Updated August 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Darlington Borough Council**
Clinical Commissioning Groups	**Darlington CCG**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**16/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£810,000**
2015/16	**£7,800,000**
Total agreed value of pooled budget: 2014/15	**£1,393,000**
2015/16	**£8,662,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Darlington CCG
By	Martin Phillips
Position	Chief Officer
Date	19/09/14

Signed on behalf of the Council	Darlington Borough Council
By	Ada Burns
Position	Chief Executive
Date	19/09/14

Signed on behalf of the Health and Wellbeing Board	Darlington Health & Well Being Board
By Chair of Health and Wellbeing Board	Cllr Bill Dixon
Date	<date>

c) Related documentation

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

Document or information title	**Synopsis and links**
Appendix 1	Wider footprint for the Acute Community and MH providers
Appendix 2	7 Day service to support discharge
Appendix 3	Business Group Terms of Reference
Appendix 4	One Darlington Perfectly Placed (SCS) http://www.darlington.gov.uk/dar_public/documents/_People/DevelopmentCommissioning/Darlington%20Together/Connecting%20with%20Communities/SCS/25894%20Community%20Strategy%20FINAL.pdf
Appendix 5	Project Briefs for major schemes
Appendix 6	Transformation strategic overview
Appendix 7	2 Year Project Plan
Appendix 8	Project monitoring descriptive
Appendix 9	Programme Board Terms of Reference
Appendix 10	Portfolio review Terms of Reference
Appendix 11	Programme Team meeting Terms of Reference
Appendix 12	Project Team Terms of Reference
Appendix 13	Joint Commissioning Group Terms of Reference
Appendix 14	Risk Log
Appendix 15	Darlington Mental Health & Well Being Discussion Paper

2) VISION FOR HEALTH AND CARE SERVICES

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

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

Virtual Tour of Darlington's health and care system in 2020

Arriving at a GP practice at 2pm on a Saturday, we note that

- The practice is open and offering both emergency appointments and clinical sessions to patients who have booked their appointment through the multi-agency Single Point of Access (SPA).

- A mixture of local point of testing, locality based x ray and digital health care systems providing a local integrated diagnostic support system.

- We note the GPs working on the Saturday sessions are from a range of local practices, the local GP federation providing a locality based approach to 7 day working and medical cover.

- A frail elderly Multi-Disciplinary Team (MDT) meeting is in progress with a local specialist GP, Social worker, community matron, a community diabetic specialist nurse, CPN and Third Sector volunteer are holding a video conference with a community geriatrician and a consultant psychiatrist who are linked in from the local community hospitals where they are contributing to the assessments of patients to move back to home based settings.

- The Multi-Disciplinary Team are all using integrated ICT systems so that there is a core single record which is the basis of the case management of both high risk patients and those who are being discharged from hospital. The social and community staff linking in through their mobile working laptop system, all patients on the MDT system having agreed to share their information.

- Leaving the practice we note that a programme of Long Term Conditions support sessions are planned for Monday. At these sessions consultants and specialist nurses are booked to provide integrated support to frail elderly patients with multiple conditions - diabetes, vascular and supporting podiatry, retinal and dementia screening. The sessions are being carefully planned to allow access to clients until 7pm.

Travelling to a local care home on Sunday we note

- A community matron and a band 4 nurse are undertaking a review of 6 patients, 3 identified in a local MDT meeting from risk stratification process as having a risk of escalation and 3 recent arrivals from a planned discharge process 2 from a community hospital and 1 from a DGH.

- The patient discharged from hospital, arrived an hour ago, the community led integrated intermediate care / discharge team planned the discharge from the hospital with essential medication being provided from the new 7 day pharmacy service.

- The patients hospital discharge information pack, included a web generated nutrition plan, and a digital health monitoring pack. This cheap and flexible digital health pack, brought by the ISIS HCA in the boot of his car, was connected and put on line and started taking readings within 10 minutes. The information, being cloud based, allows decisions around additional care to be made by local GPs accessing clinical information. This INR dependant patient is also utilising the digital monitoring system to dose check as required.

