and national bodies may help to avoid these issues.

From our analysis it would seem that there is a need for new governance arrangements at two levels:

- At a sub-regional level, possibly building on the current local public service forum extended to include leading councillors and non-executive directors;
- At a local authority or PCT level, building on the existing joint commissioning arrangements.

These issues require further discussion and work locally, but government support for this work and a commitment to a flexible approach to enable progress to be made will be important.

Commissioning Practices

During the course of the project the importance of commissioning has been reinforced, on both a local and national scale, to the success of the proposed approach. Three aspects are particularly important.

First, the challenge of decommissioning which can be a difficult and lengthy process. The need to decommission services can occur within any part of the system but the rate and approach varies noticeably. Local organisations need to be confident in their strategic planning to allow successful decommissioning and reinvestment of funds. Local and national leaders and organisations need to offer more support for evidenced based decommissioning decisions and be prepared to take brave decisions in the best interests of the local area. Without clarity over decommissioning, funds that could be reinvested in the system to support approaches like the one set out in this report may be lost.

Second, the need for a mechanism which can deliver a more joined up approach, ensuring that preventative initiatives impact other parts of the system. For example, a

preventative project designed to keep people out of hospital needs to be closely linked with the hospital in question to ensure that the value of the initiative can be seen and its successes used to ultimately reduce costs at the hospital. To ensure this whole system approach to prevention can be successful it is important for both local and national bodies to drive the concept as a significant priority.

Finally, third sector organisations have highlighted the risk averse nature of current commissioning practice. Proper procurement processes are important, but a more creative approach may be appropriate when commissioning some services from the third sector.

Government initiatives, programmes and requirements

The approach we are proposing is in line with the current thrust of government policy as set out in relation to, for example, transforming community services, the NHS operating framework and QIPP. But the Total Place approach has the potential to create the conditions in which agencies in



Bournemouth, Dorset and Poole are more ambitious about the extent of change they can secure than would otherwise have been the case. There is a danger that the particular requirements of these and other initiatives could undermine this ambition or impede the rate of progress – through, for example, imposing deadlines which distract partners in this area from developing a full risk-assessed business case for change. We need to ensure that any government targets and funding mechanism supports the shifts we are proposing.

The next stages of this work could usefully include a joint review of these issues with government.

In the course of our work we are identifying a number of aspects of national policy and regulation which could impede the ability of the organisations in Bournemouth Dorset and Poole to achieve this shift. They include:

- The constraints imposed by the current GP contract on the scope for developing the role of GPs in delivering and commissioning community services;
- The impact of the 2010/11 DH Operating Framework (and in particular the use of 2008/09 emergency admissions as a baseline) for this proposition;
- Ambulance trust tariffs/and performance indicators introducing perverse incentives to transport older people to hospital, the three response time indicators may not always be appropriate, especially when dealing with older people in their homes (See Annex three);
- Poor communication, different approaches and protocols by the three inspecting, target setting organisations (Audit Commission, Care Quality Commission (CQC), DH) impacting on delivery.

Research has suggested that the relationship between the CQC, Audit Commission and DH can be a significant barrier to local service delivery. We have been made aware that in some cases poor communication between the three organisations nationally can have a negative impact locally. This can manifest itself in a number of ways, such as requests for specific data sets coming from each organisation, with a different recording protocol for each set, when in fact the data required is very similar. Effort is being made by the three organisations nationally to join up data requests and reduce the duplication of requests but more could be done to lift this burden.

The amount and rate of data collection needed to substantiate performance indicators is also an issue for local organisations. The number and extent of statutory returns and how this information is compared and evaluated nationally (rather than the number of indicators) is a significant burden that needs to be addressed. It has also been brought to our attention that despite a drive to join up local bodies, especially local authorities and PCT's, significant barriers remain which include legal obligations, funding and service priorities and performance indicators that encourage organisations to continue to work alone.

We are aware of the high level of government interest in the costs of regulation and inspection, but, given the need to focus on our core question, have not been able to quantify the cost of this to local agencies.

Capacity Issues and the challenge of partnership working

Total Place has pushed the experience and pace of partnership working across the sub-region farther than ever before. It has also highlighted the resource demands on participants that result from working together in this way.

