DARLINGTON VISION 2020: BCF PROJECT BRIEF		
Project Name	Hospital to Home (working title)	
Project Sponsor	Suzanne Joyner Alison Wilson	**Clinical lead:** **Officer Lead:** Vicki Pattinson
Distribution List	**Project Board Members** Unit of Planning	**Project Manager:** Pat Simpson
	Delivery Team Members Jane Hayward Carmel Reilly Hilary Hall NECS Jenny Steel Jeanette Crompton CDDFT (internal transformation rep) TEWV Rep	

Project Definition

This project brings together and builds on a number of initiatives introduced in BCF 2015 to reduce delays to discharge from hospital for medically stable people back to a community setting: wherever possible, this is their usual place of residence.

Project objectives

To help people make a safe and timely transition out of hospital as soon as it is appropriate to do so, minimising length of stay, and maximising the options available at the time of discharge.

Project deliverables and/or desired outcomes

An MDT approach to Discharge Management in the acute setting – an integrated discharge management function – that has at its disposal a range of options to facilitate safe and timely discharges while promoting independence and wellbeing. These options will include intermediate care and reablement support, community bed facilities, use of telecare, equipment at home, VCSE support, primary care and community nursing as well as close liaison with families and carers.

Culture and practice will shift to see a move towards a discharge to assess model which supports the individual to return to their usual place of residence to allow for a more accurate assessment of their needs to take place.

This shift in practice would require a change in relation to risk appetite and a greater move towards increasing and maintaining independence for individuals. Appropriate resources and funding systems would need to be in place to avoid any delay and to ensure demand for resources is shared across the system. The same approach will be adopted in terms of potential benefits which should be shared by all. There will be a joined up approach to

commissioning of appropriate resources within the community to support this way of working.

With more accurate assessment in place this should assist with preventing readmissions to hospital as well as reducing permanent admissions to residential care.

Aligned criteria and policies in respect of home adaptations

A review of processes around CHC with a view to reducing blockages

Project scope – what this project will affect

Discharge Management Resources

Commissioning model and process

Health and social care packages to facilitate discharge

Reablement/RIACT/Intermediate Care

Procurement of a new provision of Intermediate Care beds combining block and spot purchase

Community Equipment Service

Adaptations & DFG

DFG and Housing adaptations eligibility criteria

Assistive Technology

Dementia Adviser

Review of current CHC model and process

VCSE Sector in Darlington

Any exclusions/Out of Scope items

In development

Constraints and Limitations

Domiciliary care market conditions – fragility of the local independent sector

Current Capacity of the community and voluntary sector in Darlington

Absence of a VCSE infrastructure organisation

Intermediate care bed availability

Current commissioning and procurement approaches

Current eligibility criteria for DFG

Current CHC process

Current transformation plans for integrated DMT

Financial constraints

Interfaces and Interdependencies

CCG “Not In Hospital” workstream

Long Term Conditions project

Mental Health Forum

Better Health Services Programme

Good Friends scheme (DBC Economic development and Age Concern)

The home from hospital service provided by Care Connect

Prevention and signposting (social prescribing) a strong community support network
Availability and training to deploy assistive technology
Other BCF Projects

Project organisation and roles, and communications

Delivery Group meeting four - six weekly
Officer lead to project manager weekly (email or phone)
Project Manager to project sponsor fortnightly
Monthly update to UoP and CCG/DBC sponsors of BCF via BCF highlight report
BCF Dashboard updated on a rolling basis

Measures of success

		16-17 plans			
		Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	702.6	684.6	666.6	647.1
	Numerator	585	570	555	540
	Denominator	83,260	83,260	83,260	83,455

Relevant targets from CCG Financial Sustainability Plan (FSP), NHS Mandate (2020 Goal) (NHS20), NHS Mandate 16/17 deliverable (NHS16), or CCG Commissioning Intentions (CI)

Improve electronic record sharing	NHS Mandate - 16/17 deliverable
Reduced delay to transfers of care	NHS Mandate - 2020 goal
Measurable progress towards integrated assessment	NHS Mandate 16/17 deliverable

Communications and Stakeholders

A list of Users & Interested Parties (Stakeholders)

Primary Care, Secondary Care, Social Care, Mental Health and the VCSE Sector, service users, care home providers (independent sector forum), domiciliary care providers, Carers, Healthwatch Darlington, Extra Care and Sheltered Housing managers
CCG, Unit of Planning, Darlington Chief Officers' Group (list to be expanded by the delivery group)

Resources

Expenditure Plan

Supported Discharge (Home From Hospital transfer from Care Connect)	19,600
Packages to facilitate discharge	158,000
Reablement/RIACT	942,600
Community Hospitals	674,572
Intermediate Care – staffing (RIACT)	1,056,678
Intermediate Care (Step down beds at Ventress Hall)	222,000
Integrated Care – Reablement spot and block purchase beds	509,600
Community Equipment Service (CCG contract amount)	295,506

The Supported Discharge Service is provided through Care Connect and runs until the end of July this year. There is the option to extend through 3 x +1 extension clauses

Delivery timetable

In development

Risk

The fragility of the domiciliary care market remains a source of risk in Darlington. Changing what we commission may help stimulate this market and mitigate this risk.
For other risks see the BCF Project risk register (see dashboard)