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

In a local elderly persons home

- An advanced nurse practitioner is visiting to check out a person on the local risk of admission register, the persons carer has called for help from the SPA as they were concerned.

- The ANP is using a digital stethoscope to listen and transmit in real time the heart and lung function to a COPD consultant operating in 'the front of house' team of the local A&E unit. The conclusion is that a course of IV antibiotics supported by the local nursing team in the persons home and an enhanced support package , which includes a 3rd sector sitting service, organised by the social worker through the SPA will prevent risk of admission.

- Advanced care planning for a new resident is in progress, with primary, social care, 3rd sector and community clinical input. The plans have been updated with a case manager community matron aligned to the patient. This allows the care home, paramedics and acute hospital to easily contact a key worker should the patient require any escalation.

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

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

- A memory clinic is planned for tomorrow supported by local mental health trust and 3rd sector

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

At the local acute hospital site

- The redesigned A&E area, now part of a community system, is an integrated system with clear and distinct triaging for children and adults with rapid access to consultant decision makers 24/7. This access is extended to GP and to community hospitals via digital consulting links.

- There are no emergency ambulances at the door, although a local 'floating' GP who moves around the locality on a 7 day rota system, and is in the A&E unit notes she has this morning worked with paramedics in a see and treat approach to prevent 3 admissions.

- The redesigned A&E unit with facilities designed from benchmarking best practice has also had effective 7 day staffing put in place to match projected demand.

- The mental health hospital liaison team provide 24 hr 7 day a week support into A&E diverting individuals into more appropriate services or treatments.
  .
- The mental health liaison service are facilitating the earliest discharge for patients with dementia or delirium who have been admitted for necessary procedures but supported back to their homes through assertive outreach.

- Mental health emergency admissions and issues are now better managed on a 7 day basis by the local acute and 3rd sector mental health services, working closely with ED

- In the diagnostics area it is noted that the MRI schedule includes for non-urgent scans prioritised slots for community geriatric patients referred by the MDT to prevent admissions over routine inpatient scans.

- This rapid assessment process for those frail elderly community patients has 7 day coverage , and geriatrician support that aligns with GP opening times

- On a medical ward the in hospital MDT that is meeting and is finalising the discharge plan for a frail elderly patient on the high risk register. The community matron and social worker from community are pulling the patient out of hospital using the advanced care plan as the basis of the discharge plan.

- Clinics and ward rounds on the speciality service areas run on a 7 day basis, the trust having reviewed and realigned its delivery across its 2 main sites to ensure it has clinical cover by
  - Only delivering some services on one site
  - Delivering key services on both sites 8-8 with one site being 24/7
  - Realigning support services

In the Community

- Walking across the town's Market Square we see the banners outside the Dolphin Leisure Centre promoting the details of physical activity programmes, weight management support and LTC specific education programmes.

- Community, voluntary and peer support networks are evident in the activities across the Borough, which support people at home helping them feel confident about managing their conditions.

- Outside the Town Centre, in the more rural parts of the Borough, GPs, Health Workers and Social Care Workers provide accessible information on local third sector activities and services for identified cohorts of residents at risk of deterioration of their long term condition.

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

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

- The voluntary sector provides dedicated support to those leaving hospital who will benefit from on-going support within their community. We note that those who have experienced a fall have both physical activity opportunities in the community and have a proactive volunteer who will visit them regularly and co-ordinate their needs following discharge from statutory services.

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

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

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

- Social care staff are based within the multi-disciplinary teams. There are three community teams and one health and social care hub (RIACT) which is the single point of access for all referrals into health and social care. The hub; screens, signposts, provides information, triage and quickly allocates to named professional within the team. There is one IT system used by health and social care across Darlington.

- The integrated teams consist of Social care, the voluntary sector, community nurses, occupational therapists, physiotherapists, specialist long term conditions staff including community matrons. Together they respond to the needs of people who have had falls, stoke, diabetes, dementia, heart disease, Housing staff are

working alongside the team .supporting those with housing needs including homelessness.

