Programme Definition Document

Implementing Better Care in Darlington 2020

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Creation date: 03/07/2015

Version history: v1.3 FINAL

This version saved on: 30/11/2015 15:37:00

Background

The Darlington Together partnership of Darlington BC, County Durham and Darlington Foundation Trust, Tees, Esk and Wear and Valleys Foundation Trust, Darlington Clinical Commissioning Group, and Darlington Primary Healthcare have a shared objective of restructuring the way physical and mental health, wellbeing, and social care services are delivered in the town of Darlington, to improve services for people and at the same time reduce costs through stripping out wasteful cost. This programme is a means to ensure individual partners' potentially disparate projects and activities, including the SeQuiHS programme, are aligned and tested against this shared objective. The aim of this programme is to reduce the risk of duplication and unnecessary use of scarce resources by the partners: everything we do has the same overall purpose.

Programme definition

Programme objectives

- Reduce avoidable early deaths
- Extend and equalise life expectancy
- A good quality of life for people in Darlington at all stages of life
- A measurably high level of public and service-user satisfaction
- Measurably reduced total cost of health and social care in Darlington per head of population
- Measurably increased value for health and social care spending

Delivered by

- Health and social care services designed round the individual, across current organisational boundaries
- Increased autonomy for individuals to look after themselves
- Focus – organisation and individual - on prevention
- Maximised use of partners' resources including skills, expertise, property and other assets.
- Minimised duplications and waste in service delivery processes

- Understood and managed demand
- Full integration of service delivery with community and voluntary sector
- Transparent budgets and the “cost to care”
- Data shared appropriately and safely in the interests of individuals

Programme vision

By 2020 there will be a sustainable health and social care economy in Darlington that places citizens at the centre of the model and which builds strategies and services around them. Personal responsibility, prevention of harm, self-management of conditions, prompt access to primary care and easy access to acute (physical and mental health) services, will form a continuum of provision in Darlington, with some, more specialist services, provided elsewhere.

The vision is expressed in full as a “Virtual Tour” of Darlington’s health and care environment, supported by a blueprint for delivery, which is given at Appendix 1.

Delivery will be quantified by changes in

- life expectancy, lifestyle and health outcomes
- increasing population and LTC prevalence dealt with within LHE budgets
- the ability of residents of Darlington to self-manage and take ownership of their health and well-being needs
- workforce retention & morale
- operating performance
- partnership arrangements

Delivery will be driven by a transformation strategy which sets out

- What, how, when and in what order (priority)
- A shared understanding of the vision – what does it mean to me and my organisation
- Resources and time frames, including decision making processes
- An integrated Implementation programme approach
- Effective monitoring and review stages – that can stop, reroute or correct the journey as we learn

Lessons which inform the approach to delivery

As part of developing this programme definition a number of stakeholder engagements were carried out including one for HWBB and UoP representatives. They were asked to identify what had made the MDT implementation so successful in 2014/15, and this is their recipe for success, which is the approach promoted by this programme.

Evolutionary - setoff and build on learning as we went, from a core of accepted existing good practice

Real focus on the patient

Physical co-location of practitioners. Peer support and challenge – all professionals together, sharing expertise, knowledge, to co-design.

Leading to

Good trusting relationships across all sectors

Unlocked by

Funding for the specific purpose

Risk-taking and appreciation of change management – willingness to work together informally

Driven by

Recognised corporate priority – momentum and sense of urgency

Supported by

A single info system

Strong, very senior leadership with clear vision and good communication

An information sharing agreement

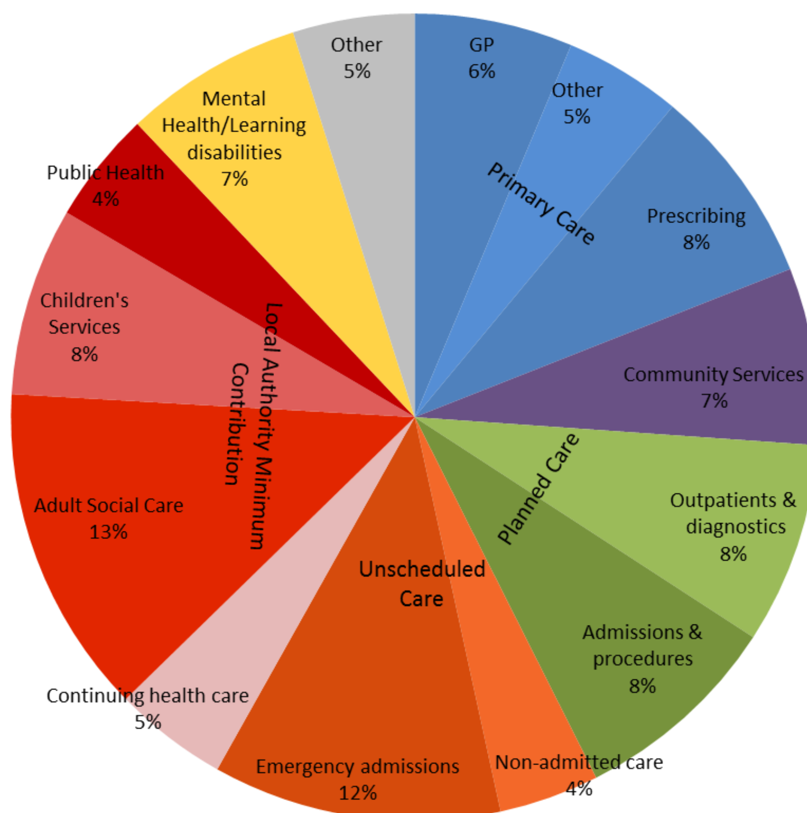
Programme Performance Measures

Performance Measure	Target	Date
Avoidable Early Deaths (PHE Life Expectancy Indicators) • Reduce the life expectancy gap across Darlington's Wards • Reduce the life expectancy gap between men and women to UK Average • Increase life expectancy at birth to UK Average • Reduce smoking-related deaths to UK Average	Amber Green	2020 2025
Disease and poor health indicators (PHE) • Reduce hospital stays for alcohol-related self-harm • Reduce hospital stays for self-harm • Reduce prevalence of opiate use • Reduce recorded instances of diabetes	Amber Green	2020 2025
Adults' Health and Lifestyle indicators (PHE) • Reduce number of obese adults • Reduce N° women smoking at time of delivery	Amber Green	2020 2025
Cost of care – the Darlington £ • Establish baseline (2015) • Establish target reduction and measurement mechanism		Q3 2015/16 March 2016
Value of the Darlington £ • Establish baseline (2015) • Establish target value and measurement mechanism		Q3 2015/16 March 2016
Service User (Patient & Carer) experience (BCF Local Indicator) • Establish baseline • Establish target improvement and annual measure		Q3 2015/16 March 2016
Effective use of resources (assets, people, skills)		
Service use volumes and movement (planned/unplanned, primary/secondary/community/social		
Patient and service user outcomes		
Position within the Benchmarking Cohort of health economy in England	The lowest cost provider	March 2020

In addition to these Key Performance Indicators (KPI), used to help us define, understand and evaluate progress towards our objectives, a set of Early Warning Indicators (EWI) will support the programme risk management strategy.

An example is service-user experience; EWIs that this objective is being compromised include increased staff turnover. This will be visible *before* a KPI value is measured, and allow mitigating action to be taken to protect the KPI and increase the chances of delivering the objective.

The “Darlington Pound” £201 per head of population



Area of Expenditure	12 months to May 2015 (000)
GP	13,419
Other	9,937
Prescribing	16,942
Community Services	15,016
Outpatients & diagnostics	17,097
Admissions & procedures	17,808
Non-admitted care	8,486
Emergency admissions	24,465
Continuing health care	9,668
Adult Social Care (minimum)	27,798
Children's Services (minimum)	16,000
Public Health (minimum)	9,500
Mental Health/Learning disabilities	15,212
Other	10,326
TOTAL	**211,876**

Strategic Objectives against the Darlington Pound

Darlington Partnership
"One Darlington: Perfectly Placed" – the community strategy to 2026, is owned by the Darlington Partnership, which includes Darlington Borough Council, NHS, Police, Fire and Rescue Service, business leaders, community and voluntary sector representatives, and people from the wider community. It sets out these objectives:

- More people are enabled to live healthy and independent lives
- Our children get the best possible start in life – we provide support early on to enable them to live well later, and to be able to fulfil their aspirations and potential
- We all play a part in making Darlington a safe and caring community
- More of us are active and involved in ensuring our own wellbeing and the wellbeing of the community
- Darlington has more businesses and more jobs, and we are able to make the most of the opportunities they offer
- We all take responsibility for looking after our environment and keeping it clean and attractive
- There is enough support available, of the right kind, to help us to live independently as we grow older
- Darlington is a place that offers a high quality of life and is designed to thrive, economically and socially

The ambition of alignment

This programme gets under way with the partners still committed to their individual organisations' corporate plans, financial strategies and external regulator frameworks driving activity and operation.

However, as all have already committed to the Darlington Partnership, this programme will deliver against those objectives, and over the duration of the programme partners will, as opportunity and business planning cycles allow, align their strategic planning and business plans.

Programme scope

While the programme is seeking to deliver benefits and value through transforming existing ways of working and introducing new things in specific areas, the impact is likely to be felt beyond the areas specifically identified. For example, the introduction of new points of care delivery – perhaps at Lunch Clubs – will impact all those care activities. The development of care hubs may result in some services, not affected in themselves, being delivered from a different location, in a different environment from what is currently the case.