Revision History			
Version No	**Status**	**Author of Change**	**Date Published**
0.1	First draft	Pat Simpson	11/03/2016
0.2	Second draft	Pat Simpson/Vicki Pattinson,	14/03/2016
0.3	Third draft	Pat Simpson, Jenny Steel, Jeanette Crompton, Michelle Thompson	16/03/2016
0.4	Fourth draft	Pat Simpson with contrac tinfo from Lisa Holdsworth	16/03/2016
0.5	Fifth draft	Pat Simpson with input from Vicki Pattinson and some proofing and validation corrections from Sharon Cable	17/03/2016
0.6	Final draft	Alignment of Expenditure Plan values following agreement of expenditure plan	18/03/16

Approval			
This document requires sign off by the Project Sponsor and if the project is part of a programme, but the Senior Responsible Owner			
Name	**Role**	**Signature**	**Date**
Alison Wilson	BCF Sponsor (CCG)		
Suzanne Joyner	BCF Sponsor (DBC)		

DARLINGTON VISION 2020: BCF PROJECT BRIEF		
Project Name	Long Term Conditions collaborative	
Project Sponsor	Andrea Jones	**Clinical lead:** Basil Penney
Distribution List	**Project Board Members** Unit of Planning	**Project Manager:** Elaine Taylor
	Delivery Team Members tbc	

Project Definition

Background
This project has been in place for more than a year, established under BCF 2015. The work done to date reveals

- Unclear pathway for Diagnosis in Primary Care as many diseases can cause Breathlessness leading to inconsistent tests and varying levels of referral to Secondary Care
- No written information given to the patient following outpatient appointment or in Primary Care until Diagnosis is made
- Only 2-2.5% of very high risk population have a care plan in place and the risk factor of patient doesn't include the number of primary care appointments
- A high level of avoidable contact with service users
- Lack of cross training for staff resulting in multiple appointments for patient
- Multiple speciality outpatient appointments for complex Breathlessness leading to lengthy timescales for Diagnosis and waits for the patient
- Unclear guidelines over transfer of care so follow ups being done by Secondary Care that could be managed in Primary Care
- Automatic referral to the community Heart Failure or Respiratory team on discharge from hospital
- Manual triage of an electronic referrals resulting in printing, wasting resources of staff, paper and ink.
- Multiple points of access for an appointment
- No urgent slots on Out Patient clinics but referral criteria for some diseases demand an urgent appointment, leading to manual referrals being faxed from GP
- Unclear and untimely medication changes due to delays in communication from outpatients
- Duplication in provision of Mental Health Services – IAPT and practice counsellors and low referral rates into IAPT service
- Unnecessary waiting times and delay in communication to customers due to work handoffs within and between departments
- Non-standard time slots on clinic templates; not all staff dictating in clinic; no standard discharge template letters;
- Inconsistency in how annual review appointments are organised and multiple appointments for different diseases

Project objectives

Reviewed and Improved

- 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
- Self-management – developing on the above process to 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.

Project deliverables and/or desired outcomes

Coordination and support of RPIW outputs for breathlessness pathway

- Key worker
- Funding identification, procurement and rollout
- Transfer of Care and Discharge
- Patient Information
- Commissioning issues identification and resolution

Coordination and support of Primary Care algorithm

RPIW Follow up actions

- Identification of intermittently housebound breathless patients
- Anxiety and Depression
- Exacerbation pathway

Self-management support

- Person centred management – putting the patient/service user at the heart of the planning and decision making process, no decision about me – without me.

Output from the Clinicians'/Practitioners' Event to inform subsequent stages

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

Project scope

- Care Planning, MDT & Key Worker
- Transfers of Care & Discharges
- Patient Information
- Commissioning Issues
- Primary Care Algorithm
- Intermittently housebound & Housebound
- Mental Health Pathway for Breathlessness
- Exacerbation Pathway for Breathlessness
- Self-Management for Breathlessness (use of digital technology, staff & patient training programme)
- Self-Management for Mental Health – specifically Anxiety & Depression
- Alignment of plans for Darlington Breathlessness Care planning & training with the Diabetes Project
- Lifeline/Assistive Tech to support anxiety

Any exclusions/Out of Scope items

- Breathless - Medicines & Pharmacy
- Identification of Risk & Prevention Strategies
- Review of Risk Factor to incorporate Primary Care activity
- Co-Ordination of Training across organisations
- Patient Information Co-Ordination
- Remaining diseases outlined in the original PID – Chronic Kidney Disease & Asthma

Constraints and Limitations

Availability of clinicians

Interfaces and Interdependencies

- Close integration with the Self Management deliverable of the Vision 2020 Programme
- Will be informed by and contribute to the blueprint for New Models of Care
- The CCG “Not In Hospital” workstream
- Alignment of plans for Darlington Breathlessness Care planning & training with the Diabetes Project

Pulmonary Rehab – location of service, referral form & effectiveness of the service require reviewing
Home Oxygen service – duplicate client visits as staff can only do home oxygen assessments.
Wheelchair Service – service takes too long
IAPT service & PC Counselling service
Smoking Cessation – currently out for tender – led by DBC-Public Health