The range of partnerships across the public sector system and the need to continue with business as usual, mean that organisations (especially those with smaller budgets and numbers of staff) are faced with significant capacity issues when asked to commit to working in new or expanded partnerships. The Total Place project has been fortunate that senior leaders and professionals from across the place were willing to commit time and effort to the process. However, if this work is to be taken forward, partner organisations will again have to commit significant resource to the project which will be a concern that will need to be addressed. This is discussed in more detail in Section 8, 'next steps'.



7 | Lessons from the journey

We will be preparing a more detailed assessment of the lessons from this process for inclusion in our Next Steps report for our Project Board. This short section sets out some initial reflections which may be of interest nationally and in other places.

First, the decision that the pilot should cover Bournemouth, Dorset and Poole has undoubtedly complicated our task to a significant extent. It has made securing collective ownership of the project and the recommendations more difficult to achieve; and has had implications for the level of ambition we have been able to agree. However, it has usefully allowed pan-Dorset organisations such as the Police, Fire and some TSO's to address cross boundary issues with all relevant partners.

Second, the existence of a dedicated project team, two members of which have been seconded to it fulltime, has undoubtedly enabled us to maintain progress on the pilot. But the location and composition of the team (in County Hall with its full-time members seconded from the County Council) has undoubtedly influenced perceptions of the pilot among the participating organisations.

Third, history, both long and short term, has inevitably cast its shadow over the project. This includes both the process by which the pilot was established (in response to a proposal from the County Council) and inter-organisational dynamics relating to current and previous organisational boundaries and structures.

Fourth, while the tight government timetable has undoubtedly focussed effort on the project – and a number of people across the agencies involved have devoted significant time and effort to it – the timetable has made it impossible to secure consistent engagement in the work. This has been exacerbated by changes in key senior personnel and severely limited capacity in a number of the organisations involved. It is also worth noted that the timetable for this pilot aligned helpfully with that for the Transforming

Community Services Strategies and served to accelerate the pace of a number of other partnership initiatives already underway.

Fifth, determining the level of ambition we aspire to has been an important, difficult and sensitive process. Despite a positive engagement with colleagues in Whitehall, concerns about how our conclusions would be treated, particularly in the current expenditure context, have undoubtedly influenced the content of our work and the presentation of our conclusions and recommendations.

Sixth, the absence of a formal partnership arrangement for dealing with health and social care issues at a sub-regional level has made it difficult to secure as much collective engagement with political and non-executive leaders as we would have liked. But the project has prompted a potentially important debate about future governance arrangements.

Seventh, the practice we have adopted of regularly exposing our work to challenge – both within the sub-region and beyond – has positively enriched our work. Lessons, evidence and constructive challenge from elsewhere are invaluable.

Finally, the pilot has prompted an extensive network of conversations and engagement across and between the organisations involved. People have talked about Total Place creating the opportunity for discussions that were not previously taking place. This could well have a significant and lasting impact on the area.

8 | Next Steps

Our work to date has, in broad terms validated the proposition that improved services for older people can be secured at less cost through a shift in investment from secondary care [and intensive local authority care] to community and preventative services. The next steps are extremely important in terms of further testing and developing the proposition and preparing for implementation.

Three initial strands of activity will be particularly important:

- Further developing and testing the proposition;
- Maintaining and extending engagement with the project;
- Exploring the appropriate geographical levels for further developing and implementing the proposition.

Further developing and testing the proposition

Considerable more work is required to develop the propositions set out in this report and to develop an overall financial and business case. Key elements of this include:

- Continuing work led by the PCTs on the Transforming Community Services strategies;
- Further work by the three councils with social care responsibilities on the scope for diversion from intensive social care and their contribution to enhanced community services and preventative activity;
- An assessment of the implications of and for work underway and planned on the integration of health and social care;
- Detailed work on the financial case for each of the elements of our proposition, building on the work the PCTs have already carried out. This work will need to clarify the extent to which the expenditure required and savings anticipated are already included in budgets and financial plans (including those of the hospital trusts – see below). It will also need to explore in more detail the circumstances in which investment by one organisation is necessary in order to secure savings elsewhere, including the need identified by local government partners for an element of up-front transitional funding;

- Agreeing the nature of the neighbourhood/locality arrangements to be pursued (which could well be different in different areas) and refining the financial implications of doing so;
- Further exploring what action is needed to sustain and where appropriate expand the contribution of universal services and social capital.