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

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

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

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

Underpinning the vision set out in the virtual tour virtual are two key factors; the evidence base of need and the most effective ways of meeting those needs. Our task is to ensure that the profiles and issues identified in the JSNA are managed more effectively or that they are reduced in terms of the impact they make on delivering a sustainable health and social care economy. There are three key conditions that underpin our work in Darlington. The first condition is that we help to build strong and resilient communities that are better equipped to meet more of their own needs for longer. The second condition is that we spend all public money wisely and that, in particular, means evidence based activity which is shared across the public sector. Finally, the third condition is that we grow the local economy and increase the prosperity of the population and, in doing so, address the wider determinants of health.

For health and social care services we expect that more people will be enabled to live healthy and independent lives and that for those who require services, they get the right services in the right place at the right time. We have agreed our broad health and well being priorities to be that:

- Children get the best start in life

- We will all make our communities safe and caring

- We will all actively seek to ensure our own well being and that of others

- There will be enough support for people, and of the right kind, when they need it, to support health and independence for as long as possible

- Frail and elderly citizens will be treated with respect and dignity

Specifically with reference to the Better Care Fund programme the Strategic Needs Assessment (SNA) population projections show an increasing number of elderly people living in Darlington with the number of people aged 65 and over projected to increase from 17,400 in 2008 to 23,800 in 2023. The number of people aged 85 and over is projected to increase from 2,400 in 2008 to 3,800 in 2023. Projections also indicate that

by 2020 there will be an increase in significant conditions such as obesity, falls and limiting long term conditions particularly in the population of older people (65+) in Darlington.

By 2020 there will be significant increases in the number of people aged over 65 years in Darlington to have:

- dementia - an increase of 21%
- early onset dementia - an increase of 7%
- a profound hearing impairment - an increase of 19%
- hospital admissions as a result of falls is expected to rise by 18% if existing services remain as they are now

The rate of admissions to Residential and Nursing Homes is above the National and Regional averages (Darlington 988.4, North East 831.4, and England 697.2 per 100,000 population) and that admission to hospital from Care Homes is also higher and has increased from 540 to 735 in two years.

The rate of avoidable emergency hospital admission was 2712.64/100,000 population for 2012/2013, which is higher than the National Figure of 2046.55. This costs the local health economy over ……

Our rate of Delayed Transfers of Care from hospital is 544 bed days per month/100,000 population. This costs the local health economy over £1m a year. The National figure is 273.

Amongst the older population in Darlington, Dementia remains as the most significant reason for a mental health admission. Population projections also indicate that numbers of people who develop early onset dementia is likely to increase by 2020. National data suggests that a significant proportion of individuals with Down's Syndrome will go on to be diagnosed with dementia before the age of 60, contributing significantly to the rates of dementia in the whole population and the demands on services in future years.

With respect to the impact of falls and fractures in the over 65s, Darlington is in line with the regional average for admission to hospital for fracture neck of femur. However local analysis of the data suggests that for Darlington the age profile for those admitted following this fracture is older with a disproportionate number occurring in those aged over 75. This has resulted in a greater than expected number of inpatient bed days for this group, which results in a greater proportionate cost to the health economy. The older age profile also suggests that individuals would require more intensive support for discharge following a fractured neck of femur and would be more likely to require an admission to residential care on either a short or long term basis.

The number of carers in Darlington is slightly increasing with over 11,000 carers in Darlington, of which nearly 2500 are over 65. Those with limiting long term conditions often depend on informal carers for their support and care, particularly those who live in the community in their own homes. In Darlington there are around 2500 carers over 65. The age profile of carers in Darlington is expected to change in line with the age profile of the wider population with a greater proportion of carers being over 65 in the coming years. This will have a significant impact on the sustainability, resilience and cost to health and social care services that provide support to the over 65s in future.

Individuals with long term conditions (LTCs) are the most frequent users of health and social care services, with 71% of the total health spend is on people with LTCs and numbers are expected to rise in line with the population profile depicted earlier. Many people with long term conditions also have mental health problems and all of this influences the level of social care needs of the individual. By 2030 the number of people (65+) in Darlington predicted to have a limiting long term Illness is expected to rise from 8,750 to 13,490.