Project organisation and roles, and communications

Dlievery Group meeting on current schedule

Project Manager to project sponsor fortnightly

Monthly update to UoP and CCG/DBC sponsors of BCF via BCF highlight report

BCF dashboard updated on a rolling basis

Measures of success

- In the level of information the customer has access to about their test results and care.
- Single, Standardised & Individualised Pro-Active Care Management Plan which includes self-management & digital solution options to be put in place for all relevant people with LTC's – 100%
- Reduction in the number of appointments in a reduced number of locations that a person needs to attend by 50%
- Fewer professionals involved in the care of an individual by 5%
- Less overall staff effort in the process by 50%
- Cross skilling of staff to save duplicate client visits, reducing the overall visits required per client
- Named key worker for 'appropriate' individuals with LTC – (appropriate' to be defined in RPIW) – 50%
- MDT approach for complex cases – 100% for defined cohort
- Moving of activity from Outpatients into Primary Care/Community team with access to specialist in the community
- Evaluate appropriateness of introducing Rapid access to clinics in primary or secondary care to reduce length of stay or turn around in A&E
- Standardised approach across GP practices in Darlington
- NEL Admissions by 5% (for this population only)
- Ambulance Conveyances by 2.5%
- A&E Attends by 5%
- Urgent Care Attends by 5%
- Out Patent First Appointments 5%
- Out Patient Follow Up Appointments by 5%

Relevant targets from CCG Financial Sustainability Plan (FSP), NHS Mandate (2020 Goal) (NHS20), NHS Mandate 16/17 deliverable (NHS16), or CCG Commissioning Intentions (CI)

Reduction in NEL admissions (also contributed to by BCF project, the MDT deliverable). FSP

100% population has access to weekend/evening routine GP. NHS20

Improved access to enhanced GP services including evening and weekend access and same-day GP appointments for all over-75s who need them. NHS20

Measurable progress towards integrated assessment. NHS16

Measurable reduction in variation in management and care for people with diabetes. NHS20

Improvements in management of cholesterol for people with diabetes. CI

Reduction of risk of complication for stroke among people with diabetes. CI

Reduction of additional risk of complication for heart failure for people with diabetes. CI

Reduction in respiratory admissions with pneumonia as primary cause of admission. CI

Reduction in length of stay for respiratory admissions. CI

Reduction in smoking rates. CI

Reduction in admission to 24 hour care

Communications and Stakeholders

A list of Users & Interested Parties (Stakeholders)

Primary Care, Secondary Care, Social Care, Mental Health and the VCSE Sector, service users

Darlington COG, UoP,

Existing stakeholder plan.

Resources

LTC Project Coordinator

Delivery timetable

Task	Due Date
1. Co-Ordination and support of RPIW outputs for Breathlessness Pathway	
Self-management training options to incorporate effective care planning sourced	Q4 15/16
Staff to be trained in Self-Management/Motivational Interviewing established	
Appropriate training programme and costs identified	
Health Coaching for options appraisal	
Task & Finish working group with Nurses established	
Template finalised and put into SystmOne	
Potential cohorts identified by practice	
New process documentation completed	
Costs identified	
Practices identified as willing to operate the new system	
Benefits realisation timescale agreed for Care Planning	
Resources sourced to conduct metric measurement of success via practice data systems analysis – NECS	
The change is required in practice to incorporate care planning & algorithm into everyday work identified	
Comms Plan identified	Ongoing
Care Plan is standardised across Darlington & Durham & template is changed	Ongoing
Key Worker	
Numbers identified for trial and source key workers	Q4 15/16
Capacity & Costs CVS (Key Worker) established	
Guidance completed	
Current training offer reviewed and amended to suit this cohort	
Gaps in training capacity identified	
Funding Procurement & Roll out	
Options appraisal to obtain funding	Q4 15/16
Source funding	
Procure	TBC

Task	Due Date
Staff updated on the process in participating practices	TBC
Key Workers trained	TBC
Self-Management identified staff & patients	
Trial started	TBC
Review	TBC
Roll out	TBC
a. Transfer of Care & Discharge	
Support for changes gained via CDDFT respiratory group & cardiology group	Q4 2015/16
Multi- speciality clinic schedule identified	
Demand confirmed for Breathlessness OP clinic	
Demand confirmed for rapid access & 2 week wait slots	
Confirm demand for urgent slots	
Clinic templates reworked to standardise appointment times and overbook policy	
Standard templates developed and agreed for OP letters to GP/client	
Follow up criteria and process standardised	
Support for changes gained via CDDFT respiratory group & cardiology group	
Gain support for changes from Primary Care	
Electronic Triage of Choose & Book appointments	TBC
b. Patient Information	
Costs established for changes to OP letter	Q4 15/16
Letter inserts reviewed to see if cost can be reduced	
Test leaflet in Primary Care as part of Algorithm roll out	Q1 16/17
Electronic method established for keeping Patient Information in a central/linked location via Intranet & GP team-net	
Establish what info needs to go onto the portal • Identify what information is provided by each clinical group and if this differs from primary to secondary care. • Respiratory CVD/ HF- • Anxiety • Social needs, Housing needs- Health watch	Q2 16/17
A job role identified to undertake responsibility of keeping it up to date	
2. Co-Ordination and support of Primary Care Algorithm	
Breathlessness Algorithm for use in Primary Care	Q4 15/16
Standardisation of CVD/HF templates for annual review	
Performance measures & read codes	
Roll out/PC training plan for Algorithm	
Implementation started	
Monitoring period to capture improvement/success	

Task	Due Date
3. RPIW follow up actions	
a. Intermittently housebound & housebound breathless patients	
Cohort identified & differentials in approach.	Q1 2016/17
Criteria clarified and standardisation in approach communicated across Primary Care & Secondary Care	
Change plan identified	
Changes risk assessed	
Implementation started	
b. Mental Health strand (LTC & Anxiety/Depression)	
Current work identified in NECS re new contract for IAPT, Counselling etc.	Q1 2016/17
Task & Finish group set up	
Scoped	
Project Plan developed	
Improvement & Delivery Plan developed	
Implemented	Q2 16/17
c. Exacerbation Pathway for Breathlessness	
Issues to resolve identified	Q4 15/16
Improvement & Delivery Plan implemented	
Task & Finish Work planned	Q2 16/17
Implemented	
4. Self-Management Support	
Self-management 5 year plan developed	Q4 2015/16
Self-Management Options approved & Funding secured	Q1 16/17