An integral element on this work should be a review of the scale of ambition of the proposals – in relation to the level of diversion from secondary health care and intensive social care - in the light of:

- Further exploration of the issues raised in this report;
- Clarification of the scale and speed of anticipated reductions in public expenditure;
- The results of wider engagement.

Maintaining and extending engagement

The further development and implementation of these proposals will hinge to a significant extent on whether they are owned by individuals, organisations and across the place and places concerned. The way in which the next stages of work are planned and delivered provide an opportunity to further build that ownership by working collaboratively.

In this respect, it is important to recognise that the timescale, the complexity of the issues and the number of organisations involved in the pilot means that a number of important players have not yet been fully engaged in this work. A crucial next step will be to begin a programme of wider engagement involving: the acute hospital trusts (including at least two outside the sub-region – Yeovil and Salisbury); the ambulance trust; GPs; and housing associations. It will also be essential to continue to engage with older people and their representatives, including their direct representation in the policy-making and implementation processes.

The next stages of this project should be designed in such a way as to address these issues of ownership through the course of doing the work.

Geography

As was noted earlier, the idea that this pilot should be conducted at a Bournemouth, Dorset and Poole level was instigated by government. The administrative geography of the sub-region is very complicated, with two PCTs, two unitary councils, a county council and six district councils. The main geographical boundary – between the Bournemouth/Poole conurbation and rural Dorset – straddles PCT and council boundaries, as do the catchment areas for the acute trusts.

The Transforming Community Services Strategies are central to our proposition. Work at PCT level is therefore crucial. However, the catchment areas for the three acute hospitals overlap both PCT and local authority boundaries and therefore there is a case for the programme to be addressed at a wider geographical level. Other elements of the proposition, for example in relation to social capital and some preventative activity, could best be implemented at more local levels.

Governance

Three elements of our proposition highlight the importance of appropriate governance arrangements being in place:

- The sensitivity of some of the decisions required, particularly in relation to changes in provision of secondary care;
- The possibility of some important decisions being taken at a sub-regional level;
- The enhanced collaboration between agencies that our proposition would involve, including potentially significant budgetary implications.

The current joint commissioning arrangements and the pan-Dorset local public service forum have been identified as potential building blocks of any new arrangements.

Thinking about governance arrangements needs to go hand in hand with the further development of the proposition and conclusions in relation to geography. But it will be important to secure ownership of the approach among politicians and non-executives,

and to encourage them to prepare for the new roles they are likely to have to play. One way of doing this could be to continue to engage the forum and commissioning groups/boards in the work.

Wider engagement

The pilot has benefited from two other forms of engagement:

- A constructive dialogue with government, particularly the Department of Health, Treasury and Communities and Local Government;
- Contacts with other councils involved in Total Place and others who are adopting innovative approaches to the provision of services for older people.

It would assist the project if both forms of engagement were maintained.

Project team and timescale

The existence of a dedicated project team with two full-time members of staff has undoubtedly helped to maintain the momentum of this project. It will be important to maintain that momentum over the next stage of work. It will therefore be necessary to establish a fresh mechanism for taking this work forward at PCT – local authority level.

An essential first step should be the development of a project plan and timescale which takes account of the timelines for other elements including the Transforming Community Services Strategies and the financial planning processes of the key organisations.

Dialogue with government

The pilot has benefited from a constructive dialogue with government, particularly the Department of Health, Treasury and Communities and Local Government. It will be important to maintain this dialogue, particularly in order to explore some of the issues identified in the previous section.

Leadership and cultural change

Finally, it is crucially important that action is agreed to address the leadership development and cultural change issues identified in the previous section.

Betty

Betty lives alone in a rural part of Dorset and was becoming increasingly isolated. Betty rang the ambulance service to the cost of £19,000. Betty did have a health condition, but the calls to the ambulance service were not because of this, it was because she was increasingly lonely and isolated. Betty's GP put her in touch with a community befriending scheme, which cost £2,000 to set up, who ring and visit Betty. Betty has not rang the ambulance service since.

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