Draft narrative plan to accompany the second submission of the BCF plan March 21 2016

Darlington's draft narrative

1. The Local Vision

1.1. The Darlington Chief Officers have worked throughout 2015 to develop a shared, agreed vision for Health and Social Care in Darlington in 2020, starting with a "straw man", developed into a road map, consulted on through a "Health and Social Care Summit" in the summer of 2015, refined through specific engagement with clinicians, work with Healthwatch to seek the public's input and most recently with corporate "enablers" – finance, estates, organisational development and HR, ICT and performance. The agreed, shared vision is:

1.2. "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 services will form a continuum of provision in Darlington, with some, more specialist services, provided elsewhere."

1.3. The programme objectives associated with this vision are

- 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

1.4. 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 VCSE sector*
- Transparent budgets and the "cost to care"
- Data shared appropriately and safely in the interests of individuals

*Outcomes contributed to by the BCF programme

1.5. This vision has been blueprinted and a programme description set out for delivery through a number of projects and activities over the coming years, starting with work to build on our MDT approach for frail elderly, support high-impact users of public services to change behaviours and achieve better outcomes, facilitate and support self-management of long term conditions, and development of "social prescribing" to a resilient and ready third

sector, all in the context of implementing a major new model of care, based round the concept of the Care Hub, currently the subject of blueprinting.

1.6. A schematic of governance around this programme is attached as ***figure 1*** along with ***figure 2***, an illustration of the approach we are taking to primary care provision through hubs.

1.7. The programme approach to delivering Darlington's Vision 2020, which incorporates delivery of BCF 2016/17, results in clear action planning following standard project management principles. Delivery groups have been established for our 6 priority deliverables (three of which are delivered through BCF – MDT approach, Social Prescribing, and Long Term Conditions), comprising lead clinicians supported by management leads, and standard exception reporting, milestone mapping and delivery scheduling approaches are being implemented, with overall control through a programme office function overseen by Unit of Planning, and the Darlington Chief Officers.

1.8. The BCF expenditure plan does not this year include any additional contributions to the pooled budget. Additional funding from the Borough Council in 2015 served to underwrite the double-running costs of developing new approaches while paying for existing levels of NEA. The exact makeup of the 2016 Expenditure Plan has been determined and agreed through a cross-organisational group or senior managers/Directors at the Borough Council, the CCG and has had clinical input.

1.9. The schemes that we will deliver under BCF in 2016 17 recognise our increasing elderly population: 65 – 90 is the only age-group forecast to grow (at around 300 per year) while other age-groups are static or reducing. They seek to delay recourse to public services through increasing wellbeing, helping people avoid crises, and ensuring all options for support are fully considered at the right time.

1.10. A project brief for each project is attached to this narrative plan, setting out the outcomes, the things that need to change (service quality, inefficiencies etc). A summary of each is given here:

- **Multi-Disciplinary approach (MDT):** 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 multi-disciplinary team approach supporting frail elderly and at risk patients in care homes, in their own homes, sheltered and Extra Care facilities, and at locations used for social activities.

  Reduce the number of frail elderly people, identified as being at high risk of emergency admission to hospital, actually having an emergency admission

  Through a re-run of our risk-stratification, 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.

- **Social Prescribing** (prevention and Signposting): 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.

- **Hospital to Home**: 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.

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

- **Safe at Home:** 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.

  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.

- **Self management of long term conditions**

Supported by cross-cutting work

- Caring for Carers
- Assistive technologies (Nutricall, pill dispensers, just checking)
- 7-day working

2. The HWB Expenditure Plan for BCF

2.1. Our Expenditure Plan is slightly changed from 2015 with schemes excluded which do not directly contribute to BCF outcomes, or did not deliver during 2015. The list of schemes in the expenditure plan are grouped together into five projects and three cross-cutting activities (See annex) to allow more flexibility in delivery during the year.