It is widely accepted that the stresses of living in poverty are particularly harmful to a number of vulnerable groups including older people. Darlington has some of the most deprived areas in England, and is ranked 79th most deprived local authority out of 324 in England (compared to 87th in ID2007). Almost 35% of Lower Super Output Areas (LSOAs) are in the 30% most deprived nationally, and 11% of its LSOAs in the most deprived 10% of LSOAs nationally; indicating that income deprivation for older people is a significant issue in Darlington.

In order to deliver our vision, against this evidence base, the BCF programme will ensure that.

- All service development will be based on a good understanding of the needs and wishes of the community
- We will work to embed a true approach to co-production, involving partner agencies and users of services
- Our focus will be on enabling people to remain at home or as close to home as possible
- We will identify an agreed set of outcomes, outputs, benefits and improvements for people's social and healthcare in Darlington
- We will develop a set of priorities with identified timescales and investment required.

The result will be that patient and service users' outcomes and experiences will be improved, for example, by developing improved community based support we will enable people who can and should be supported at home to receive out of hospital care.

Patient and service users will have increased choice and control including an increased use of personal budgets, better targeted community support and more flexible services, including named key workers for all at risk of hospital admission and more services available 7 days a week and beyond the current '9 to 5' opening hours.

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

Through the BCF programme we will deliver the right care, in the right place at the right time, where frail, elderly and patients with a complex or long term condition will be managed within a system which identifies and responds to their individual needs, supported by a framework of integrated support services and when required, intervention/treatment to keep them safely independent and cared for outside of hospital.

Specifically we aim to:

- build outside of hospital capacity including community and voluntary sector;
- offer targeted and proactive individualised case management in a community setting with a range of additional support services for patients aimed at maintaining and improving their current health;
- improve routine care for all patients with long term conditions to encourage and support self-management as well as prevent deterioration in their overall condition;
- reduce avoidable unplanned hospital admissions and readmissions for all patients following an exacerbation of their long term condition or deterioration of general health;
- identify the need for and improve access to a range of integrated support services for identified cohorts of patients at risk of admission on a 24/7 basis to allow them to better manage their own condition and remain as independent as possible, and thus avoid unnecessary A&E attendances;
- facilitate better management of patients at risk of admission and readmission by health and social care professionals through early identification and risk assessment of their condition, thus supporting better health outcomes;
- develop targeted preventative services based in the community and provided by the voluntary sector to help develop a community support approach to prevention;
- work collaboratively with all of our partners to ensure we develop and sustain an effect health and social care system and workforce for the people of Darlington throughout the planned transformations.

All public sector partners in Darlington fund a voluntary sector organisation to implement a *Good Friends* scheme, recruiting sufficient volunteers to ensure that 1,500 additional people are supported to remain safe in their own homes and avoid or defer the need for their entry to the health and social care system. This scheme and other opportunities for social prescribing involving volunteers from the Darlington community supporting one another aims to strengthen involvement of the voluntary and community sector to ensure we take a holistic approach.

As part of the vision for urgent care in Darlington we are moving forward in 2014/15 to fully integrate urgent care and the Emergency Department at CDDFT. We are aware there are multiple points of access for urgent care services in hours and out of hours. In

order to ensure we succeed with our vision of right care, right place and efficient and effective use of health resources, NHS Darlington, CCG and CDDFT are developing an integrated UC/ED service on the same site. The early phased move of the urgent care centre to DMH is already demonstrating benefits whereby minor ailments are being dealt with by urgent care practitioners rather than emergency care staff. Locating urgent care services alongside the Emergency Department will mean that people will be directed to the most appropriate service for their needs. This should lead to fewer people using the Emergency Department inappropriately and more people being treated quickly by the urgent care service.

Emergency Care Intensive Support Team and NHS Improving Quality are working with the CCG, CDDFT and system partners locally to develop the local systems for improving urgent and emergency care services and building the common narrative for the urgent care strategy (across County Durham and Darlington).