Risk

BCF Project risk register (see dashboard)

Revision History			
Version No	**Status**	**Author of Change**	**Date Published**
0.1	Existing V 2020 documentation re-formatted	Pat Simpson	11/03/2016
0.2		Pat Simpson with input from Vicki Pattinson in respect “admittance to 24hr care” being an additional metric, and the use of Lifeline services in combatting anxiety in this group	17/03/2016
0.3	Final draft	Updated after the sign-off meeting	18/03/2016

DARLINGTON VISION 2020: BCF PROJECT BRIEF		
Project Name	MDT Approach to reducing emergency admissions	
Project Sponsor	Alison Wilson (CCG) Suzanne Joyner (DBC)	**Clinical lead:** Dr Jenny Steel **Officer Lead:** tbd
Distribution List	**Project Board Members** Unit of Planning	**Project Manager:** Pat Simpson
	Delivery Team Members Existing MDT Implementation group – review and refresh: Eileen Carbro, Jane Haywood, Elaine Shaw, Elaine Taylor, Carl Bashford, David Bruce, Mandy Armstrong, Vicki Pattinson, VCS brokers, Sally Hutchinson, Michelle Thompson	

Project Definition

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.

Project objectives

Reduce the number of frail elderly people, identified as being at high risk of emergency admission to hospital, actually having an emergency admission
Identify a cohort of people who will in time become “frail elderly at high risk of emergency admission to hospital” and plan interventions which reduce the likelihood of that transition

Project deliverables and/or desired outcomes

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, overnight support, assistive technology etc

12. Transport provision
13. An external, independent evaluation of the 2015/16 stage of this project
14. A procurement of VCSE brokers following review of pilot engagement
15. A means of tracking NEA from among the specified cohort

Project scope

All service provision in individual people's normal residential setting

GP-based MDT meetings (already established)

Patient lists

Dementia provision

Darlington's VCSE sector – community support network

Carers

Assistive Technology

An evaluation and measurement of integrated care (use of the BCF Local Integration Fund money - £25,000)

Any exclusions/Out of Scope items

To be identified

Constraints and Limitations

Patient information/data sharing
Availability of a single patient list
Shift in practice and culture associated with risk

Interfaces and Interdependencies

Existing programmes of social events

Social prescribing project

Assistive technology project outputs

CCG "Not in Hospital" workstream,

Mental Health Forum,

Better Health Services Programme,

Good Friends scheme (DBC Economic development and Age concern).

The Self Management deliverable of Vision 2020

New Models of Care blueprint

Long Term Conditions project

Care Planning

GP Practices/PHD

Project organisation and roles, and communications

Delivery Team meeting six weekly

Officer lead to project manager weekly email/phone

Project Manager to project sponsor fortnightly

Monthly update to UoP and DBC/CCG Sponsors of BCF via BCF highlighting report

BCF dashboard updated on a rolling basis

Measures of success

Non Elective Admissions from among the identified cohort – not currently measured.

Non Elective admissions from Care Homes.

A&E attendances from among the identified cohort.

Measures identified by the external, independent evaluation of the 2015/16.

The size of the cohort when re-run in 2017.

NEA in total.

Relevant targets from CCG Financial Sustainability Plan (FSP), NHS Mandate (2020 Goal) (NHS20), NHS Mandate 16/17 deliverable (NHS16), or CCG Commissioning Intentions (CI)

Increase in the number of people able to die in the place of their choice, including at home. NHS20.

Reduction in NEL admissions. FSP

Reduce Continuing Healthcare funding (adults) (FSP) and reducing social care funding (DBC)

Measurable progress towards integrated assessment. NHS16.

Provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over-75s who need them. NHS16.

Communications and Stakeholders

A list of Users & Interested Parties (Stakeholders)

Primary Care, Secondary Care, Social Care, Mental Health and the VCSE Sector, service users, Care Home providers (Independent Sector Forum), Extra Care and sheltered housing managers, NEAS, OOH, 111.

CCG, Health and Wellbeing Board, Unit of Planning, Darlington COG (existing stakeholder plan)

Resources

Multidisciplinary Team	Community Matrons/HCA's	405,381
Multidisciplinary Team	Adult Transitions	90,293
Multidisciplinary Team	Software Licence	10,833
Multidisciplinary Team	MDT Brokerage Service	68,000
Reduction in Admissions	Social work input to MDT	120,000

Jo Dawson, TEWV	
Dr Elizabeth Loney, CDDFT	Only when in connection with diagnostics
Vicki Pattinson, DBC	
Chris Binns, TEWV	
Yvonne Mineham	
MDT Implementation Group (existing)	

Delivery timetable

In development

Risk

BCF Project risk register (see dashboard)

Revision History			
Version No	**Status**	**Author of Change**	**Date Published**
0.1	Existing V2020 documentation re-formatted	Pat Simpson	11/03/2016
0.2	Second draft	Pat Simpson	15/03/2016
V0.3	Third draft	Pat Simpson/Jenny Steel	16/03/2016
V0.4	Fourth draft	Pat Simpson/Vicki Pattinson	17/03/2016
V0.5	Final draft	Updated resource values after expenditure plan agreed	18/03/16