An initial view of what the programme may impact:

Adults

- all services involved in dealing with people with challenging lifestyles
- all services involved with care of the frail elderly MDTs
- all services involved with supporting people with long term conditions including diabetes

Care Hubs

- Service contact and access processes
- Consultants, pharmacists, diagnostics: hours/days of availability in the service of other care processes
- Integrated care delivery – mobile working, revised team configuration, short and long term care support, enhanced third sector support

Women and Children

- all services involved with the well and poorly child pathway
- services that can be delivered closer to the community (in Care Hubs) such as obstetrics & gynaecology
- services involved in delivering targeted family support

Self-managed care and health improvement

- Social prescribing: patient expectations, social activity providers' capacity, quality etc
- Public Health and Prevention: activities relating to healthy lifestyles, life expectancy, poor health.
- Parity and equality: the processes all services use to ensure we hear from those with small voices

Urgent and unplanned care

- Integrated A&E, primary and urgent care provision
- development of integrated care delivery will introduce mobile working, new team configuration, different approaches to short and long term care support
- Intermediate and long term care development

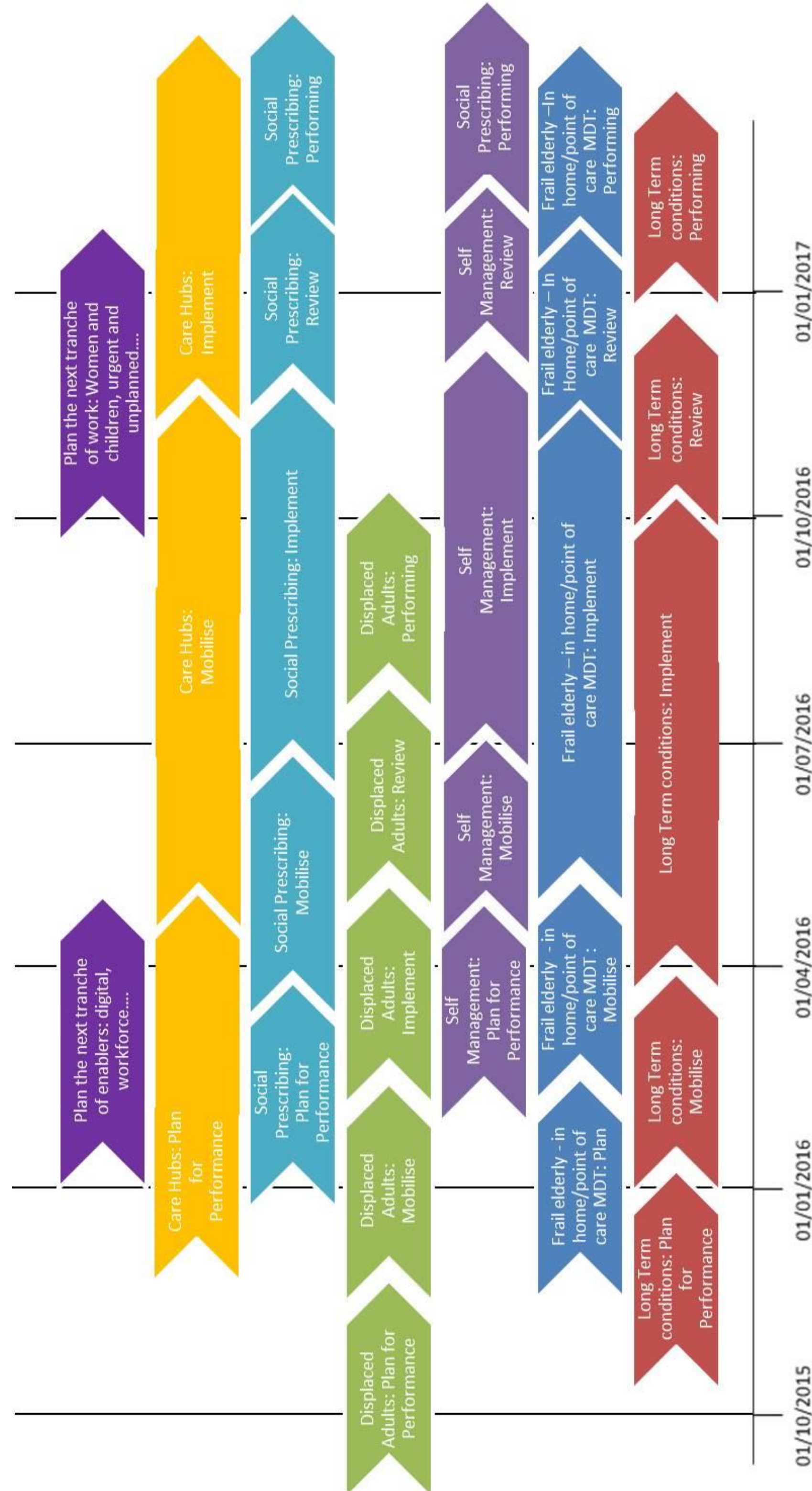
Enablers

- Joint Commissioning of health and social care
- A revised and joint (health and social care) approach to contracting
- Relationships with community voluntary and social enterprise, as service delivery arms
- Requirements around capacity and quality resilience in the CVSE sector
- A transformation hub with
    - programme coordination and resource ,
    - a design team function
    - transformation lead and support to facilitate the integrated design of the next stages within a common language
    - clear and agreed contacts in support systems to act as contacts and champions
- IT, finance, HR estates etc.
- Financial modelling and profiling
- Corporate strategies and plans including estates, asset management, ICT, resources
- Existing regulatory frameworks – need to reflect new priorities
- Information governance and data sharing
- Predictive planning and patient centred risk profiling
- Discharge processes
- Digital health care and equipment

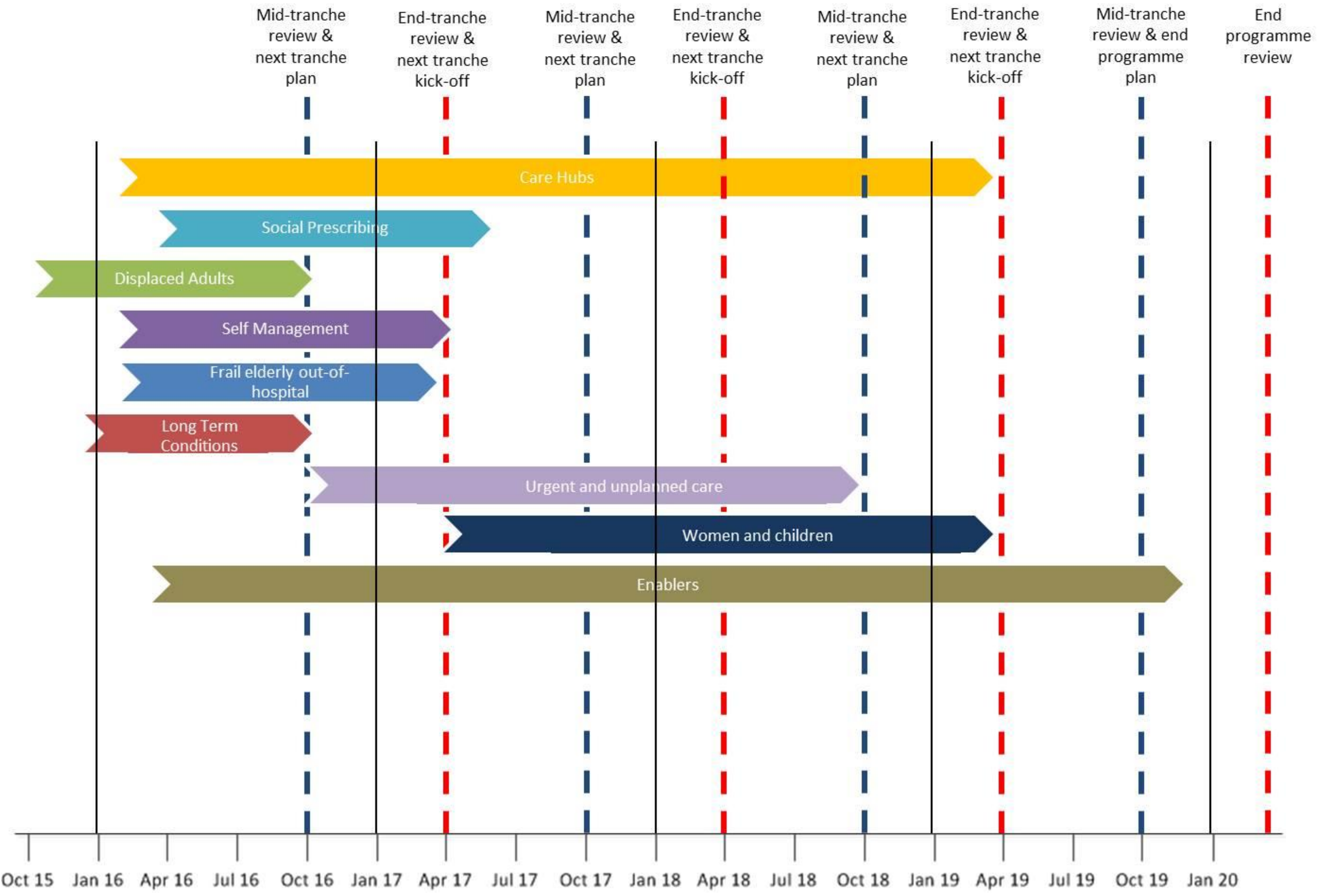
First tranche priorities for delivery

Timescales are not fully set for individual deliverables, but there is agreement which six come first; this chart is indicative. Specific timings will be set out in individual project documents as they are worked up.

An initial, indicative timetable is given at Appendix 3. The first tranche will deliver outcomes and benefits in relation to Frail elderly, High Impact service access, Self-care, Long-term conditions, Social prescribing, and Care Hubs:

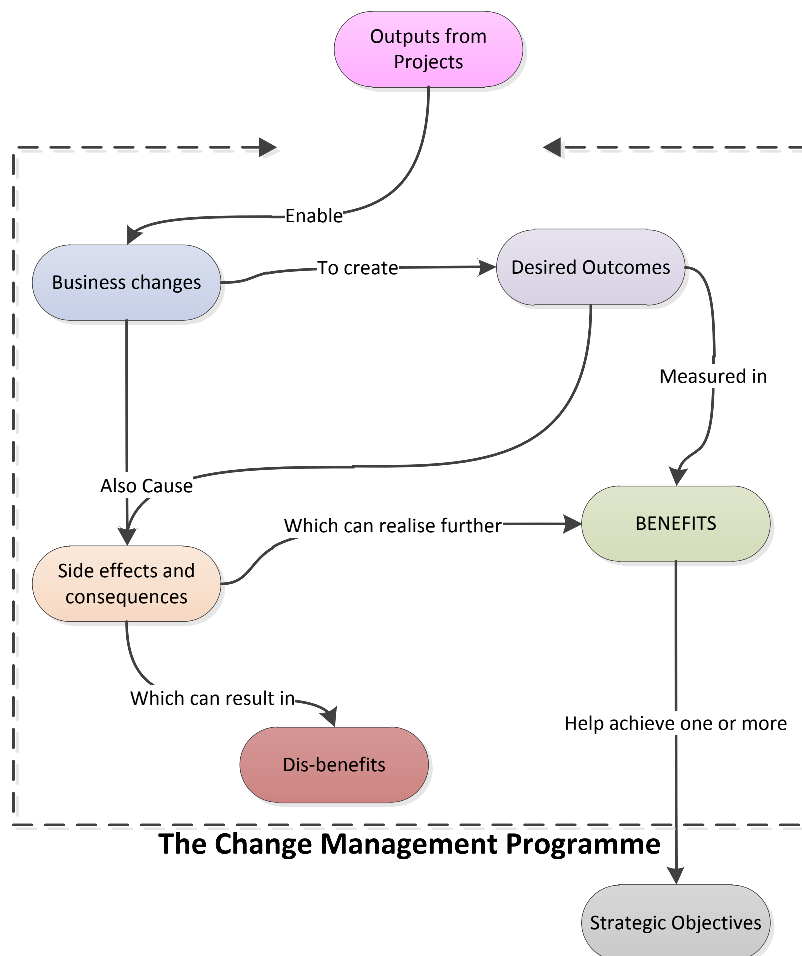


All tranches:



Benefits (Results) Outline

Benefits are the quantifiable effect of the outcomes from the programme, delivered through applying business change to the individual project outputs. They are accumulated throughout the programme, as projects delivery their new things and they, together, deliver transformation to release the benefits for which the programme was designed. The benefit owner holds the programme to account for delivering the benefit.