Locally we are at the early stages of development of the use of LACE scores. Currently, 9 out of 11 Darlington practices are participating in the risk profiling enhanced service in 2013/14. The Better Care Fund and the direction of travel in recent planning guidance (Everyone Counts) provides an opportunity to develop schemes to put primary care are at the centre of a modern model of integrated care, in particular for the 75yrs and older demonstrating plans to proactively manage this cohort of patients and reduce avoidable admissions/ readmissions. Risk profiling tools such as LACE can help us to identify risky patients which we will need to wrap both preventative and proactive services around to keep them safely cared for outside of hospital. Targeted services such as the extension of short term intervention services/RIACT and Darlington Good Neighbours are two examples which would be part of this wrap around care.

Support for carers has been improved, with a joint council and CCG Carers' Strategy in place and a shared delivery plan. Progress in relation to the Strategy is monitored at Carers' Strategy Steering Group meetings, which are chaired by the DBC Carers Lead and attended by reps from DBC Services for People, NECS, County Durham and Darlington Foundation Trust, TEWV, the voluntary sector and carers in Darlington. Darlington CCG and DBC jointly fund the Carers' Support Services.

The local mental health service for older people (MHSOP) will be more strongly linked into each of the 11 GP practices across Darlington, supporting GPs to detect people with the earliest signs of Dementia so they are included in the register and facilitated into the practice based memory clinics. Patients receive immediate professional support, advice and intervention to slow down the impact of the Dementia for the patient and their carers by providing earlier and more focused treatments in tandem with treatment of their wider physical ailments.

Following a successful pilot, MHSOP clinicians are an integral part of the intermediate care system working with the teams supporting individuals with Dementia or other mental health needs to ensure they receive the most appropriate community support package in their own home or the care home from which they have been referred, preventing long and often unnecessary stays in acute hospital.

The acute hospital mental health liaison team have a 24 hour 7 day a week presence in A&E quickly identifying individuals with Dementia, Delirium and a wider range of mental health problems and diverting them into the most appropriate community support service.

Integration of provision as a key driver

The BCF is a key driver in supporting the wider ambition of both the Council and the CCG to develop a more integrated approach beyond the BCF areas. At the heart of these ambitions is the desire to improve the quality of life for people in Darlington.

In Darlington we are very well placed being co-terminus, with close working between DBC and DCCG already in place, including shared agendas, shared services and the stated intention of both organisations to explore and progress closer integration.

There are three key drivers for closer integration of services in Darlington:

- Better use of public spending in Darlington;
- A more joined up approach to addressing need;
- Both organisations are small and by integrating they can increase their ability to service Darlington well.

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

The BCF programme is a key agent in the delivery of significant developments to ensure that people get the right care at the right time, in the right place within a sustainable health and social care economy. The BCF programme, led by the Health and Well Being Board, brings together the HWBB Strategic Outcomes, the NHS Everyone Counts, the Sustainable Community Strategy - One Darlington Perfectly Placed, the Darlington Together Strategy, as well as both of the Foundation Trust's Clinical and Quality Strategies.

The BCF programme will mean fewer people needing support outside of their own family or community and a greatly increased role for the voluntary and community sector in filling gaps in local informal support systems.

It will mean easier access to GPs and their teams through extended hours and weekend working.

It will mean that a single conversation with a health or social care professional will ensure that a multi-disciplinary support plan can be put in place if required.

It will mean that …….

3) CASE FOR CHANGE

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

Risk strat & data analysis and findings to go here – link to opportunity to improve quality and reduce costs, bespoke to area – not generic

Quantify level of unmet need, issues re service quality or inefficiencies in service delvery

Integration Aims and Objectives

Principles:

- A pooled budget will be established and jointly managed by the Borough Council and CCG with an agreed host organisation.
- The BCF will be used to further develop and accelerate the provision of community and out of hospital services which enable people to remain at home.
- The BCF will support the wider integration vision of both organisations.
- Partners and people who use our services will be actively engaged in the design and planning of new services.
- The funding will be used to support current services which are effective and new services which support the BCF vision.
- Services will be evidence based and provide value for money.
- Investment to the support the workforce will be critical to the success of BCF.