2.2. Main changes to note include the increase in Care Act funding (as per the "ready reckoner" calculation), and some new additions including assistive technology, directly in response to our BCF outcome ambitions. Excluded this time, as not contributing to BCF outcomes, are short breaks for disabled children, and the Front of House project, the outcomes of which are being delivered by a different route so this expenditure is no longer required. Non-recurrent capital – social care grant and the IT allocation for the Care Act - have been omitted. Expenditure assigned to Long Term Conditions in 2015 has been committed for use in the coming year so is not included in the 2016 plan.

2.3. Some lines have been replaced. One set of intermediate care beds is at the end of contract and a new procurement is under way so both lines are shown, and new step-down beds have been added as part of our hospital to home journey. The pharmacy worker role was found to be unnecessary so has been replaced with a sum for assistive technology, which includes the engagement of pharmacists with deliverables such as filling and issuing pill dispensers.

2.4. Some values have changed as a result of inflation or small changes to the service content since 2015. One key change is the community hospitals value which is reduced as a consequence of alternate provision being made through the new step-down beds. The planned expenditure in relation to prevention and signposting is increased and reflects the

importance placed on having a resilient VCSE sector, accessible and meeting needs in Darlington.

3. The national conditions

i) Plans are jointly agreed

3.1. BCF delivery is embedded in Darlington's five year programme to transform health and social care (***see figure 1***), which is a jointly agreed and owned programme of CDDFT, TEWV, Primary Healthcare Darlington, Darlington CCG and Darlington BC.

3.2. At Darlington the DFG is located with Adult Social Care, not Housing.

ii) Maintain provision of social care services

3.3. Our approach is

- To focus on information, advice, guidance, signposting, prevention and early intervention.
- Focus on meeting the statutory requirement to meet unmet eligible needs of Darlington residents (including the new criteria within the Care Act).
- Based on a social asset model of helping people with health and social care needs to meet those needs by retaining their dignity and independence in their own homes through access to family, neighbours, Good Friends and Community Support together with specialist essential health and social care support where need is identified.
- Safeguarding vulnerable adults is a priority area and the Darlington Safeguarding Adults Partnership Board oversees the multi-agency approach in relation to safeguarding adults at risk.

3.4. Our emphasis is on personalisation, prevention and early intervention, developing joined up care which helps to ensure that individuals remain healthy and well, and have maximum independence.

3.5. Additional resources have been invested in social care during 2015 to deliver enhanced reablement services which will reduce hospital admissions and admissions to residential and nursing homes. Social workers are involved in multi-disciplinary teams, in advanced care planning and in the delivery of 7 day services.

3.6. The capital funding associated with Disabled Facilities Grant (DFG) within the BCF ensures joint working with housing partners in securing wider investment in homes that promote independence, as well as adapting existing Registered Social Landlord housing stock.

3.7. Ensure the effect of spend and service provision is assessed through, for example, joint reviews after a DFG is made, to identify resultant changes to care package requirements, social work support and occupational therapy.

iii) Delivery of 7-day services

3.8. Weekend discharge has been in place since October 2015 with the Adult Transitions Team in the role of Trusted Assessor and a GP working as part of that team and is generating positive feedback. We have taken an outcome focus for 7 day service delivery based on what we need to deliver for our population on a 7 day basis to meet need rather than a dogmatic unfocussed implementation of 7 day services, building on the Early Adopter for 7 Day services status awarded to the locality in 2013. In 2016 we will be bringing together the Adult Transitions team with the emerging Integrated Discharge Function

3.9. The RIACT service in Darlington operates a 7 day service 8 till 8, preventing admissions and enabling planned hospital discharges. This is a joint service between social care and CDDFT Community Health Services (Therapists, Stroke, Falls, Nursing, Social Care, In-house Reablement service and independent providers). This is an integrated system, co-located with a single point of access offering support to GP's, out of hours GP's and hospital services covering core hours, 8 till 8 seven days a week.

3.10. As part of the wider Darlington Vision 2020 plans are currently in development to implement a care hub approach which will meet this requirement. (***Figure 2***) RIACT health staff provide 7 day service and we are starting to develop trusted assessors within RIACT to facilitate discharge at weekends.

iv) Data sharing

3.11. The NHS number is attached to all health and care records in all settings, with a small percentage in social care being added in retrospect on a monthly basis; they will be able to be added in real time once a new system has been implemented, from October 2016. CDDFT, CDD Community Health Service and North of England Commissioning Support (NECS) have received national recognition (HSJ Awards) for the work on information sharing within our multi-disciplinary teams – enabling true patient level service planning.