Benefit profile:	
Benefit Description	Improved patient experiences
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	A measurably high level of public and service-user satisfaction
Benefit Owner	COG
Stakeholder beneficiary	Service users
Measurement & Costs	Satisfaction surveys

Benefit profile:

Benefit profile:	
Benefit Description	Fewer avoidable deaths/improved life expectancy
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	Reduce avoidable early deaths; Extend and equalise life expectancy
Benefit Owner	Director of Public Health, COG
Stakeholder beneficiary	Public Health (DBC); CDDFT;
Measurement & Costs	ONS Data

Benefit profile:	
Benefit Description	Parity of esteem between mental health services and other health services
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	All – delivered through • Health and social care services designed round the individual, across current organisational boundaries • Increased autonomy for individuals to look after themselves • Focus – organisation and individual - on prevention
Benefit Owner	COG
Stakeholder beneficiary	All Service users
Measurement & Costs	Service User Surveys

Benefit profile:	
Benefit Description	Increased proportion of elderly people who can live independently following discharge
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	A good quality of life for people in Darlington at all stages of life Measurably reduced total cost of health and social care in Darlington Measurably increased value for health and social care spending
Benefit Owner	Director of Adults and Children's service, DBC
Stakeholder beneficiary	Elderly people cohort
Measurement & Costs	TBC

Benefit profile:	
Benefit Description	Patients discharged to the community or home as soon as they are medically stable
Benefit Type	Financial - Saving to the CDDFT, cost to social care (perceived disbenefit)
Delivering which objective enables this benefit to be realised?	A good quality of life for people in Darlington at all stages of life Measurably reduced total cost of health and social care in Darlington
Benefit Owner	CDDFT
Stakeholder beneficiary	CDDFT (financial saving), the patient
Measurement & Costs	DToC indicators

Benefit profile:	
Benefit Description	Capable, resilient community/voluntary sector in Darlington
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	Through these approaches to delivery of objectives • maximised use of partners' resources including skills, expertise, property and other assets. • Full integration of service delivery with community and voluntary sector
Benefit Owner	COG
Stakeholder beneficiary	Commissioners; people trying to find a service
Measurement & Costs	A sustainability measure/maturity model is required, in order to assess the state of the VCS nation and its capacity

Benefit profile:	
Benefit Description	Healthier residents
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	Reduce avoidable early deaths Extend and equalise life expectancy A good quality of life for people in Darlington at all stages of life
Benefit Owner	Director (Public Health), COG
Stakeholder beneficiary	Residents, DBC
Measurement & Costs	ONS Data – Adults health and lifestyle statistics, and Disease and Poor Health statistics. Campaigns will need funding.

Benefit profile:	
Benefit Description	Easier access to services for people
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	A good quality of life for people in Darlington at all stages of life A measurably high level of public and service-user satisfaction Measurably increased value for health and social care spending
Benefit Owner	COG
Stakeholder beneficiary	Residents
Measurement & Costs	Survey – ideally piggy-back on existing survey, or basket of existing measures taken by CQC.

Benefit profile:	
Benefit Description	More personalised, independent living for older people in Darlington
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	A good quality of life for people in Darlington at all stages of life A measurably high level of public and service-user satisfaction Measurably increased value for health and social care spending
Benefit Owner	COG
Stakeholder beneficiary	Older people living in Darlington
Measurement & Costs	Healthwatch

Benefit profile:	
Benefit Description	Improved staff morale, turnover and absence
Benefit Type	Non-financial
Delivering which objective enables this benefit to be realised?	A measurably high level of public and service-user satisfaction
Benefit Owner	Employing bodies
Stakeholder beneficiary	Staff; employing bodies
Measurement & Costs	Staff surveys (CDDFT); HR statistics

Benefit profile:	
Benefit Description	Reduced admissions to hospital
Benefit Type	Financial - cashable
Delivering which objective enables this benefit to be realised?	A good quality of life for people in Darlington at all stages of life Measurably reduced total cost of health and social care in Darlington Measurably increased value for health and social care spending
Benefit Owner	CDDFT
Stakeholder beneficiary	CDDFT
Measurement & Costs	Existing performance indicators.

Benefit profile:	
Benefit Description	Reduced total cost of health and social care in Darlington per head of population
Benefit Type	Financial - cashable
Delivering which objective enables this benefit to be realised?	Measurably reduced total cost of health and social care in Darlington; Measurably increased value for health and social care spending
Benefit Owner	COG
Stakeholder beneficiary	All five partners.
Measurement & Costs	New indicator: the Darlington £

Benefit profile:	
Benefit Description	Improved operating performance - efficiency
Benefit Type	Financial
Delivering which objective enables this benefit to be realised?	Measurably increased value for health and social care spending
Benefit Owner	COG
Stakeholder beneficiary	All partners
Measurement & Costs	Darlington pound; budget books;

Programme Organisation

Name	Role	Responsibility
Darlington Health and Wellbeing Board	Sponsoring Group	The investment decisions (of people, time, expertise, funds, assets etc) Definition of direction Keeping the programme aligned to the strategic direction
Darlington Chief Officers' Group	Programme Board	Drive the programme and keep momentum, ensure benefits are realised, and close the programme. Manage the escalation of whole programme risks, and any project risks that compromise the programme's ability to deliver the agreed benefits
Director of Commissioning	Senior Responsible Owner	Accountable for the programme meeting its objectives and realising the benefits. Sits on the Sponsoring Group and the Programme Board
Clinical Reference Group	Reference Group	Consultative and advisory
UoP	Reference Group	Delivery and Enabling
Head of Transformation	Programme Manager	Leads and manages the programme, delivering the new capabilities, and maintaining governance.
Transformation Comms group	Programme Comms coordination	Ensure a coordinated and holistic approach to communications on behalf of the programme, ensuring organisational boundaries are not an impediment either in delay, or duplication
	Business Change function	A role which provides the bridge between the programme and "business as Usual", ensuring new things are embedded fully, people are trained etc. This role knows the "on the ground" environment into which change is being introduced and can plan effectively for the arrival of the new thing and how it can be turned into actual changed practice or behaviour.
	Programme Office Function	The organisation and coordination of all programme information, communication, monitoring and control activities, programme risk and issue management, change control administration, budget control and procurement, statistics and measures, scheduling and coordination of deliverables and associated change management work, communications coordination.

Projects Dossier

The programme, once agreed, will provide a framework for a range of projects and other pieces of work delivered individually and collectively (by two, three four or all five partners), ensuring alignment of effort and reduced likelihood of duplication. Projects include workstreams rolled forward from BCF, the currently agreed New Models of Care project, existing pieces of work being delivered elsewhere, and individual deliverables from programmes such as the children's and Young People's mental health plan, SeQuiHS, The Care Act implementation etc. Some new projects may be required.

The anticipated contributory projects and pieces of work are shown schematically, at Appendix 2; the first six deliverables (Programme First Tranche) are:

Priority	What's it about	Lead org'n	Lead people	Which project it is delivered through of
MDT Frail Elderly – housebound and care home	Building on the practice-based MDT approach for frail elderly implemented under the Better Care Fund, to deliver high quality and effective planned care outside of hospital via a multidisciplinary team approach to frail elderly and at risk patients in care homes, people who are housebound, and at locations used for social activities such as lunch clubs.	Darling-ton CCG	Jenny Steel supported by Eileen Carbro	Access to Services (building on the BCF)
MDT for High Impact users or multiple services	Improve access to the most appropriate services for users where alcohol, tobacco, drugs and mental health are factors; a service design or combination of designs that will result in a sustainable increase in people finding the best service to meet their needs first time, a reduction of repeat low-value demand from this group of service users, and a service design or combination of designs that enables those individuals who can break their repeat usage, to do so.	TEWV	Susan Waterworth supported by Andrew Stainer	Access to Services (building on the BCF)
Social Prescribing	To identify and implement non clinical options for individuals to support their health and wellbeing, and to empower the individuals to make these choices and for professionals to 'allow' them to make these choices in partnership with the professional. (In the context of in-year and anticipated cuts to public health funding)	DBC	Ken Ross	New Models of Care
Self Management	To put in place processes and practices to promote and support a culture among	Third Sector	Third Sector supported by	New Models of Care

	Darlington residents of personal responsibility for self-management of conditions, and for staying healthy:- Information Self-empowerment / Partnership in treatment and care planning Choice		Elaine Taylor (with input from Basil Penney)	
Long Term Conditions Collaborative	Improve the journey of patients with a long term condition by working across organisations, to drive our waste and duplication in the system.	CDDFT	Basil Penney supported by Elaine Taylor	BCF
Care Hubs	Delivering out-of-hospital care in a patient-focused, locality-based cost-effective way in a "care hub", in line with one or more models expressed in the Five Year Forward View.	PHD	David Gray/Chris Mathieson supported by (tba)	Access to Services (building on the BCF)

A summary of the proposed content of the first tranche deliverables is provided at Appendix 2, after the full Projects Dossier schematic.