Approval			
This document requires sign off by the Project Sponsor and if the project is part of a programme, by the Senior Responsible Owner			
Name	**Role**	**Signature**	**Date**
Alison Wilson (CCG)	BCF Sponsor		
Suzanne Joyner (DBC)	BCF Sponsor		

DARLINGTON VISION 2020: BCF PROJECT BRIEF		
Project Name	Safe at Home – Promoting Independence and Wellbeing (working title)	
Project Sponsor	Suzanne Joyner	**Clinical lead:** **Officer Lead:** Vicki Pattinson
Distribution List	**Project Board Members** Unit of Planning	**Project Manager:** Pat Simpson
	Delivery Team Members initial list Vicki Pattinson Primary Care Jane Hayward Commissioning - Hilary Hall? Housing - Hazel Neasham? Jeanette Crompton DMT rep CDDFT? TEWV rep	

Project Definition

This project brings together and builds on a number of initiatives introduced in BCF 2015 to help maintain independence among frail elderly people at home, reducing and delaying admission to 24 hour care, reviewing how domiciliary care packages and support is commissioned to better support people at home.

Project objectives

To help people outside of the “high risk of emergency hospital admission” cohort remain at lower risk, supported at home to be as independent possible, through a range of interventions including new technology.

Project deliverables and/or desired outcomes

Delaying and preventing need for 24 hour care, in line with the Care Act.

Increasing the number of people choosing Extra Care or sheltered housing before 24 hour care becomes the only option.

A review of current commissioning approaches in relation to the kind of support people can access at home.

A review of the use made of short breaks in residential homes, the duration of these breaks and the frequency within which they lead to a permanent admission.

An understanding of the capacity of Darlington’s VCSE sector, the demands made on it and gaps in resilience or provision.

A better understanding about the options, other than residential care, available to practitioners to support people thought to be unable to manage at home.

A review of current rehabilitation provision of all kinds

Increased use of assistive technology to support prevention but also as a way of meeting need.

Greater use of equipment and adaptations as a preventative measure but also as a way of meeting need.

Project scope – what will this project affect

Telecare (Lifeline)
Primary Care
Equipment and Adaptations
Rehabilitation -Sensory Loss, post-stroke, falls and osteoporosis
Palliative Care
Advance Care Planning
Dementia Advisor
Assistive Technology – pill dispensers and "just checking" systems, and other teleheath
MH and Physical Disability Support Workers
VCSE Sector – community support network (Prevention and Signposting – social prescribing)
Carers

Disability Facility Grants (DFGs) and housing adaptations policies and criteria

Internal administrative processes (eg the tri-partite agreement process)

Internal comms across practitioner groups to improve knowledge and understanding of options for people

Any exclusions/Out of Scope items

In development

Constraints and Limitations

Domiciliary care market conditions and fragility of the independent sector in Darlington
Intermediate care availability
Temporary nature of the step-down provision currently provided at Ventress Hall
Current approaches to commissioning and procurement
Absence of a VCSE infrastructure organisation
Current capacity and resilience of the VCSE sector in Darlington
DFG and housing adaptation eligibility criteria and policies
Financial constraints
Culture and practice, risk appetite

Interfaces and Interdependencies

CCG "Not In Hospital" workstream, the Long Term Conditions deliverable, Mental Health Forum, Better Health Services Programme, Good Friends scheme (DBC Economic development and Age Concern), the home from hospital service provided by Care Connect.

The Integrated Discharge Management Team transformation work at DMH

Carer Support

Prevention and signposting (social prescribing) a strong community support network

Availability and training to deploy assistive technology

Project organisation and roles, and communications

Delivery Group meeting four - six weekly

Officer lead to project manager weekly (email or phone)

Project Manager to project sponsor fortnightly

Monthly update to UoP and DBC/CCG sponsors of BCF via BCF highlight report

BCF Dashboard updated on a rolling basis

Measures of success

Relevant targets from CCG Financial Sustainability Plan (FSP), NHS Mandate (2020 Goal) (NHS20), NHS Mandate 16/17 deliverable (NHS16), or CCG Commissioning Intentions (CI)

Increase in the number of people able to die in the place of their choice, including at home. NHS20.

Reduction in NEL admissions. FSP.

Reduce Continuing Healthcare funding (adults) (FSP) and reduce adult social care costs (DBC's medium term financial plan).

Measurable progress towards integrated assessment. NHS16.

Provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over-75s who need them. NHS16.

Reduced admissions from falls. Local CI (CCG Not-in-hospital workstream.

		Forecast 15/16	Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	852.4	812.8
	Numerator	175	170
	Denominator	20,530	20,915

		Forecast 15/16	Planned 16/17
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	74.4%	80.0%
	Numerator	186	200
	Denominator	250	250

A new local indicator around the use/capacity of Extra Care or sheltered housing with a target around vacancies/voids as part of reducing the number moving into 24 hour care.

A new local indicator in relation to admissions to short term breaks in residential care homes - both their number and cost.

An indicator around the deployment of assistive technology, linked to the "saved" cost of other packages that would be deployed.

Organisational targets for staff undertaking assessments to consider assistive tech as part of assessing support needs.

An indicator around outcomes and referrals to the third sector – analysis of type of need being met and gaps.