Measuring the aims and objectives of the BCF programme

The BCF programme will be monitored through a combination of quantitative and qualitative indicators, expected to include the following:

- The best care for people.
- Zero tolerance of readmissions.
- Early identification and intervention.
- Support centred on people not services/organisations.
- Care delivered though communities.
- Retelling of ‘patient stories’ minimised.

- Services will be focused on out of hospital care.

- Self-management, choice and control, primary and secondary prevention will be core features of our strategies and operating plans.

- Intermediate care, end of life care, medicine management, carers support, reablement and preventative services will all be included in the offer.

- The delivery of services will focus on public service rather than public sector, with a range of providers anticipated.

- Resources will move from acute and residential care to community support, so that only people who have to be in acute settings are.

We will use the national conditions and BCF metrics as key monitoring areas for each scheme and develop specific targets and measuring tools and programme management which will correspond with the numerical targets agreed as part of our BCF submission and the financial target of reducing the demand for acute spend by £3.9m.

The key success factors therefore will include a reduction of hospital admission to non-surgical beds equivalent to10% [sixty beds] and a reduction in delayed transfers of care.

Our local metric – Proportion of adult social care users who have as much social contact as they would like- will measure part of the success of our voluntary sector led community work where we know isolation and early support are key issues.

The details of the monitoring and escalation plans are set out in the governance section and are further expanded upon [see Appendix 8-13].

Health gain to the population

Prevention activities, early identification and risk assessment of conditions for individuals will reduce prevalence of disease and health conditions in Darlington's population, improve overall wellbeing, reduce the mortality rate from preventable causes and increase healthy life expectancy. Focussing on those most at risk should also reduce variations in health outcomes. Implementing interventions targeted at the frail elderly will improve health-related quality of life for older people and could reduce injuries due to falls and hip fractures. Supporting adult social care users and carers also has the potential to reduce social isolation.

People want to stay in their own homes - supporting this is likely to improve self-reported wellbeing. For example, the Alzheimer's Society reports that staying in their own home is very important to 8 out of 10 people with dementia (Alzheimer's Society, 2011, *Support. Stay. Save.*). Reducing numbers being admitted to hospital should also reduce the exposure to potential risks and harms caused by medical interventions and to healthcare associated infections.

The Public Health Outcomes Framework Indicators below are most likely to be impacted by the implementation of the BCF Plan. It will take some time for the impact to be seen on some of these indicators, particularly the overarching measures of life expectancy:

- Healthy life expectancy at birth
- Life expectancy at birth
- Social isolation (adult social care users and carers)
- Self-reported wellbeing
- Mortality rate from causes considered preventable
- Emergency readmissions within 30 days of discharge from hospital
- Injuries due to falls in people aged 65 and over
- Health-related quality of life for older people
- Hip fractures in people aged 65 and over

4) PLAN OF ACTION

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

October 2014 – multi-discipinary team (MDT) in place with all GP practices to support delivery of the advanced care plan Enhanced Service requirements. Minimum staffing of the MDT to include GP, Practice Nurses, Social Worker, Community/Voluntary Sector link worker and Community Matrons

January 2015 – Front of House MDT in place at Darlington Memorial Hospital, providing 7 day access to geriatricians, occupational therapy and physiotherapy

March 2015 – Rapid Response MDT, incorporating RIACT, for the escalation of cases that can no longer be managed at practice level - with access to same day diagnostics

Workforce Development Plan in place for Social Care staff to reduce Admission to Nursing Homes.

Roll out of Care Home Pilot

Co-Location of Immediate Care & A&E
Letting of HELS contract
Mental Health Acute Liaison

Integration of Immediate Care & A&E

Description of Planned Changes

We have outlined in part 2 [finance section] the planned changes to services which are key to improving the outcomes for our population by increasing the choice and quality of community provision and reducing the requirement for the current acute demand.

Draft project briefs for the each of the major schemes/pieces of work can be found in Appendix 5 and the Transformation Strategic overview in Appendix 6.