Programme Monitoring and Control

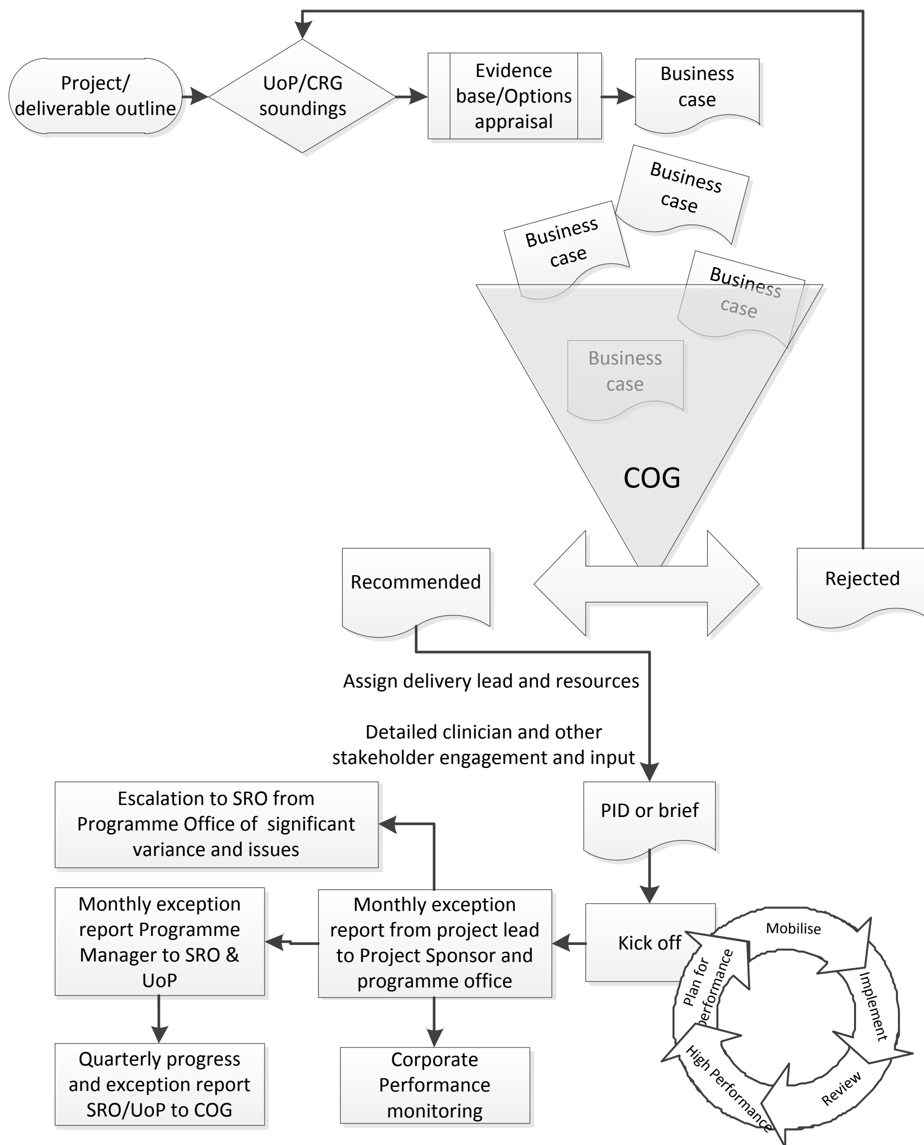
Overall control of the programme will rest with Chief Officers' Group.

Each project will have its own project board (minimum a sponsor) representing the interests of the UoP, and a supplier rep (of the lead organisation benefiting from the Project, supplying the resources to deliver).

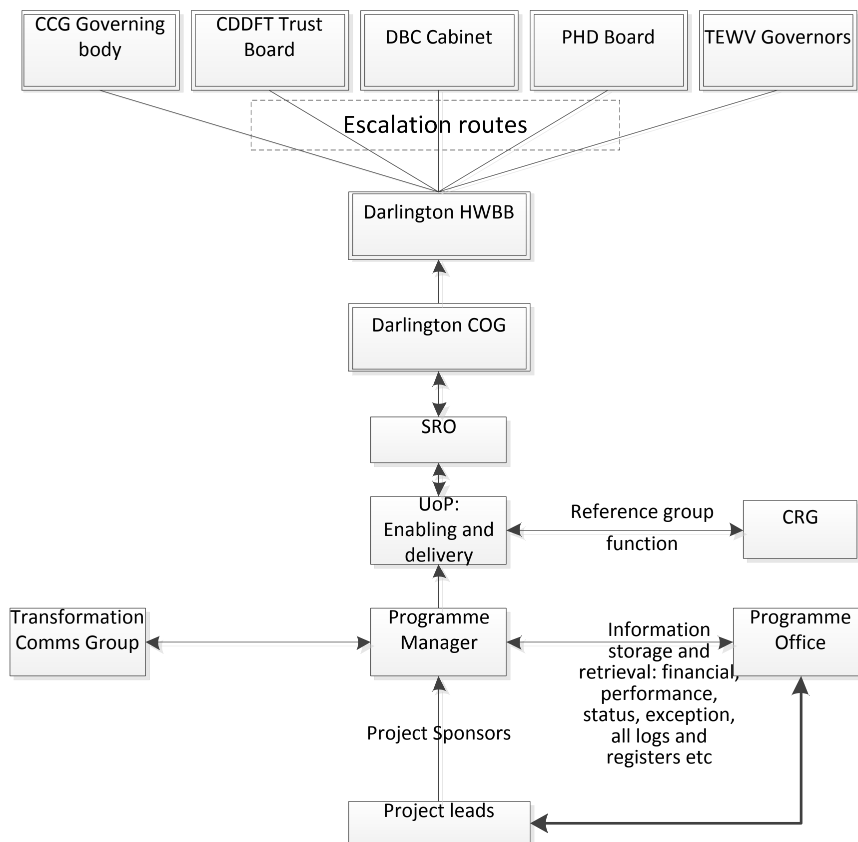
Each proposed project or piece of work will prepare a Business Case for approval by COG. Projects and proposed schemes must be able to show that the outputs contribute to the objectives of the programme and do not duplicate or overlap with other pieces of work elsewhere.

Once approved for delivery each project lead will submit a monthly exception report to the project sponsor and programme office function reporting time, cost and quality exceptions against the agreed Brief, and the status of risk and issues management.

The programme office function will report on programme delivery through a programme report monthly to UoP and quarterly to COG. A programme dashboard will be maintained and available to all stakeholders through GPTeamNet.


Project/ deliverable outline
UoP/CRG soundings
Evidence base/Options appraisal
Business case
Business case
Business case
Business case
Business case
COG
Recommended
Rejected
Assign delivery lead and resources
Detailed clinician and other stakeholder engagement and input
PID or brief
Escalation to SRO from Programme Office of significant variance and issues
Kick off
Monthly exception report Programme Manager to SRO & UoP
Monthly exception report from project lead to Project Sponsor and programme office
Quarterly progress and exception report SRO/UoP to COG
Corporate Performance monitoring
Mobilise
Implement
Review
High Performance
Plan for performance

Authority and escalation



Programme Communications

Who produces	For whom	Why	What	When
Project Leads	Project Sponsor and Programme Manager	To advise everything's on track, or not	Exception reports submitted electronically	Monthly
Programme Manager	Senior Responsible Officer	Update on status and exceptions	Programme Dashboard and Summary exception report	Monthly
SRO	Programme Board (COG)	Update on status and exceptions	Programme Dashboard and Summary exception report	Quarterly
SRO	Sponsoring Group (HWBB)	Update on progress with Programme	Programme Dashboard and Summary exception report	Six monthly

Programme Business Case

Is investing time, effort, expertise and resources in this programme worth it?

The business case for undertaking the programme is that it will allow all the partners engaged in delivery to meet the changing external climate, reducing funds, inequalities in life expectancy and increasing demand, which at the same time improving the experience of the person in the centre.

The plan is to use existing resources, and for savings generated by reducing duplication and wasteful processes to be invested in the programme where necessary in an iterative approach, or released as savings.

The business case will be revisited every year throughout delivery, in order to re-validate the investment against the realisation of benefits, and to ask again the question *Is investing time, effort, expertise and resources in this programme worth it?*

Programme Investment Summary

Investment estimates are the product of experience of implementing GP-centred MDTs in 2014/15 and delivering BCF in 2015/16. They are indicative, but informed estimates. In order to realise the benefits (including savings) planned to be realised by the programme a range of resources will be needed comprising skills, services, expertise, funding, physical and other assets.

The basis for the estimate

Project management capacity for delivery of BCF was one project manager, funded to March 2016.

In addition, a full time project manager is provided to the Long Term Conditions Collaborative project, funded to September 2016, and 70% of an fte is provided through the NECS SLA specifically to provide project management to the MDT project.

A proportion of the work of the DBC Project Manager for the Care Act implementation should be taken into account, as key deliverables such as Liquid Logic, the SPA, and the information and advice directory directly contribute to Vision 2020 objectives.

A proportion of the work of the DBC Commissioning analyst is dedicated to the management and maintenance of performance data.

A proportion of the work of the joint Transformation Programme Manager is currently given to project managing the High Impact service access priority workstream.

There is no administrative support for the BCF implementation.

The total cost of the existing provision is approximately £250,000, funded jointly by DBC and CCG.

The investment estimate

Role	Function	Cost
Vision 2020 Programme Manager	Day-to-day management of the programme. Being the day-to-day agent on behalf of the SRO, for successful delivery. Planning and designing the programme and proactively monitoring its overall progress, resolving issues and initiating corrective action as appropriate. Effective coordination of the projects and their interdependencies. Managing and resolving any risks and other issues that may arise. Maintaining overall integrity and coherence of the programme, and developing and maintaining the programme environment to support each individual project within it. Etc.	£70,000
3 x Project Manager	To run projects on a day-to-day basis and ensure that the project produces what's needed to the right standard of quality and within the specified constraints of time and cost. Liaise with programme management or related projects to ensure that work is neither overlooked nor duplicated. Take responsibility for overall progress and use of resources and initiate corrective action where necessary. Etc.	£150,000
Project Support	To keep all programme and project information in one place, keep the programme registers up to date, provide support to all clinical leads, meeting administration etc	£30,000
Analytics (50% FTE)	To maintain all data relating to the performance of the programme and its constituent projects. Commission and manage profiling and other data analysis. Prepare reports.	£25,000
		£275,000.00

Commitments of time

The programme also requires partners to commit to supplying specific resources from time to time with authority and expertise including financial, technology, estates, and workforce/HR.

It is difficult to precisely quantify the time that, for example, clinical or functional leads might need to fulfil their role in delivering Darlington 2020. For some, this role might be assumed to be "part of their day job", but for clinicians with formal roles in delivering the programme, experience suggests that (say) 1 or 2 sessions per week may need to be dedicated, and their clinical work covered by others.

Chief Officers are already committed to attendance and participation in COG, the sponsoring group for this programme, and senior officers from all partners are committed to participating in the enabling and delivery control group UoP.