Communications and Stakeholders

A list of Users & Interested Parties (Stakeholders)

Primary Care, Secondary Care, Social Care, Mental Health and the Voluntary Sector, service users, carers, Healthwatch Darlington, care home providers (independent sector forum), domiciliary care providers, Extra Care and Sheltered Housing managers, NEAS, OOH, 11
Unit of Planning, Darlington Chief Officers' Group, Darlington Health and Wellbeing Board, DBC Health and Partnerships Scrutiny, Adults and Housing Scrutiny, CCG Executive

Resources

Expenditure Plan

Reduction in Admissions to 24h Care	120,000
Telecare (Lifeline)	15,000
Workforce Development	4,200
Increase in Physical Activity	2,000
Adaptations	360,000
Sensory Loss Rehabilitation	94,500
Community Stroke Services	45,228
Falls and Osteoperosis	16,084
Dementia Advisor	25,000
MH and Physical Disability Support Workers	101,000

The Dementia Advisor Service is provided by the Alzheimer's Society until January 2017. We then intend to go out for quotes for an initial 2 year period plus a +1 extension clause.

Delivery timetable

In development

Risk

Key risks are around the capacity and resilience of the VCSE sector in Darlington
Domiciliary market
Risk – culture and practice

BCF Project risk register (see dashboard)

Revision History			
Version No	**Status**	**Author of Change**	**Date Published**
0.1	First draft	Pat Simpson	11/03/2016
0.2	Second draft	Pat Simpson/Vicki Pattinson	14/03/2016
0.3	Third draft	Pat Simpson, Jenny Steel, Jeanette Crompton, Michelle Thompsons	
0.4	Fourth draft	Pat Simpson with contract info from Lisa Holdsworth	16/03/2016
0.5	Fifth draft	Pat Simpson with input from Vicki Pattinson and proofing/validation checks by Sharon Cable	17/03/2016
0.6	Final draft	Updated after sign-off meeting	18/03/16

Approval			
This document requires sign off by the Project Sponsor and if the project is part of a programme, but the Senior Responsible Owner			
Name	**Role**	**Signature**	**Date**
Alison Wilson (CCG)	BCFSponsor		
Suzanne Joyner (DBC)	BCF Sponsor		

DARLINGTON VISION 2020: BCF PROJECT BRIEF		
Project Name	Social Prescribing (working title)	
Project Sponsor	Andrea Jones	**Clinical lead:** tbc **Officer Lead:** Ken Ross (public Health)
Distribution List	**Project Board Members** Unit of Planning	**Project Manager:** Pat Simpson
	Delivery Team Members (Clinical Partners) Ingrid Whitton, TEWV; Jo Dawson, TEWV; Ian Barrett; Dr Elizabeth Loney, CDDFT (diagnostics elements only); Jacqui Dyson, TEWV; Michelle Thompson; CVS Strategic implementation group. DBC Operational rep (Margaret Young/Julie Wheatley	

Project Definition

To identify and implement non-clinical options for individuals to support their health and wellbeing, and to empower individuals and professionals in making these choices as a partnership.

Project objectives

A clear definition and understanding of “social prescribing” in Darlington
Agree common terminology – prescription to recommendation, for example
An understanding of a prescriber’s responsibilities for the patient for any ‘Social prescribing’
Criteria for selecting people for this option
Single source of information about VCSE provision
Community, voluntary and peer support networks
To be able to track and monitor outcomes from non-clinical interventions

Project deliverables and/or desired outcomes

In development – see checkpoint report attached

Project scope

Referral process
Measurement and associated metric valid in the short to medium term.
Operationalization approach
Capacity and resilience of Darlington’s VCSE sector
Use/capture of the NHS number in non-medial settings

Any exclusions/Out of Scope items

Project still in scoping stage (see checkpoint report attached)

Constraints and Limitations

Data sharing with the VCSE sector
Capacity and resilience of the VCSE Sector in Darlington
Lack of a VCSE Infrastructure Organisation in Darlington

Interfaces and Interdependencies

CCG "Not In Hospital" workstream, the Long Term Conditions deliverable, Mental Health Forum, Better Health Services Programme, Good Friends scheme (DBC Economic development and Age concern), the "Safe at Home" BCF project, MDT VCSE Broker service.

Project organisation and roles, and communications

Delivery team meets 4 – 6 weekly

Lead officer to project manager weekly/fortnightly by phone/email

Project Manager to project sponsor fortnightly

Monthly update to UoP and CCG/DBC sponsors of BCF via BCF highlight report

BCF Dashboard updated on a rolling basis

Measures of success

To be devised in line with any procurement of services from VCSE in this context, and in relation to the way NHS number can be captured and tracked.

Relevant targets from CCG Financial Sustainability Plan (FSP), NHS Mandate (2020 Goal) (NHS20), NHS Mandate 16/17 deliverable (NHS16), or CCG Commissioning Intentions (CI)

Reduction in NEL admissions. FSP

Reduction in smoking rates. CI

Communications and Stakeholders

A list of Users & Interested Parties (Stakeholders)

Primary Care, Secondary Care, Social Care, Mental Health and the VCSE, service users

Resources

Resource	Notes
Ingrid Whitton, TEWV	
Jo Dawson, TEWV	
Ian Barrett	
Dr Elizabeth Loney, CDDFT	Only where diagnostics are involved
Jacqui Dyson, TEWV	
Michelle Thompson, Healthwatch	
VCS Strat & Devt group rep	

Good Friends	15,000
Prevention and signposting	400,000

Delivery timetable

In development

Risk

BCF Project risk register (see dashboard)