3.12. We also have in place a cross-organisational reference group of corporate "enablers" which include ICT managers, to which issues around data sharing which are preventing delivery on the group, can be put to be resolved as and when they arise.

3.13. The work to be commissioned using the Local Integration Fund will develop the evidence base used for BCF 2015, and provide data to allow the effect of our interventions to drive changes to "the Darlington Pound" and to key public health indicators. Our risk stratification approach to BCF 2015, which identified the top 3% of the population at risk of unplanned admission will be repeated and extended.

3.14. The predictive modelling carried out at the start of BCF in 2014/15 will be repeated this year both to ascertain where the originally identified "at risk" cohort is now, and to establish a refreshed cohort for the coming year and beyond.

3.15. Our original Combined Predictive Model (CPM) calculation was based on a comprehensive dataset of patient information, namely inpatient (IP), outpatient (OP), and accident & emergency (A&E) data from secondary care sources as well as GP electronic medical records.

3.16. Of the cohort identified as frail elderly in 2015 10.8% are at very high risk of admission and 69.2% at high risk of admission. We are extending our BCF interventions into the "high risk" group along with adult patients with long term conditions in order to try to reduce the size of the "very high risk" cohort in future years. Our risk stratification will be re-run this year.

v) A joint approach to assessments and care planning

3.17. The MDT approach ensures a joint approach to assessments with an accountable professional; the clinical lead on this project is a GP. The format and content of advance care plans has been standardised and work to embed reference to care plans across all partners including out of hours and the ambulance service are under way.

3.18. 2% of our frail elderly currently have a care plan and care coordinator; in 2016/17 we plan for this to increase.

3.19. We are planning joint reviews of the impact of Disability Facility Grants on the use of domiciliary care, social work input, and OT.

vi) Impact on providers

3.20. The Chief Executive of the council and the Chief Officer of the CCG formally meet with the Chief Executives of both Foundation Trusts and Primary Healthcare Darlington to ensure that there is a clear flow of information and influence between the commissioners and the providers in the interests of securing a stable and sustainable health and social care economy for Darlington.

3.21. Sustainability of the Independent sector remains a risk to provision in Darlington. The Independent Providers' Forum are invited to contribute to delivery planning of BCF outcomes during 2016. Our plans include a review of our commissioning arrangements which will take into account the need to stimulate the market.

3.22. A market position statement is in place and is currently being updated.

vii) NHS commissioned out of hospital

3.23. The new model of care currently being consulted upon in Darlington (***see figure 2***) is one which seeks actively to divert people from A&E through a primary care hub, which refers people to where they will be best served – the urgent care centre and thence possibly to hospital or trauma centre; back to the community for self care or community support; or to a front of house service for further assessment and possible transfer to hospital, primary care or to the community. Care plans are key to this process, sitting with the care hubs and providing a route map for each person in the identified high risk cohort, ensuring personalised care in accordance with individuals' wishes. Implementation of this model will require investment in out-of-hospital services and to that end the BCF delivery is located in the CCG's "not in hospital" workstream and associated development of commissioning standards. This in turn is linked to the CDDFT Better Care Services Programme's not in hospital workstream.

3.24. In 2015 our performance on the 3.5% reduction in emergency admission target was only partial, achieving just half the desired reduction at the end of the year.

3.25. However, the NEA statistics are for the whole population over 18, and our interventions were directed at 3000 frail elderly people over 65, so the NEA statistic in its current form is a blunt measure: we cannot tell if the avoided NEL were among the target cohort. In an effort to see impact among the target cohort, examination of admissions from care homes – in which a small proportion of our cohort live – show that there were 69 fewer emergency admissions from care homes in the calendar year 2015 compared with the calendar year 2014 – a 10% reduction, and in terms of the overall reduction in NEA, accounts for almost a third of it.