We are planning the necessary changes based on some significant groundwork carried out over the last 12 months.

We have undertaken a 'high level' review of our current services which support patients and service users being cared for at home.

We have identified 27 services which need to be reviewed with a focus on integration in order to better support our BCF vision [these are outlined in Template Part 2]

We have also identified a number of services/plans which we have decommissioned in order to identify an additional £387k to invest in the Transformation in 2014/15.

We have established 6 new schemes and 4 enabler schemes to support the BCF vision. These schemes are based on our understanding of the local needs and enable the acute sector to manage down the acute service demand in order to provide better care in the community resulting in 3 less wards being required, thus releasing the £3.9m required for reinvestment in out of hospital services.

Schemes

1/ Setting up the Portfolio, Programme and Project Teams-

We recognise that to speedily transform the way we respond to the needs of our patients, service users and population we need dedicated and skilled support to oversee the programme of change. We have established a Portfolio approach to ensure strategic oversight of 4 associated programmes; the Better care Fund, health transformation, social care transformation and public Health transformation. All 4 programmes in the Portfolio share a single transformation manager and a single model of change management. Each of the programmes has a dedicated delivery lead, lead by a Programme Sponsor and a programme manager. These teams are supported by colleagues across the partnership including, ICT, HR, legal and professional and clinical leadership and engagement. Each programme consists of a number of separate but related projects.

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By September 2014 – We will have

A/ agreed the Job descriptions and recruited to/seconded into –

1/ A dedicated Portfolio lead for Transformation
2/ A dedicated Programme Manager
3/ A dedicated Project Manager for the Long term Conditions project

B/ Confirmed the structure of the Portfolio management and agreed the governance arrangements for the wider transformation work

2/Workforce Development and Communication.

We recognise that a coordinated programme to support staff in this rapid transformation will require a targeted programme of support.

By October 2014 we will have –

A/ Identified a programme of support for the designated workforce leads in each organisation
B/ Planned and delivered a joint approach to communication for BCF.
C/Communicated the workforce programme to staff.
D/ started to run the staff development programme

By June 2015 we will have –

A/ Agreed a joint procurement strategy for managing communications

3/Estates

The reconfiguration of services and staff will require us to make the best use of our estate resource and this scheme of work will ensure we are using the resources to their full potential and challenge where the current built environment impedes successful delivery.

By September 2014 we will have

A/ Scoped out the current estate provision across the partnership
B/ Cross referenced each organisations current estates strategy
C/ Agreed a BCF estates strategy for the multi-disciplinary teams and for the co-location of urgent care and the emergency department

4/ ICT

This scheme will focus on both enabling the partnership to identify and commission the best solutions to support the sharing of information , integration of assessment and review functions as well as performance and financial reporting systems.

The work will us support the identification and commissioning of new technologies which will support the digital health and care service we will offer to improve outcomes and achieve cost efficiencies.

By September 2014 we will have –

A/ Identified membership from across the partnership
B/ Developed high level plans which outline development areas and timescales.
C/ Agreed a project plan to achieve an integrated method of sharing information and case planning.
D/ Agreed which digital solutions are best for us to invest in to achieve our identified outcomes.

5/ Development of Integrated multi-disciplinary Teams built around GP practices

We have agreed that we should develop more effective groupings of our clinical and social care staff with an initial development of up to three locality teams with both statutory and voluntary agency professionals, based around GP practices.

By October 2014 we will have –

A/ Held our first MDT meetings in each GP surgery
B/ Scoped out the development of two subsequent phases of MDT work – front of house at the hospital and a rapid response team

By January 20154 we will have

A/ Opened 7 day MDT working at Darlington Memorial Hospital.

6/ The development of a directory of services

We plan to develop a universal directory of services, including an e market to enable the community and staff to have easy access to information and advice ranging from general public health advice, what universal services are available in their local community through to advice and information about social care and specialist provision.

By September 2014 we will have -

A/ Identified Third Sector partners to develop this work in conjunction with health and social care

By October 2014 we will have –

A/ Agreed a project plan to implement a directory of services and e market offer by April 2015.