Revision History			
Version No	**Status**	**Author of Change**	**Date Published**
0.1	Existing V2020 documentation re-formatted	Pat Simpson	11/03/2016
0.2	Second draft	Pat Simpson, Jeanette Crompton	
0.3	Third draft	Pat Simpson with input from Vicki Pattinson	17/03
0.4	Final draft	Adjustments following sign-off meeting	18/03/16

Approval			
This document requires sign off by the Project Sponsor and if the project is part of a programme, but the Senior Responsible Owner			
Name	**Role**	**Signature**	**Date**
Alison Wilson (CCG)	BCF Sponsor		
Suzanne Joyner (DBC)	BCF Sponsor		

Darlington Vision 2020 Programme: checkpoint report	
Project Name	New Models of Care
Project Lead	Andrea Jones (Sponsor) Pat Simpson (Project Manager)
PRODUCT ID 36	Social Prescribing
Description	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.
Organisation owner	DBC
Clinical lead	tbd
Clinical partners	Ingrid Whitton, TEWV; Jo Dawson, TEWV; Ian Barrett; Dr Elizabeth Loney, CDDFT (diagnostics elements only); Jacqui Dyson, TEWV; Michelle Thompson; CVS Strategic implementation group.
Management Lead	Ken Ross
Report submitted by	Ken Ross

Date of Update	w/e February 12 2016
Period covered	November 2015 - date
Things completed	Initial meeting of the clinical partners.
Things started	Definition and naming of this deliverable. The initial meeting of the group considered two alternative definitions arising from the November clinicians' engagement and agreed a definition more or less on these lines: *Connecting for Wellbeing is a mechanism for lining people with non-medical sources of support within the community*. This is supported by a subsidiary definition relating to the sources of support being around providing *options to make available new life opportunities that can add meaning* etc. Common terminology. "People" not "patients", "refer" or "connect with", not prescribe. An initial cohort based on people in the Long Term Conditions cohort. A twin approach through a single source of information, and a network of networks (connected hubs and spokes). Outline timetable

Things planned	Validation and awareness-raising of the outcomes from the initial meeting with as many of the relevant delivery group and networks as can be identified, including the CCG "Not In Hospital" workstream, the Long Term Conditions deliverable, Mental Health Forum, Better Health Services Programme. A referral process design that must be very clear and very transparent if it is to be credible. A measurement and associated metric valid in the short to medium term. Identification of potential resources sources. Next meeting of this group (post the validation and awareness raising) to begin to map out the operationalization approach Risk workshop focusing on the risks raised by the clinicians engagement and the enablers' engagement.
Issues and problems	No clinical lead has yet been identified, nor has a representative of the CVS Strategic Implementation Group.
Surprises and delights	General agreement that this is the right sort of approach, and that it can work in Darlington.
General commentary	The initial meeting was interesting and engaging with a high level of common ground. Prescribing is definitely not the appropriate word, and a number of alternatives including recommendation, advice, connect were made. Reference was made to the description in the Vision 2020 "Virtual Tour" - *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*. This led to Wellbeing emerging as a key word, along with connection. The discussion also ranged as far as training as part of the GP Induction, and waiting-room advertising to the target cohort. The need initially to target a specific and defined group, in order to legitimately measure effect, was agreed. That this defined group might be those making up the Long Term Conditions cohort, was also agreed. The need for the referral process to be absolutely clear and transparent was agreed, and the overall approach of a network of networks was broadly agreed. The group then considered advantages and disadvantages of the two approaches and agreed they make two sides of the same coin. This was a good kick-off meeting, which augurs well for a good product.

BCF 2016 cross-cutting activity in support of projects

Project Name	BCF 2016	
Project Sponsor	Suzanne Joyner and Alison Wilson	
Distribution List	**Project Board Members** UoP	
	Delivery responsibility Lisa Holdsworth (DBC) Alison Ayres/Ruth Kimmins (NECS)	

Revision History			
Revision Date	**Previous Revision Date**	**Summary of Changes**	**Changes Marked**
16/13/2016		First Issue	

Activity Description	**Support for Carers**

1. Purpose

Supporting and engaging carers cuts across all the main activities and projects identified as contributing to BCF outcomes as well as being a fundamental of our Care Act obligations. Consequently our delivery will need to be cognisant of what is going on across all projects, directed at

- Keeping people safe at home
- When people leave hospital to return home, possibly through some reablement and rehabilitation steps
- When people are unexpectedly admitted to hospital
- When decisions are made about admissions to 24 hour care
- In developing self-management approaches to long term conditions
- In combatting social isolation and seeking respite

2. Composition

Support for carers is made up of many parts:

Contracted packages of support for adult and young carers, including emergency support

Carer breaks

Short–term admissions for the cared-for person, into residential care

Referrals through the Multi-Disciplinary Team VCSE brokerage to activities and support offered by VCSE groups

Assessments of need in line with the Care Act

3. Derivation

Support is derived from a number of specifications contained within contracts mainly (aside from emergency support) delivered through the VCSE sector in Darlington:

Who is supported	Commis-sioned by	Start	Finish	Supplier	Annual Value
Adult Carers	LA	01/09/2013	31/03/2017	Darlington Association on Disability	50,000
Adult Carers	CCG	01/09/2013	31/03/2017	Darlington Association on Disability	50,000
Carer Breaks	CCG	01/06/2015	31/05/2016	Arrangements currently under review	111,000
Young Carers	LA	01/09/2013	31/03/2017	Developing Initiatives Support Communities (DISC)	30,000
Young Carers (Info/advice/support)	CCG	01/09/2013	31/03/2017	DISC	30,000
Carers Emergency Support	CCG		31/03/2017	HSG - Shared with Durham	5,247
Carers Emergency Support	Local Authority		31/03/2017	HSG -Shared with Durham	1,700

Adult Carers/Young Carers will be re-tendered during 2016 for new services to commence from April 2017 for an initial two year period plus 3 x +1 extension clauses.