3.26. Our risk/gain-sharing agreement will be in respect of the unmet part of the NEA target from 2015, and will be focused on reduced NEA within our target population of frail elderly people at risk of admission to hospital. £200,000 is deemed "at risk" if NEA from within our target cohort do not reduce. The detail of the agreement, including allocation of the risk/gain, is being worked up for review by Darlington HWB.

viii) Agreement on a local target and action plan for Delayed transfers of Care (DToC)

3.27. We have worked hard to bring down and keep down the Delays to Transfer of Care, and we are currently below the national average, with a few hundred days delay per quarter, typically affecting a few tens of people. But we can do better. The development of an integrated discharge function is a key intervention for 2016/17 and through that we plan to reduce further the number of days people are delayed to be consistently below 500 per quarter. Consideration will be given to targeting excess bed-days as a means of further reducing DToC.

3.28. As part of the unscheduled care group - a workstream within CDDFT's transformation plan, we are reviewing our progress against the High Impact Change Model. SRG oversee this work. Discharge Management Function supports Change 1 & 3. Patient Flow systems are being developed within the trust and they use a command and control system to manage any blocks. Our hospital to home project will support change 4, home first/discharge to assess, RIACT health staff provide 7 day service and we are starting to develop trusted assessors within RIACT, change 6. Focus on choice - change 7 is being addressed through SRG temporarily funding a brokerage service to support people who need to move from hospital to a care home. Change 8 relates to enhancing health care in homes, which is being addressed through matron and GP alignment.

3.29. Local step-down capacity has been examined and reviewed and a new procurement of a differently arranged intermediate care provision is under way, taking account of that review. A new provision of short stay step-down beds has been implemented with people moving into them from the hospital for stays from two days to a maximum of two weeks.

3.30. These step-down beds are for people who may be recovering from acute conditions such as chest infections or fractures from falls. Although fit enough to be discharged, they require extra care before going back home, so these beds – not all of which require nursing care, are a place where they can further recover before returning home, enabling them to get out of hospital that much quicker.

4. Metrics – how we did in 2015, and how we've set the targets for 16/17

4.1. Our approach to delivering BCF outcomes is a whole system approach, comprising a basket of schemes and working arrangements that collectively attack unnecessary emergency admissions and readmissions as a way of ensuring patients are cared for in the most appropriate place and reducing the demand on acute capacity.

4.2. Local partners (County Durham and Darlington FT, Tees, Esk and Wear Valleys FT, Primary Healthcare Darlington, Darlington CCG and Darlington BC) meet each month at Unit of Planning and in Multi-Disciplinary Team implementation groups and review metrics, issues and progress. They receive a regular Exception Report as well as a detailed metrics report, backed by a programme dashboard. Reports are made quarterly to the Darlington Chief Officers Group (The Chief Executive Officers of the five partners) and to Health and Wellbeing Board.

4.3. The effect to date has been to reduce non-elective admissions – although not by the targeted proportion overall, by much more than the targeted proportion within our specific

target cohort (see paragraph 3.27 above) - reduce admissions into 24 hour care, and dramatically reduce delays to discharge.

4.4. A service user experience survey has also been implemented for MDT service recipients.

4.5. In terms of metrics for 2016/17

- Our admissions to 24 hour care metric is based on keeping a small reducing trajectory in the face of a growing elderly population – our targeted number of admissions is only slightly lower than current performance, but the demographic changes in Darlington mean the rate per 100,000 target is more significantly smaller.
- We cannot demonstrate that our reablement target has been met because we know that our count of "still at home" is not as robust as it could be. This target is being re-set for 2016/17 with a renewed methodology for identifying accurately that a person is still "at home" following a period of reablement. We are also planning an independent review of the service in order to identify where we can improve the process, including how we record our performance.
- DToC is as described at paragraph 3.27.
- Local performance metric: we are taking this opportunity to change our local performance metric as the one currently selected (the proportion of social care users who have as much social care as they would like) – in the absence of an integrated care metric as part of the ASCOF framework – has already been fully met and is meaningful only to a narrow area of work. In its place we will be looking at the ASCOF measure of ease of getting information, as this ties in with our focus on community network development, social prescribing and VCSE this year. Should an integrated care metric in Domain 3 of the ASCOF framework be made available nationally, we will adopt it as our locally agreed metric.