Management of risk and uncertainty

The programme manager will be responsible for monitoring and managing risks as they arise during the programme (via the programme office function). Risks which meet the criteria of any of the partners' "Corporate Risk" are referred to the appropriate corporate risk register but the project sponsor is assigned as the owner irrespective of the partner for which that person works.

Early Warning Indicators form part of the risk management approach and will be set out separately in the Vision 2020 Risk Management Strategy and approach.

The status of significant risks for individual projects will be updated as part of exception reports. Similarly, the high-level programme risks will be updated in the summary exception report for the programme board and be reflected in the dashboard.

Changes in the status of risks that threaten the successful delivery of benefits or objectives of projects will be escalated to the Programme Manager. The escalation route, should the Programme Manager be unable to resolve the issue, is to the SRO.

Whole Programme Risks at the outset

Cause – the situation that gives rise to risk	Event – what may happen to bring about the threat or opportunity	Effect – the impact on the programme objectives if the event happens
Five bodies working together	External performance regimes drive different behaviours and delivery	Deliverables that can be created only collaboratively are not delivered
	Lack of trust between partners – public talk not supported by private action	Resources are diverted to individual partner projects; shared objectives are not supported; delivery is not effective; confidence, support and momentum is undermined.
Existing contracting and commissioning processes	We are unable to change the way contracting operates	Cost shunting persists
	We are unable to jointly commission and thereby reduce waste and inefficiency	Commissioning decisions are made according to where the cost/benefit is to the commissioning body, not the whole health and care system.
Increasing (and more complex) demand and decreasing resources	Unforeseen demand diverts resources from delivering programme objectives	Resources are diverted to individual partner projects; shared objectives are not supported; delivery is not effective; confidence, support and momentum is undermined.
New national initiatives diverting resources	Organisational objectives prioritised over programme objectives	Progress is slow, deliverables aren't delivered, benefits not realised
	Financial pressures lead to organisations taking actions contrary to the partnership objectives, in order to transfer cost away to another partner	Vision 2020 becomes diluted and de-prioritised, leading to a decision point.
Darlington is small	When examined and scoped in detail,	Some objectives may not be

	some planned deliverables may not be sustainable in such a small area	achieved to the expected time in the initially expected way
Five sets of technology	Data (a single version of the truth) cannot be readily shared, maintained and updated	Integrated care design is impeded as workarounds are developed
	Unrealistic expectations of early integration are allowed to take hold	Unavailability of integrated IT becomes an excuse for not progressing delivery of the programme objectives.

Vision 2020 - a Virtual Tour of Darlington's Health and Care landscape

Our vision for health and care services in Darlington in 2020 is illustrated by a virtual tour of how services will be configured and how needs will be met promptly. In the sections which follow the virtual tour we set out the evidence from the SNA for Darlington and from other data which underpin the vision.

In the Community…

Walking across the town's Market Square we see the banners outside the Dolphin Leisure Centre promoting the details of physical activity programmes, weight management support and Long Term Conditions (LTC) specific education programmes. The centre is 'digitally enabled' with access to digital health monitoring systems and video consulting/conferencing links to allow the facility to open and operate flexibly as a health hub for screening and monitoring. Some health improvement/fitness programmes are being delivered to this and other health and well-being hubs via local television and video links.

Help Hubs in key locations are providing financial advice, debt management and access to food banks where required. The Social Fund strategy ensures that anyone accessing the Fund more than once is given targeted support through a service jointly provided by health, social care, the Drug and Alcohol team, Housing Services and the Police. The national award-winning data sharing protocols developed in 2014/5 are allowing multi-agency access to high risk groups' information for planning and care delivery through an integrated MDT approach. Predictive planning and commissioning based on NHS-number tagged information is now being delivered from the connecting health cities programme. Service planning is effectively focussed on actual population data and growth scenarios.

Community, voluntary and peer support networks are evident in the activities across the Borough, which support people at home helping them feel confident about managing their conditions and offer information and support to carers. Using the new digital hubs in each LTC/vulnerable person's home, with existing commercial broadband links and the monitoring and social networking systems developed as part of the 'internet of things' initiative, people have become more self-managing.

In the more rural parts of the Borough, GPs, health workers and social care workers provide accessible information on local third-sector activities and services for identified cohorts of residents at risk of deterioration of their long term condition.

Social prescribing is one of the first interventions available in the Health and Social Care "offer" in Darlington and people have access to a range of wellbeing activities which build resilience and promote self-care.

Everyone who has been identified as at risk of hospital admission, using the new predictive modelling and monitoring process, or who have a long term condition, has a key worker/lead professional. This may include a key worker from the voluntary sector who has linked them in with our 'good friends' scheme. They enjoy the opportunities to socialise and attend physical activity sessions which help to keep them mobile. They are also helped to eat well through individual support and our community cafes, and their homes are warm in the winter. The key workers have ensured they also have their paths cleared by the 'snow patrol' service during snow/icy conditions.

The voluntary sector provides dedicated support to those leaving hospital who will benefit from on-going support within their community. Support will also be offered to their carers. We note that

those who have experienced a fall have both physical activity opportunities in the community and have a proactive volunteer who will visit them regularly and co-ordinate their needs following discharge from statutory services.

The menu of services provides a single source of information for the public, patients, service users, carers and professionals. The Directory is easily accessible, and is used as a key source of information in Darlington. It links to the e-market developments which produce information about providers in the area.

There is a place-based budget for Darlington which is used to provide appropriate levels of care and support to the population. Staff and the public of Darlington do not need to think of "which budget" or go through lengthy bureaucratic processes to move money between public bodies.

There is an established co-production group, which includes the wider partnership patients and carers. The group is directly involved in designing and developing provision in Darlington.

Arriving at a Local Health and Wellbeing hub at 2pm on a Saturday, we note that….

The recently built building is multipurpose and was a part of a new care delivery model started in 2015 when pathfinder work to develop a central urgent care centre and local community health and well-being hubs was begun. This was linked to the successful healthy new towns bid which allowed the key health, care, and housing partners to develop an integrated infrastructure to underpin sustainable and flexible care facilities on a 20-year plan based on the big data predictive planning first implemented in 2014.

As we approach the first of the pathfinder H&WB hubs outside the Town Centre, we notice the new housing development has been planned to include accessible green space for recreation, and cycle lanes link key amenities.

The local school is now part of the community infrastructure with buildings open seven days and playing fields available to community groups year round.

The H&WB hub has a central multipurpose building at its centre. The approach to this is well-lit and through a garden area that is split into sections where key groups can manage and grow a range of plants; competition is clearly keen on the best display.

The car park is well placed with space to position a health screening minor-operations vehicle if needed, with cycle lanes and walking pathways clearly marked.

The two-storey multipurpose building is a seven-day facility that has flexible space to deliver consultations, group sessions and luncheon clubs.

The GP practice area is open and offering clinical sessions to patients who have booked their appointment through the multi-agency Single Point of Access (SPA). A mixture of local point of testing, locality based x-ray and digital health care systems are providing a local integrated diagnostic support system, linked to patient records and the big data systems.

The GPs working on the Saturday sessions are from a range of local practices, with the local GP collaboration providing a locality-based approach to seven-day working and medical cover. The focus of these new hubs is elective care, long-term care, and frailty, with support from acute clinicians in local clinics. The urgent/unplanned care is focussed on the central health and well-being

centre which offers non-appointment access to urgent and unplanned care through GP, urgent-care practitioner, and A&E services, triaged on arrival. A screen in the new hub describes current waiting times.

A frail elderly Multi-Disciplinary Team (MDT) meeting is in progress. A local specialist GP, social worker, community matron, a community diabetic specialist nurse, community psychiatric nurse (CPN) and third sector volunteer are holding a video conference with a community geriatrician and a mental health professional from the local community hospitals, who are contributing to the assessments of patients to move back to home-based settings.

The MDT, some of whom are based upstairs as their local base, are all using integrated ICT systems so that there is a core single record which is the basis of the case management of both high-risk patients and those who are being discharged from hospital. The social and community staff link in through their mobile working laptop system, and all patients on the MDT system have agreed to share their information.

Leaving the practice we note that programmes of Long Term Conditions support sessions are planned for Monday. Two types of sessions are being offered:

- Luncheon club sessions for core groups of housebound people and their carers, at which a regular session of social activity is available, with transport via third sector volunteers and food provided from the spare capacity at the local hospital kitchens which are now less pressured as fewer patients are in hospital beds. At these sessions health improvement advice is given and a health care assistant, using point of care testing developed as part of the 2015 digital test bed program. Core preventative readings and blood tests are taken and fed back to the MDTs via the digital platform set up in 2014.
- Integrated care sessions at which consultants and specialist nurses are booked to provide integrated support to frail elderly patients with multiple conditions - diabetes, vascular and supporting podiatry, retinal and dementia screening. The sessions are being carefully planned to allow access to clients until 7pm.

In a local elderly person's own home…

We notice the development is cleverly planned to have a mixture of housing, with clusters of good family homes which can be easily customised to suit those needing assisted living support. Close to the H&WB hub a group of houses have been configured to be a virtual care home with digital hub capability and access to the kitchen facilities in the hub.

A key care worker - in this case a community matron - is visiting to check out a person on the local risk of admission register. The person's carer has called for help from the SPA as they were concerned. The matron is looking at data gathered by the digital hub system in the home fitted at time of build, and which is part of the entertainment/digital TV box in the home. This data includes monitoring of utility meters, fridges etc. a package of domiciliary monitoring matched to the persons needs and is part of the 'internet of things' approach.

The nurse is using a digital stethoscope to listen and transmit in real time the heart and lung function to a COPD consultant operating in 'the front of house' team of the local A&E unit. The conclusion is that a course of IV antibiotics supported by the local nursing team in the person's home is required,

with an enhanced support package which includes a third sector sitting service, organised by the social worker through the SPA, will prevent risk of admission.

The carer has on their carer patient portal a contact name and support person named to discuss their concerns if required.

The handyperson service operated jointly with the third sector and fire service is fitting some additional hand rails and a ramp through the Disabled Facilities Grant to reduce the risk of falls, and the Lifeline Service is in place, providing a 24/7 on-call service in the event of any trips and falls.

Travelling to a local care home on Sunday …

As we pass the reception office we are asked in to look at the care home digital health portal, a system pioneered in Darlington in 2015. This allows the care home staff to carry out basic monitoring functions and the information for high risk patients is fed through to local MDTs – key measures of hydration, nutrition etc. – with a nurse/dietetics support making preventative interventions where possible, saving GP/geriatrician time to focus on complex patients.