Carer Breaks –direct awards for 1 year will be made from June 2016.

Carers Emergency Support – A Durham led re-procurement process is envisaged.

4. Quality Criteria

The Care Act specifies responsibilities in relation to carers with which all provision must comply.

DBC commissioned breaks services are accessed following a statutory carer's assessment during which eligible need is identified.

Adult Carers/Young Carers Support Services/Carers Emergency Support and Carer Breaks not directly commissioned by DBC are accessed through a number of routes including self-referral, referral from a range of health and social care providers and as a result of proactive identification/awareness raising work by the contracted providers.

5. Quality Method

Contract Monitoring process provide quality assurance. This is carried out by the Carers' Lead Commissioner.

BCF 2016 cross-cutting activity in support of projects

Project Name	BCF 2016	
Project Sponsor	Suzanne Joyner and Alison Wilson	
Distribution List	**Project Board Members** UoP	
	Delivery responsibility Ian Dove/Catherine McShane (CDDFT Healthcall Project) Steven Bennett/Pat Simpson (DBC Managing the Cost of Care project)	

Revision History			
Revision Date	**Previous Revision Date**	**Summary of Changes**	**Changes Marked**
16/13/2016		First Issue	
18/03/16		Second issue	Updated resource value

Activity Description	**Assistive Technology**

6. Purpose

Technological innovation can impact all parts of the patient journey and can be particularly useful in helping people stay safe at home and avoid a premature admission to 24 hour care or unexpected hospital admission. Consequently our projects need to be able to access appropriate technology options and evaluate their contribution to the patient's wellbeing and the cost of care, when:

- Keeping people safe at home
- When people leave hospital to return home, possibly through some reablement and rehabilitation steps
- Avoiding unexpected admissions to hospital
- When decisions are made about admissions to 24 hour care
- In developing self-management approaches to long term conditions

7. Composition

Assistive technology comprises:

Tools to evaluate the need for support packages – "Just Checking" for example

Tools to support people with their medication and thus reduce the need for short "meds visits" – pill dispensers filled by pharmacists

Telehealth – for example monitoring patients who are at risk of undernutrition or prescribed oral nutritional supplements (ONS)
Call devices to summon help – Lifeline, for example

8. Derivation

The tools available to us are derived from a number of sources. Darlington BC is piloting a range of assistive tech tools as part of its "Managing the Cost of Care" project, and CDDFT are delivering the Heathcall project.

Over time, the Digital Health benefits planned to be delivered through the Healthy New Towns status will have an impact, but for the coming year we have allocated £50,000 to supporting the deployment and embedding of new tools, with an associated metric relating to the frequency with which assistive tech options are considered, and the value of alternative provision which has been avoided as a consequence.

Tech	Commis-sioned by	Start	Finish	Supplier	Annual Value
Lifeline (OOH Mobile Response)	LA			Local Authority	15,000
Assistive Technology	LA			Various depending on the outcome of trials and pilots	40,000

9. Quality Criteria

All deployments are evaluated before roll out, including service user and carer feedback.

Evaluation of benefit in terms of avoided care costs, and days/weeks delayed admission to 24 hour care

10. Quality Method

Metric components to be specified and collection method established.

BCF 2016 cross-cutting activity in support of projects

Project Name	BCF 2016	
Project Sponsor	Suzanne Joyner and Alison Wilson	
Distribution List	**Project Board Members** UoP	

Revision History			
Revision Date	**Previous Revision Date**	**Summary of Changes**	**Changes Marked**
16/13/2016		First Issue	
18/03/16		Second issue	Updated resource value

Activity Description	**7 –day working**

11. Purpose

This cross cutting activity brings together those aspects of support required “behind the scenes” to enable weekend discharge, for example, or to avoid an admission over the weekend, and includes access to specialists such as geriatricians and to diagnostic services for example, that all help

- Keep people safe at home
- When people leave hospital to return home, possibly through some reablement and rehabilitation steps
- Avoiding unexpected admissions to hospital

12. Composition

7-day working in the context of supporting BCF delivery comprises:

Diagnostics

Rapid response to support needs (domiciliary care)

Use of Trusted Assessors in the discharge process

13. Derivation

The services are derived from a number of sources, including trials carried out under BCF in 2015 on, for example, rapid response domiciliary care services, and 7-day "Front of house" approach for frail elderly.

Front of house has not been commissioned in 2016/17 as weekend admissions were not sufficient in the cohort, and services such as a geriatrician were not available.

Service	Commis-sioned by	Start	Finish	Supplier	Annual Value
7 day diagnostics	CCG			CDDFT	98,400

There are also NHS national mandate objectives in relation to 7-day working.

14. Quality Criteria

Consistency of service delivered on Saturday and Sunday; instances of variation in service/response delivered on Saturday and Sunday.

Where delivery of BCF objectives is put at risk by the absence of some service availability over the weekend this will be escalated as a service gap. 7-day provision of all services is not required in this context.

15. Quality Method

A metric is to be designed around capturing weekend activity in relation to BCF objectives and identifying variation. The objective is no variation.