5. Key successes and challenges

5.1. The key elements of our 2016 17 BCF work will build on the learning and interventions implemented in 2015 16, and are an integral part of the Transforming Health and Social Care in Darlington Vision 2020 (see below) and embedded in the CCG's "Not in Hospital" workstream. In particular, the MDT for frail elderly people at risk of admission will extend its GP-based focus to those not able to visit the surgery and care home residents; the target cohort will be extended to include "high impact users"; the recently introduced MDT approach to discharge management will be embedded fully; and "self-management of conditions" and "social prescribing" will be the subject of new focus.

5.2. As part of developing the vision and programme for Darlington 2020 a number of stakeholder engagements were carried out including one for HWB and UoP representatives. They were asked to identify what had made the MDT implementation so successful, and this is their 10-step recipe for success, which is the approach we will take in 2016/17.

1. **Evolutionary** - setoff and build on learning as we went, from a core of accepted existing good practice
2. **Real focus on the patient**
3. **Physical co-location of practitioners**. Peer support and challenge – all professionals together, sharing expertise, knowledge, to co-design.

Leading to

4. **Good trusting relationships** across all sectors

Unlocked by

5. **Funding** for the specific purpose
6. **Risk-taking and appreciation of change management** – willingness to work together informally

Driven by

7. **Recognised corporate priority** – momentum and sense of urgency

Supported by

8. **A single info system**
9. **Strong, very senior leadership** with clear vision and good communication
10. **An information sharing agreement**

5.3. The evaluation process set out in the "Reflecting on 15/16, planning for 16/17 has been instigated with Unit of Planning and Darlington has made a successful bid to the Local Integration Support fund for external evaluation in a format that will support evaluation of 16/17 BCF and beyond.

5.4. The evaluation process is beginning to bring forward views from our stakeholder on specific aspects that have worked well and which could be improved, which we will take forward. A high level overview of the key interventions follows:

MDTs at the centre

- At the heart of our 2015 BCF approach is the 'multi-disciplinary team' (MDT) in Darlington for Complex and Frail Elderly people over 60 who are most at risk of unplanned hospital admission. The MDTs, held monthly at each GP practice in Darlington, comprises social workers, community Matron/practice nurse, Mental Health professional, and a broker from the voluntary or community sector with the "on the ground" knowledge to identify sources of support perhaps invisible to the clinical or social care people.

What works?

- 'Care Coordinators' coordinate the care planning and management for the cohort of patients across the MDT. The Care Coordinators – who may be Community Matrons in a care home setting, a GP, Practice Nurse or other professional - also ensure consistency in care planning documentation and processes working with the Darlington GP practices, towards meeting the requirements of the Primary Care 'Unplanned Admissions Direct Enhanced Service' (DES).
- Community Matrons at the weekend manage the reactive needs of care home residents and housebound patients, and are now also working in Darlington Memorial Hospital (DMH) to prevent unnecessary admissions and to expedite discharges.
- Service users highlighted that this way of working is particularly useful for liaising with relatives as this is the highest period of visits. During the weekend a high proportion of proactive work such as Emergency Health Care Planning (EHCP) and DNACPR planning is undertaken because of the relatives' availability in the setting.
- Matrons assess around 25-30 patients over the course of the weekend. The matrons also offer expertise/advice/prescribing to the district nursing team, and contribute to the identification of patients suitable for discharge from medical assessment unit and acute wards at DMH – facilitating discharges; avoiding admission to acute services.

This admission avoidance work has been enhanced by the opportunity for the matrons to closely collaborate with the GP's who have started to work as part of this model on a Sunday.