A community matron and a band 4 nurse are undertaking a review of six patients, three identified in a local MDT meeting as having a risk of escalation and three recent arrivals from a planned discharge process - two from a community hospital and one from a District General Hospital.

The patient discharged from hospital arrived an hour ago. The community-led integrated intermediate care/discharge team planned the discharge from the hospital with essential medication being provided from the new seven-day pharmacy service.

The patient's hospital discharge information pack included a web-generated nutrition plan and a digital health monitoring pack. This cheap and flexible digital health pack, brought by the Health Care Assistant in the boot of his car, was connected and put on line and started taking readings within ten minutes. The information, being cloud-based, allows decisions around additional care to be made by local GPs accessing clinical information. This INR dependant patient is also utilising the digital monitoring system to dose check as required.

The care-home staff are preparing for a visit from a local care home support team of GP, community matron, pharmacist and a practitioner from the Mental Health Service Older People (MHSOP) community liaison team. They provide focussed support to help avoid hospital admission, and targeted medicines audits.

Advance care planning for a new resident is in progress, with primary, social care, third sector and community clinical input. The plans have been updated with a case manager community matron aligned to the patient. This allows the care home, paramedics and acute hospital to easily contact a key worker should the patient require any escalation.

A trial using CHC aligned beds has been extended, allowing the opportunity of moving hospital patients requiring assessment to the home to free up beds.

A memory clinic is planned for tomorrow supported by the local mental health trust and the third sector.

The MHSOP community liaison nurse is working with care home staff on the proactive and reactive strategies required in order to prevent further challenging behaviour episodes from a recently difficult client to prevent hospital admission.

At the local acute hospital site…

We notice the site has been remodelled to lose its acute appearance and to become a health and well-being centre.

Using space being freed up by moving care closer to home, the redesigned A&E area, now part of a community system, is an integrated system with clear and distinct triaging for children and adults with rapid access to the most relevant clinicians, ECP, GP and - if needed - consultant decision makers 24/7. This access is extended to GPs and to intermediate care teams in the community via digital consulting links.

There are no emergency ambulances at the door. A local 'floating' GP moves around the locality on a seven day rota system, and is today in the A&E unit having this morning worked with paramedics in a see and treat approach to prevent three admissions.

The redesigned urgent care unit, now fully integrated with urgent care, A&E and GP consultation areas, has facilities designed from benchmarking best practice. It has also had effective seven day staffing put in place to match projected demand.

The mental health hospital liaison team provide 24 hour/seven day a week support into A&E, diverting individuals into more appropriate services or treatments.

The mental health liaison service are also working with acute in-patient staff to facilitate the earliest discharge for patients with dementia or delirium who have been admitted for necessary procedures, but supported back to their homes through assertive outreach.

Mental health emergency admissions to our acute hospitals and related issues are now managed on a seven day basis by the local acute and third sector mental health services, working closely with the Emergency Department (ED).

In the diagnostics area the MRI schedule includes four slots for community geriatric patients referred by the MDT to prevent admissions, prioritised over routine inpatient scans.

This rapid assessment process for those frail elderly community patients has seven day coverage and geriatrician support that aligns with GP opening times.

On a medical ward the in-hospital MDT is meeting to finalise the discharge plan for a frail elderly patient on the high risk register. The community matron and social worker from community are pulling the patient out of hospital using the advance care plan as the basis of the discharge plan. The carer's needs are considered as part of the discharge arrangements.

Clinics and ward rounds on the speciality service areas run on a seven day basis, the trust having reviewed and realigned its delivery across its two main sites to ensure it has clinical cover by:

- only delivering some services on one site
- delivering key services on both sites 8-8 with one site being 24/7
- realigning support services

We also note that some of the freed up acute ward space has now been re-designated as community bed space and is being used for step up step down and CHC assessment areas , utilising the freed up assets in the hospital for local health community use.

Darlington Health and Social Care System - Open for business 24 hours a day – 7 days a week.

Social care staff are based within the multi-disciplinary teams. There is a health and social care hub (RIACT) which is the single point of access for all referrals into health and social care. The hub screens, signposts, provides information, triages and quickly allocates people to named professionals within the team. The hub also identifies carers and offers appropriate information/support. There is one IT system used by health and social care across Darlington.

The integrated teams consist of social care, the voluntary sector, community nurses, occupational therapists, physiotherapists, specialist long term conditions staff and community matrons. Together they respond to the needs of people who have had falls, stroke, diabetes, dementia, heart disease. Housing staff are working alongside the team .supporting those with housing needs including homelessness.

There are excellent self-care support groups available to all and from which individuals can seek support and discuss with patient experts ways of coping with their long term condition. These groups also support individuals in how to best use personal health budgets and personal budgets through social care. Support for carers is also available.

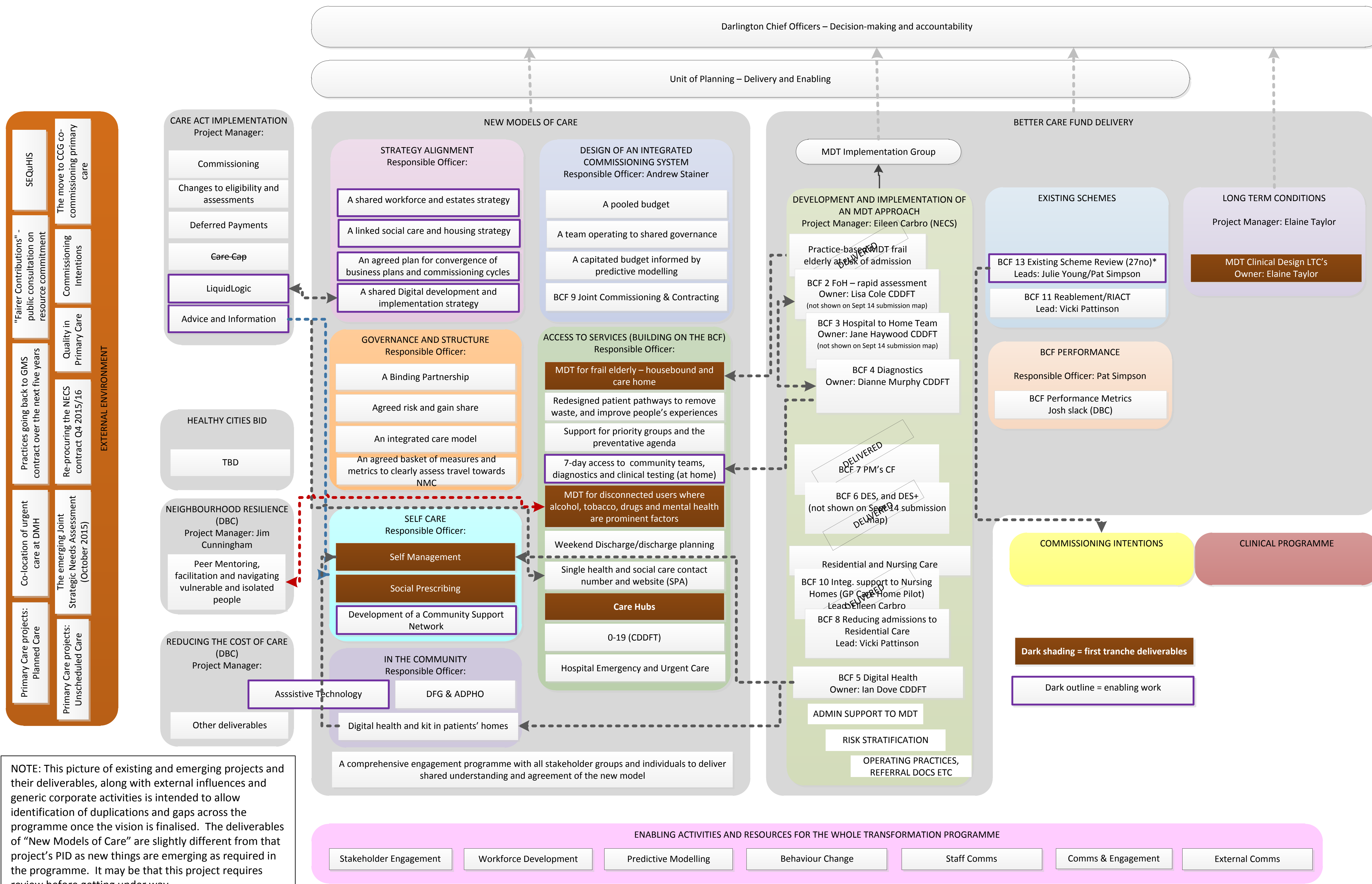
There are joint management arrangements across Darlington. Front-line staff are well supported with a sound management structure (which has saved money for each organisation).

There are sound joint arrangements for safeguarding vulnerable adults. Using the resources of all agencies, Safeguarding Adults Board in Darlington is highlighted as best practice.

Care home liaison which includes mental health, GPs, contracts staff, front-line social care and clinical staff, ensures an excellent range of quality care home establishments.

Current state	Future desired state
Practice-based MDTs in place and working well	MDTs providing wraparound care for frail elderly resident in care homes, or unable to leave their own homes independently
Disconnected users are not finding the most appropriate service to meet their needs	People know where to go first time, every time; personalised support is available to help navigate
Commissioning is based on previous years	Commissioning is on the strength of predictive planning and patient-centred risk profiling
Long term conditions are not managed holistically	Integrated care is available across, for example, diabetes, vascular and supporting podiatry, retinal and dementia screening
Little structured or rewarded encouragement to self-manage	Vigorous encouragement and opportunities for participation in self-management
A paper directory with no central owner to keep updated	An online directory of VCS, social care and helth support readily accessed by all health and care providers
Different providers have many different contact numbers, sites, and availability	A single point of access is well publicised and supported
Public expectation that all health care is available in Darlington	Centres of excellence in place and understood by the public
The solution is too often expected to be medical	A better solution may be social or physical activity
Care packages are inflexible and unresponsive	Flexible domiciliary care packages available through a mature market
Intermediate care beds are currently fragmented	Intermediate care & step-down beds (and care resources) available to meet need and location
Public expect to receive health care in a medical location	Public expect to take responsibility for their own care, and understand that healthcare is not always medical care
Health, social, economic and other elements of support for people are delivered separately	Help hubs are in place to provide access to the whole range of health, social and economic wellbeing support
Out of hospital care is dispersed	Out of hospital care is locality based
People generally travel to receive diagnostic tests	Diagnostic tests for people at high risk of admission are routinely carried out at home or in social locations.
Urgent and unplanned care is delivered at the Hospital or UCC	Some urgent and unplanned care is available in the community, through the care hub
Urgent care is provided at a separate location	Urgent care is fully integrated with A&E and GP services over seven days
Continuing health care beds are not always available at the time they are required	CHC beds are aligned with care homes so people can be moved out of hospital when they are medically ready to go
Public receive services designed by providers	Public are joint architects of services