- The impact of the Matrons at weekends is an average of four patients either prevented admission or discharged earlier due to matron involvement. Matrons have reported collaborative working relationships with consultants and doctors in the acute setting. The number of patients discharged on a weekend is dependent on the Consultant on Medical Assessment Unit's (MAU) confidence in Community Services' capacity.
- The end-of-pilot report of the Voluntary Sector brokerage that has been a key part of the MDT approach demonstrates almost 250 Darlington people have benefited from a referral to a voluntary or community organisation. This service will be re-procured with the benefit of learning from the pilot outcomes.
- The practical benefits that have accrued to people as a result of the brokers' work are financial, practical, and personal; improving wellbeing and independence for people and those who care for them.
- Interactions with GPs and supporting services such as RIACT (Rehabilitation and Reablement) and Allied Health Professionals remain positive and meaningful. Matrons attend GP surgeries for monthly MDT meetings to discuss high impact service users, twice-weekly RIACT MDT meetings, and are part of the discharge and admissions avoidance team on a weekend.
- Darlington CCG has just commissioned County Durham and Darlington Foundation Trust (CDDFT) to provide an Acute Admission Prevention Service to its care homes as part of its overall model of care. The service builds on evidence based practice that dedicated nurses working within care homes can significantly reduce emergency conveyances into acute care.

Hospital to Home (Adults Transitions Care Team)

- The Hospital to Home component was developed to avoid unnecessary admissions by working alongside the Emergency Department and Medical Assessment Unit to reduce the demand on acute capacity. The role was also to facilitate earlier discharge for patients who have already been admitted by working alongside the Discharge Management Team and the Palliative Care Discharge facilitator. Community Nurses backfill experienced full-time Community Nurses, working seven days, 9-5, linking with social care staff through an MDT approach.

What works

- Initial response from the Emergency Department and Medical Assessment Unit in referring patients was low with both units continuing to refer to the Discharge Management Team. As the staff became more involved with patients on both units the uptake for the team increased.
- The scoping process revealed the impact the community team would have in facilitating earlier discharge for patients who have already been admitted on the wards: the discharge process is now being reviewed as part of the wider integrated management function, to ensure resources are used to best effect.

- Since 2012/13 the recorded average number of days tied up by people who are medically stable and fit to leave hospital but unable to do so, has fallen consistently and is now well below the national rate.
- More recently work has been completed to include the staff within a wider Discharge Management function which now sees twice daily MDT's taking place with a range of professionals present. This team receives referrals for those who will require support as part of their discharge, a key worker is nominated to lead on the discharge ensuring delays are minimised and the discharge progresses in a timely manner.

RIACT

- RIACT provides time limited support to service users who have experienced sudden, short term deterioration in their health and or a change to their physical functioning. The service promotes rehabilitation and recovery enabling service users to attain their optimum level of independence. Following the success of the practice MDT's it was recognised that RIACT and those accessing the service could benefit from this way of working.
- The RIACT MDT meetings have been held every Monday and Friday morning since January 2015 and make use of immediate access to patient and service user information via Care First and SystmOne.
- Current attendance at the meetings includes RIACT Team Manager (Social Care), the Lead Nurse or Therapist for Health, a Community Matron and District Nurse and a representative from the voluntary sector. A member of staff aligned to the Practice MDT's from Social Care also attends as does a representative from the Ongoing Care Team, to ensure there is a link between RIACT and the other assessment teams.
- The key focus of the MDT discussion is around those people who are already receiving support through the RIACT service. Maintaining capacity within the service is key to ensuring the service can provide a rapid response to help prevent admissions to hospital or residential care and facilitate timely hospital discharges. The MDT's allow for clear monitoring of progress in relation to the persons identified outcomes and planning can take place for transition from the service.

What works

- The meetings have led to more proactive management of service provision. The flow of people moving from brief interventions via RIACT to Ongoing Care, for those people who have long term care needs, is timelier and the length of stay within a bed has been reduced. Greater use of community services including the voluntary sector has increased; there is a better understanding from all professionals of what the voluntary sector can offer and a real opportunity to make greater use of their skill and expertise.
- The development and enhancing of relationships between professionals is a real and positive outcome of the MDT meetings. Greater understanding of roles and responsibilities has been achieved and the sharing of information enhanced. Now that the relationships are established the meetings are efficient and focused, while still providing an opportunity for more in-depth case discussion, exchange of ideas, advice and support. This is vital in terms of being able to deliver positive outcomes for the

person whilst managing increasing demand for resources and capacity across all organisations.

Digital Health and assistive technology

- An innovative telehealth method of monitoring patients who are at risk of undernutrition or prescribed oral nutritional supplements (ONS) has been successfully piloted by CDDFT nutrition and dietetic services in care homes across Darlington. Healthcall Undernutrition is now going to be extended across Darlington so that more patients will be able to benefit from the service.
- Benefits include embedding as part of everyday clinical practice; increased capacity, quality and patient managed care with better outcomes and cost effectiveness; - improved patient centred care and self-management; - promotes appropriate ONS prescribing, reducing waste and cost.
- In social care the deployment of filled pill dispensers is being piloted in partnership with a local pharmacy, commissioned to fill the devices. The pill dispenser can remind people to take their medication and reduce the risk of over dosage or medication not being taken. The pharmacy will fill and programme the dispensers for those who don't have family or carers to do it for them.

6. Changes from 2015/16

6.1. We are ensuring that the work delivered and focused on through BCF is firmly part of our longer-term vision for health and social care in Darlington in 2020 and beyond, and takes account of other changes being planned or delivered in the town through:

- The Darlington Health Economy's STP and individual organisations' 2016 Operational Plans
- County Durham and Darlington FT's Better Care Programme
- The Urgent and Emergency Care Vanguard
- The recently awarded Healthy New Town status
- The One Darlington partnership

6.2. We are retaining our MDT Scheme but extending its reach to frail elderly people in care homes and who are unable to visit the surgery, or who live in sheltered and Extra Care housing as a key part of continuing to reduce unplanned, emergency admissions from this cohort. This includes the implementation of a telehealth approach to nutrition and hydration management.

6.3. A project focusing on discharge management will give this renewed impetus with the development of an integrated discharge team, and ensure a continued impact on delays to transfer of care. This is further supported by new funding for intermediate care beds.

6.4. Significant work and funding (£400,000) is planned for developing non-medical interventions through "social prescribing" and ensuring the capacity is there in the VCSE sector to deliver it.

6.5. Funding (£40,000) has moved from pharmacy support to assistive technology to ensure proper support for tools that help people both stay safe at home, and manage their own medication without the need for a care package, delaying the entry into 24 hour care. This will have an associated metric tying use of these tools to reduction in support such as short visits to administer medicines.

6.6. Sharper focus on the use of DFG and the application of assistive technologies in keeping people safer for longer at home.

6.7. Continued focus on supporting people to manage their own conditions, often with the application of telehealth or assistive technology.

6.8. Funding has increased for dementia adviser.

7. Risks, Challenges and their mitigation

7.1. A whole Vision 2020 programme risk identification, assessment and evaluation process is being applied, which includes BCF deliverables, An initial high level risk identification exercise has produced:

Source of risk	Cause	Effect
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 planned deliverables may not be sustainable in such a small area	Some objectives may not be 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	Integrated care design is impeded as workarounds are developed

Source of risk	Cause updated	Effect
	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.
Capacity and resilience of the Independent Sector in Darlington	Few providers, low rates	Lack of choice, inability to commission, unsustainable market
Capacity and resilience of the VCSE Sector in Darlington	Reduced funding, absence of an infrastructure organisation	Inability to commission from the sector, focus on two or three large organisations, reduction in the overall variety and spread of provision, unsustainable sector

7.2. A much more detailed programme risk register is in existence and capturing risks, and functions as a dynamic control tool, including those relating to BCF delivery. Risk is a standing item on delivery team agendae and risks are re-evaluated after actions are completed, following a standard Management of Risk approach. The full risk log is available here: https://portal.gpteamnet.co.uk/Library/ViewItem/eccec6f7-d2e1-4cf1-89e4-a4c700ea464a

7.3. Specific mitigating actions both against likelihood and impact will be developed, but three key mitigations are

- the existence of the Darlington Chief Officers Group, which provides a regular forum for overview of progress, escalation of issues, and exchange of information about individual partners' plans and activities, and
- Darlington's Unit of Planning, which has a membership beyond the CCG and Borough Council, including the two FTs, Healthwatch, and the VCSE sector. The UoP has an operational steering role in respect of all health and social care delivery work in Darlington, from all programmes including BCF.
- Strengthened operational governance arrangements ensuring BCF delivery is knitted in to business as usual of all partners.