Current state	Future desired state
Enablers	
Information cannot be stored for all partners to access ICT systems cannot be accessed across boundaries Licensing models prohibit information sharing	A secure shared communications and information storage approach between partners
Teleconferencing/mobile working is very limited and not used in the field	Secure teleconferencing is the norm between partners
Secure, compliant ICT infrastructure is not in place	Secure mechanisms for telemedicine and digital monitoring from all relevant locations
Individual partners operate to own strategies and standards	Shared accountability
Silo working and configuration	Joint commissioning
Individual partners have own asset management/disposal strategies	Shared/joint use of assets
Data is difficult to share across organisation boundaries	Data sharing agreements as standard
Individual partners have own organisational development strategies and training plans	Flexible and responsive skills and expertise acquisition
Performance measures reflect individual partner priorities	Performance measures reflect outcomes rather than process
Reward and recognition systems reflect individual partner priorities	Appropriate risk taking is rewarded
Nearly a 7 day model of care	7-day model of care


Darlington Chief Officers – Decision-making and accountability
Unit of Planning – Delivery and Enabling
EXTERNAL ENVIRONMENT
SEQuHIS
The move to CCG co-commissioning primary care
"Fairer Contributions" - public consultation on resource commitment
Commissioning Intentions
Quality in Primary Care
Practices going back to GMS contract over the next five years
Re-procuring the NECS contract Q4 2015/16
Co-location of urgent care at DMH
The emerging Joint Strategic Needs Assessment (October 2015)
Primary Care projects: Planned Care
Primary Care projects: Unscheduled Care
CARE ACT IMPLEMENTATION
Project Manager:
Commissioning
Changes to eligibility and assessments
Deferred Payments
Care Cap
LiquidLogic
Advice and Information
HEALTHY CITIES BID
TBD
NEIGHBOURHOOD RESILIENCE (DBC)
Project Manager: Jim Cunningham
Peer Mentoring, facilitation and navigating vulnerable and isolated people
REDUCING THE COST OF CARE (DBC)
Project Manager:
Asssistive Technology
Other deliverables
NEW MODELS OF CARE
STRATEGY ALIGNMENT
Responsible Officer:
A shared workforce and estates strategy
A linked social care and housing strategy
An agreed plan for convergence of business plans and commissioning cycles
A shared Digital development and implementation strategy
DESIGN OF AN INTEGRATED COMMISSIONING SYSTEM
Responsible Officer: Andrew Stainer
A pooled budget
A team operating to shared governance
A capitated budget informed by predictive modelling
BCF 9 Joint Commissioning & Contracting
GOVERNANCE AND STRUCTURE
Responsible Officer:
A Binding Partnership
Agreed risk and gain share
An integrated care model
An agreed basket of measures and metrics to clearly assess travel towards NMC
ACCESS TO SERVICES (BUILDING ON THE BCF)
Responsible Officer:
MDT for frail elderly – housebound and care home
Redesigned patient pathways to remove waste, and improve people's experiences
Support for priority groups and the preventative agenda
7-day access to community teams, diagnostics and clinical testing (at home)
MDT for disconnected users where alcohol, tobacco, drugs and mental health are prominent factors
Weekend Discharge/discharge planning
Single health and social care contact number and website (SPA)
Care Hubs
0-19 (CDDFT)
Hospital Emergency and Urgent Care
SELF CARE
Responsible Officer:
Self Management
Social Prescribing
Development of a Community Support Network
IN THE COMMUNITY
Responsible Officer:
DFG & ADPHO
Digital health and kit in patients' homes
A comprehensive engagement programme with all stakeholder groups and individuals to deliver shared understanding and agreement of the new model
BETTER CARE FUND DELIVERY
MDT Implementation Group
DEVELOPMENT AND IMPLEMENTATION OF AN MDT APPROACH
Project Manager: Eileen Carbro (NECS)
Practice-based MDT frail elderly at risk of admission
DELIVERED
BCF 2 FoH – rapid assessment
Owner: Lisa Cole CDDFT
(not shown on Sept 14 submission map)
BCF 3 Hospital to Home Team
Owner: Jane Haywood CDDFT
(not shown on Sept 14 submission map)
BCF 4 Diagnostics
Owner: Dianne Murphy CDDFT
DELIVERED
BCF 7 PM's CF
BCF 6 DES, and DES+
(not shown on Sept 14 submission map)
DELIVERED
Residential and Nursing Care
BCF 10 Integ. support to Nursing Homes (GP Care Home Pilot)
Lead: Eileen Carbro
DELIVERED
BCF 8 Reducing admissions to Residential Care
Lead: Vicki Pattinson
BCF 5 Digital Health
Owner: Ian Dove CDDFT
ADMIN SUPPORT TO MDT
RISK STRATIFICATION
OPERATING PRACTICES, REFERRAL DOCS ETC
EXISTING SCHEMES
BCF 13 Existing Scheme Review (27no)*
Leads: Julie Young/Pat Simpson
BCF 11 Reablement/RIACT
Lead: Vicki Pattinson
LONG TERM CONDITIONS
Project Manager: Elaine Taylor
MDT Clinical Design LTC's
Owner: Elaine Taylor
BCF PERFORMANCE
Responsible Officer: Pat Simpson
BCF Performance Metrics
Josh slack (DBC)
COMMISSIONING INTENTIONS
CLINICAL PROGRAMME
Dark shading = first tranche deliverables
Dark outline = enabling work
ENABLING ACTIVITIES AND RESOURCES FOR THE WHOLE TRANSFORMATION PROGRAMME
Stakeholder Engagement
Workforce Development
Predictive Modelling
Behaviour Change
Staff Comms
Comms & Engagement
External Comms
NOTE: This picture of existing and emerging projects and their deliverables, along with external influences and generic corporate activities is intended to allow identification of duplications and gaps across the programme once the vision is finalised. The deliverables of "New Models of Care" are slightly different from that project's PID as new things are emerging as required in the programme. It may be that this project requires review before getting under way.

Darlington Vision 2020 Programme: Deliverable Description	
Project Name	New Models of Care
Project Lead	Andrea Jones (Sponsor) Pat Simpson (Project Manager)
Workstrand	Access to Services
PRODUCT ID 1	Frail elderly MDT (Phase 2) – care home, house bound/luncheon club
Product owner	Darlington CCG (organisation owner), Jenny Steel (Sponsor) supported by Eileen Carbro (Project Manager)

1. Team Members and resource requirements:

Jenny Steel, PHD Clinical Lead
Jo Dawson, TEWV
Vicki Pattinson, DBC
Yvonne Mineham
Others tbd

Eileen Carbro, CCG Project Manager
Dr Elizabeth Loney, CDDFT
Chris Binns, TEWV
MDT Implementation Group (existing)

2. Purpose
To build on the practice-based MDT approach for frail elderly implemented under the Better Care Fund, to deliver high quality and effective planned care outside of hospital via a multidisciplinary team approach supporting frail elderly and at risk patients in care homes, in their own homes, and at locations used for social activities.

3. Composition
1. Cohort identified
2. Options Appraisal & Equalities Impact Assessment
3. A single patient list of “frail elderly”
4. MDTs aligned with housebound clients
5. MDTs aligned with Homes
6. Dementia/Alzheimers’ SoP
7. Training programme for care home staff
8. Luncheon clubs and other social activities identified or established
9. MDT aligned with locations to which the cohort is transported for social events such as luncheon club
10. Health improvement advice and point of care testing, based round lunch clubs and other social events
11. Rapid Response alternatives to hospital admission, diagnostics etc
12. Transport provision

Darlington Vision 2020 Programme: Deliverable Summary	
Project Name	BCF
Project Lead	Murray Rose (Sponsor) Pat Simpson (Project Manager)
Workstrand	Long Term conditions
PRODUCT ID 12	Long Term Conditions collaborative
Product owner	CDDFT (organisation lead) Basil Penney (clinical lead) supported by Elaine Taylor (Project Manager)

1. Team Members and resource requirements:

Basil Penney, Clinical Lead
Jo Dawson, TEWV
Dr Elizabeth Loney, CDDFT
Others tbd

Elaine Taylor, Project Manager
Paul Peter, CDDFT
Existing delivery group

2. Purpose

The original BCF submission scheme:

Improvement

- Referral processes – how people get into services
- Admission process – how we capture information on people and how we join up their future care pathway (holistic assessment?)
- Diagnosis process – how we ensure that a timely diagnosis is made in the most appropriate setting
- Treatment process – ensuring we give the right option for treatment (Crisis intervention – rapid response etc.)
- Discharge process – how we provide safe, facilitated discharges which engage the necessary parties and ensure that care is in place to support the patient/service user
- Communication processes – how we communicate externally and internally in relation to patient/service user needs. How we communicate and understand what is available in terms of services and support and how we signpost/support people to make informed decisions
- Person centred management – putting the patient/service user at the heart of the planning and decision making process, no decision about me – without me.
- Self-management – developing on the above process strengthen the ability of patients/service users to determine how they want to self-manage their condition
- Support Groups – alignment of outcomes, reduction in duplication, ease of access.