Figure 1

Managing Darlington Vision 2020 delivery

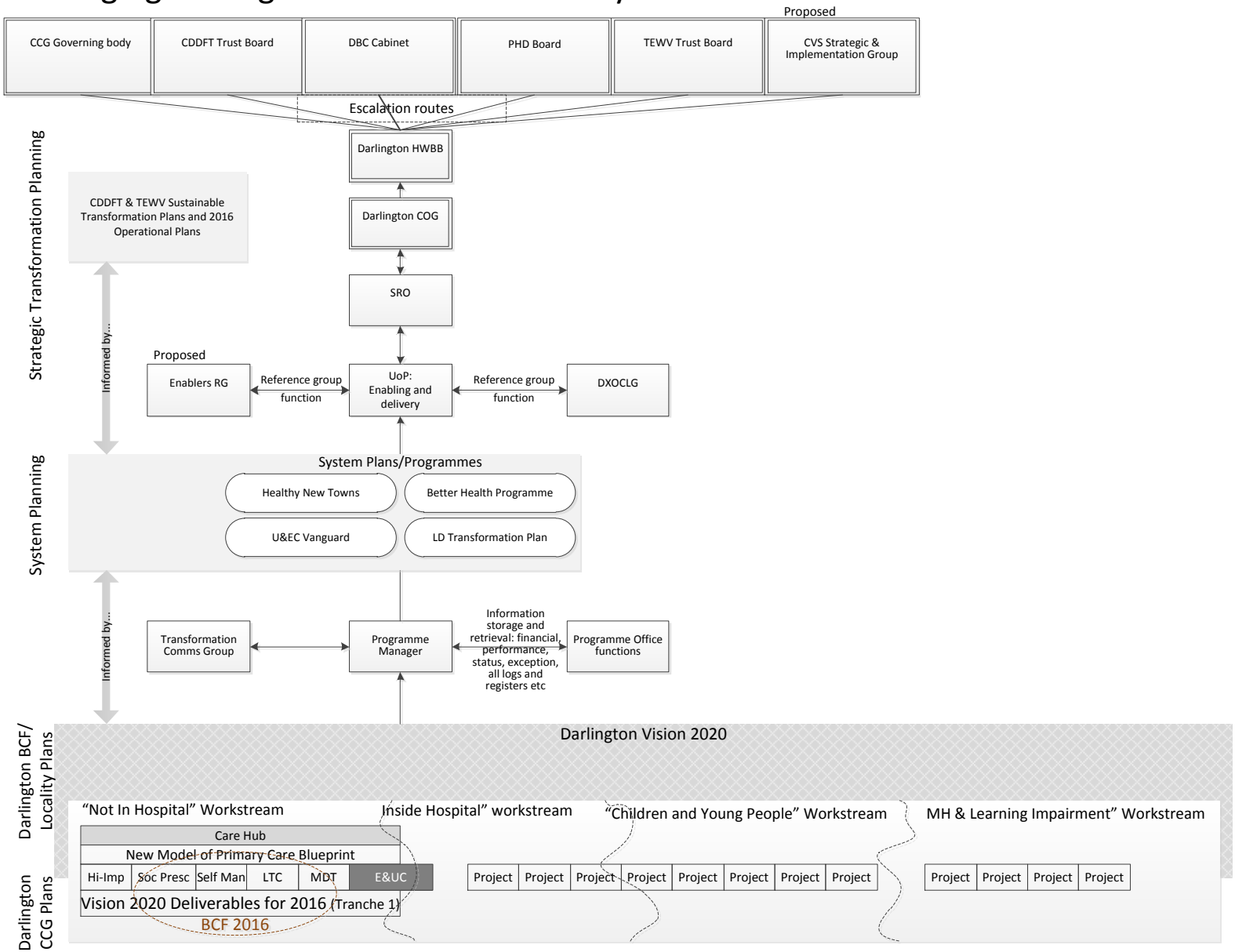

Figure 2: draft new model of primary care in Darlington