Transformation

- Portal/joined up systems – a single place to access patient/service user information
- Single management structure
- Developing organisational culture – developing lean thinking/understanding & application
- Budget realignment – to follow the patient/service user

- Service Alignment/integration – integrated locality teams, LTC practitioners

Prevention

- Proactive/predictive modelling – finding people/groups before they develop LTCs
- Risk profiling – identifying at-risk patients to plan interventions to minimise and/or prevent more intensive interventions
- Community/School/Employer engagement – co-production in delivery of care/support

3. Composition
Output from the Clinicians'/Practitioners' Event
1. Agreed definition of LTC across all partner organisations
2. A single electronic care plan
3. Embedded communication routes with patient, between specialities
4. Removal of duplication of appointments/diagnostics/investigations
5. IT interoperability, support and standardisation
6. Established trust between organisations
7. Information (verbal and written) shared routinely with patient and carer/partner
8. Signposting to sources of support
9. Patient managed by key worker – reduced number of consultants & specialists. Boundaries between primary, secondary and tertiary care removed from the patient's perspective
10. Optimised medication
11. Patients allowed to control the management of their condition – take ownership, be the expert. Keeping notes (like in Maternity)
12. Significantly increased self-checking and proactive self-management
13. Alliance contracts, gainshare, programme budgeting

Darlington Vision 2020 Programme: Deliverable Summary	
Project Name	New Ways of Working
Project Lead	Andrea Jones (Sponsor) Pat Simpson (Project Manager)
Workstrand	Access to Services
PRODUCT ID 25	An approach for users where alcohol, tobacco, drugs and mental health are prominent factors in frequent access to services.
Product owner	TEWV (organisational lead), Susan Waterworth and Andrew Stainer

1. Team Members and resource requirements:

Susan Waterworth, Clinical Lead
Jo Dawson, TEWV
Jim Cunningham, DBC (Peer Mentors project link)
Andrew Stainer, Management Lead
Dr Elizabeth Loney, CDDFT
Rep from VCS

2. Purpose

To make a contribution to reduced non-elective admissions and use of A&E services

To develop a service design or combination of designs that will result in a sustainable reduction of demand from this group of service users

To develop a service design or combination of designs that enables those individuals who wish to break their repeat usage, to do so

3. Composition

This Product is already well under development (October 2015) with these components:

1. An identified sample cohort of individuals already in a pattern of frequent service use - ask them what would make a difference and why
2. An analysis of the agencies they make demands upon, frequency and with what outcome
3. An agreed set of criteria that characterise this group of service users
4. A set of key factors or triggers likely to cause an individual to fall into this pattern of service use (including signposting failure, service design flaws etc.)
5. Adequate data sharing agreements
6. A role description for a care “navigator” (perhaps drawing on the Islington experience)
7. A pilot deployment of the “navigator” principle on the basis of consent from individuals identified through the MDTs
8. A pathway description that identifies potential points of intervention and can be expanded across more agencies than just those engaged with BCF and
9. A pathway description that allows services to anticipate potential repeat, avoidable service use
10. A set of indicators and metrics to measure impact

Additional components identified by Clinicians/Practitioners in November 2015:

11. Co-joining up services at point of use – an holistic approach
12. Proactive work with families to break the cycle
13. Use of voluntary sector – recovery approach
14. Place of safety rather than prison cells
15. Flag/threshold (like children/safeguarding)
16. MDT approach
17. Health and social services in A&E
18. An approach for parents where children are subject to medium/high level chiuld protection concerns

Darlington Vision 2020 Programme: Deliverable Summary	
Project Name	New Models of Care
Project Lead	Andrea Jones (Sponsor) Pat Simpson (Project Manager)
Workstrand	Self Care
PRODUCT ID 35	Self-management of conditions
Product owner	Third Sector (organisational lead) Third Sector supported by Elaine Taylor and Ian Briggs (with input from Basil Penney)

1. Delivery Group Members and resource requirements:

Elaine Taylor, Project Manager
Basil Penney Clinical partner
Jo Dawson, TEWV
Michelle Thompson, Healthwatch
Others tbd
Ian Briggs, Management lead
Dr Paul Walker, TEWV
Dr Elizabeth Loney, CDDFT
Third Sector rep

2. Purpose
To put in place processes and practices to promote and support a culture among Darlington residents of personal responsibility for self-management of conditions, and for staying healthy:- 1. Information 2. Self-empowerment / Partnership in treatment and care planning 3. Choice

3. Composition
1. Information – patients need the right information in a way that they can understand at the appropriate time but also be given time to process and understand the information that has been provided to enable them to make an informed decision/choice.
2. Definition of empowerment - includes those self managing taking responsibility for their care and care plan
3. Self empowerment – people who feel that they are in control of the decisions and are part of the solution they are much more likely to engage and contribute actively. Professionals cede some of that authority and control to the patient. Opportunities for people to voice their lived experience so opinions are taken into account when prescribing treatment or care.
4. Choice – to come back to professionals and change their mind or ask for more or different support as their needs change.
5. Information sharing/technology to allow access to monitoring and self mgt pathways
6. Establishing partnership in care - patients and service users equal partners
7. One condition/whole person -
8. Replace payment + contracting systems based on episodes of care with commissioning for wellbeing and funding the programmes
9. Information sharing

Darlington Vision 2020 Programme: Deliverable Summary	
Project Name	New Models of Care
Project Lead	Andrea Jones (Sponsor) Pat Simpson (Project Manager)
Workstrand	Self Care
PRODUCT ID 36	Social Prescribing
Product owner	DBC (organisation lead) Ken Ross, Brent Kilmurray (TEWV)

1. Delivery Group Members and resource requirements:

Ken Ross, Management Lead
Ingrid Whitton, TEWV
Ian Barrett
Jacqui Dyson, TEWV
VCS rep
Brent Kilmurray, TEWV, Clinical lead
Jo Dawson, TEWV
Dr Elizabeth Loney, CDDFT
Michelle Thompson

2. Purpose
To identify and implement non clinical options for individuals to support their health and wellbeing, and to empower the individuals to make these choices and for professionals to 'allow' them to make these choices in partnership with the professional.

3. Composition
1. A clear definition and understanding of "social prescribing" in Darlington
2. Agree common terminology – prescription to recommendation, for example
3. An understanding of a prescriber's responsibilities for the patient for any 'Social prescribing'
4. Criteria for selecting people for this option
5. Single source of information about third sector activities
6. Community, voluntary and peer support networks

Darlington Vision 2020 Programme: Deliverable Summary	
Project Name	New Models of Care
Project Lead	Andrea Jones (Sponsor) Pat Simpson (Project Manager)
Workstrand	Access to services
PRODUCT ID 38	Care Hubs (meeting health and social care needs through a multi-specialty community provider model)
Product owner	PHD (organisation lead) Chris Mathieson, support tba

1. Delivery Group Members and resource requirements:

Chris Mathieson, Clinical Lead PHD
Dr Paul Walker TEWV
Dr Elizabeth Loney, CDDFT

Vicki Pattinson, DBC
Michelle Thompson, Healthwatch
David Gray, PHD
Others tbd

Ria Willoughby CDDFT
Jo Dawson TEWV
Dr Caroline Gibson, Primary Care (Clifton Court Surgery)
Chris Binns, TEWV
Jessica Beard, TEWV
VCS rep

2. Purpose
Delivering out-of-hospital care in a patient-focused cost-effective way in line with one or more models expressed in the Five Year Forward View. Depending on the outcome of a bid to the Healthy Cities scheme, the development of a new build model Health and Wellbeing Hub as part of a new housing/neighbourhood development.

3. Composition

1. Identification of an appropriate model for Darlington
    a. Do we need a hub
    b. Virtual hub or actual building
    c. Acute assessment or routine care or both
2. An agreed definition, terminology
3. Identification of the source and type of benefits (for the preferred model, where are the patient experience improvements, where are the savings to be made…), and who is responsible for their realisation
4. Provision of personalized care balanced against national population planning
5. An engagement approach for those aspects of the preferred model where patient input would be useful and relevant
6. Levers and measures to drive a cultural change towards taking ownership of patients' conditions/needs, not bouncing them to other services
7. A means of making practice boundaries invisible to patients

8. A means of moving away from individual patient registration
9. Multi-specialty community provider approach
10. Urgent, same day and pre-bookable appointments for an identified population
    - Testing, x-ray and other diagnostics
    - Appointment access to GPs over the weekend
    - Non-appointment access to urgent and unplanned care
11. A capitated budget for an identified population
12. Digital tools
    - Video-conferencing access to clinicians and specialists elsewhere
    - Integrated ICT
13. LTC support and management
14. Integrated care sessions for multiple conditions

Initial Timetable

Projects	Outputs	Delivery date
Change management planning and programme preparation – strategic level	Establish and agree the case/agenda for change (the communications narrative) Establish and agree target milestones – where do we want to be at the end of each year - Establish and agree organisation (including relationship with SeQuiHS) Risk assessment Infrastructure and resources identified and agreed by COG Initial communications plan in place Definition of the Darlington Pound: Detailed analysis of current position and areas where new £/1000 can be found by 31 March 2020	Oct 6 & 21 2015 Q3 2015/16
Change management planning and programme preparation: operational stakeholder engagement	Clinicians and Practitioners' engagement: contribution to first tranche deliverables' specification and design Corporate enablers' stage one engagement (accountancy, estates, ICT, HR): seek the benefit of their expertise and identify current three year plans. Second stage corporate enablers' engagement – cross organisation by specialism: achieve some shared expertise and commitment	Nov 2015 Q3 2015/16 Q4 15/16
	Organisational Development gap survey/analysis leading to OD 2020 Strategy and Plan	End Q3 2015
	Programme sign off by HWBB and Darlington Chief Officers	End Q3 2015
First Tranche – indicative periods to be worked up in detail by the delivery teams		
Access to Services	High Impact service access: specification and planning stage	Q2 15/16
	High Impact service access: mobilisation stage	Q4 15/16
	High Impact service access: Implementation	Q4 15/16 – Q1 16/17
	High Impact service access: review	Q2 16/17
	High Impact service access: embedded and performing	Q3 16/17
LTC	Long term conditions mobilisation stage	Q3 15/16
	Long term conditions implementation	Q4 15/16
	Long term conditions review	Q3 16/17
	Long term conditions embedded and performing	Q4 16/17
Frail elderly phase 2	Frail elderly at home/in home specification and planning stage	Q4 15/16
	Frail elderly at home/in home mobilisation stage	Q4 15/16 to Q1 16/17

Projects	Outputs	Delivery date
	Frail elderly at home/in home implementation	Q1 16/17
	Frail elderly at home/in home review	Q3 16/17
	Frail elderly at home/in home embedded and performing	Q4 16/17
	Enabler planning	Q4 2015/16
Self care	Darlington self-management specification and planning	Q4 2015/16
	Darlington self-management mobilisation	Q1 16/17
	Darlington self-management implementation	Q3 16/17
	Darlington self-management review	Q4 16/17
	Darlington self-management embedded and performing	Q4 16/17
	Darlington social prescribing planning	Q4 2015/16
	Darlington social prescribing mobilisation	Q1 16/17
	Darlington social prescribing implementation	Q3 16/17
	Darlington social prescribing review	Q4 16/17
	Darlington social prescribing embedded and performing	Q4 16/17
Access to Services	Care hub specification and planning	Q3 & 4 15/16
	Care hub mobilisation	Depends on spec
	Care hub implementation	
	Care hub review	
	Care hub embedding and performing	
Second and subsequent tranches		
	Planning for the Integration program of targeted community / primary / social care / 3rd sector services for Women and children	Q3 2016/17
	Integrated UCC/ A&E / GP out of hours	
	7 day working strategy and plan implemented	
	Reconfiguration of acute services	