7) Self-management of LTCs

The aim of this scheme is to enable better self-management of conditions and for individuals to remain as independent as possible, avoiding unnecessary A&E admissions and reducing the burden on social care.

We have developed a project plan to ensure we address the following key areas

- Early diagnosis with timely, quality information and support to live well with the diagnosis. A model of patient support will build on the learning from the

"Expert Patient" programmes.

- Disease specific programmes with appropriate specialist support, including digital health, will be provided in a range of settings.

- Focus on prevention including physical activity, having a healthy diet, stopping smoking and avoiding excessive alcohol intake.

- The impact of wider determinants of health on the management of LTCs include the quality of housing, accommodation, environment, accessibility and quality of food, levels of social isolation and access to social networks.

By October 2014

……..

8/ Person Centred Case Management for the frail/elderly

The interventions and wrap around care and services will be determined at an individual level and will vary across a full spectrum of care and support from low level through to complex case management.

Linked and integral to this scheme the CCG is engaging with practices to implement the scheme for "accountable GP for over 75s". The accountable GP will be funded from current CCG allocations on the basis of £5 per head of registered patient aged 75yrs + Each patient identified is to have a lead /care coordinator with appropriate MDT services wrapped around them to ensure maintenance of condition and prevention of avoidable exacerbations/acute phase illness developing. The interventions and wrap around care and services will be determined at an individual level and will vary across a full spectrum of care and support from low level through to complex case management.

By April 2014 we will have-

A/ identified the top 5% at risk of hospital admission [by using RAIDR with other methodology and tools to identify the top 5%.]
B/ Agreed a high level plan to implement an effective scheme

By June 2014 we will have-

Agreed a full PID to implement the programme for person centred case management

9/ Integrated support to care/nursing Homes

We will build on our current developments to further strengthen the clinical and professional support into our care/nursing home. We will use our data to target those with a high level of hospital admissions and develop an offer to homes which enable community in reach to the homes to both respond to acute issues and develop preventative initiatives to improve the wellbeing of residents

By April 2014 we will have-

A/ Identified gaps in current provision which would improve the quality of care and reduce hospital admissions

B/ Analysed each homes level of hospital admission and agree a programme of support with each home.

By June 2014 we will have-

A/ Developed a PID to deliver a comprehensive support offer to homes
B/ Have agreed individual programmes of support to each Care Home

10/ Community support Network

We have been working with the voluntary sector over the last nine months, using a co-production model, to identify how their expertise can benefit the BCF agenda. A working group has been established and are currently identifying the areas that they can support best. This will include developing services in the community which build on our work through the voluntary sector such as 'good friends', delivering the personalisation agenda through personal budgets, targeted support work including those with mental health needs, and public health programmes.

By October 2014 we will have-

Agreed a model for co-production at the Health and Well Being Board

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

The overall local Governance of the BCF will rest with the Health and Well Being Board. A senior officer BCF Programme Board will monitor progress on behalf of the Board via monthly review meeting. The frequency of these meetings will remain under review to ensure they are appropriate at each stage of the BCF programme.

A BCF Commissioning Group will report directly to the BCF Programme Board and be accountable for the development and success of the programme. It will have a dedicated Programme Director, and dedicated Project Officer, and its membership will include DBC, DCCG, CDDFT,TEWV, and the voluntary sector.

All schemes will have a project initiation document (PID) setting out aims, objectives, timescales, metrics, resources and risks, and a Lead Officer. The joint Commissioning Group will meet weekly to address barriers and ensure timely progress is made.

The Programme Director will be able to call in dedicated support from data analysis, HR, Finance, estates, legal and others across the partnership as required.

Concurrent plans to develop a Unit of Planning wide 'Transformational hub' may require some amendment to the above plans as we will ensure that the BCF is part of our wider transformational agenda and therefore an integrated 'Transformation hub' may be possible. The commitment to have dedicated resources to drive through and oversee the BCF project will remain.

The Governance structure is set out in the diagram and is available in a larger format, [See Appendix 8-13], along with the escalation and monitoring processes that underpin

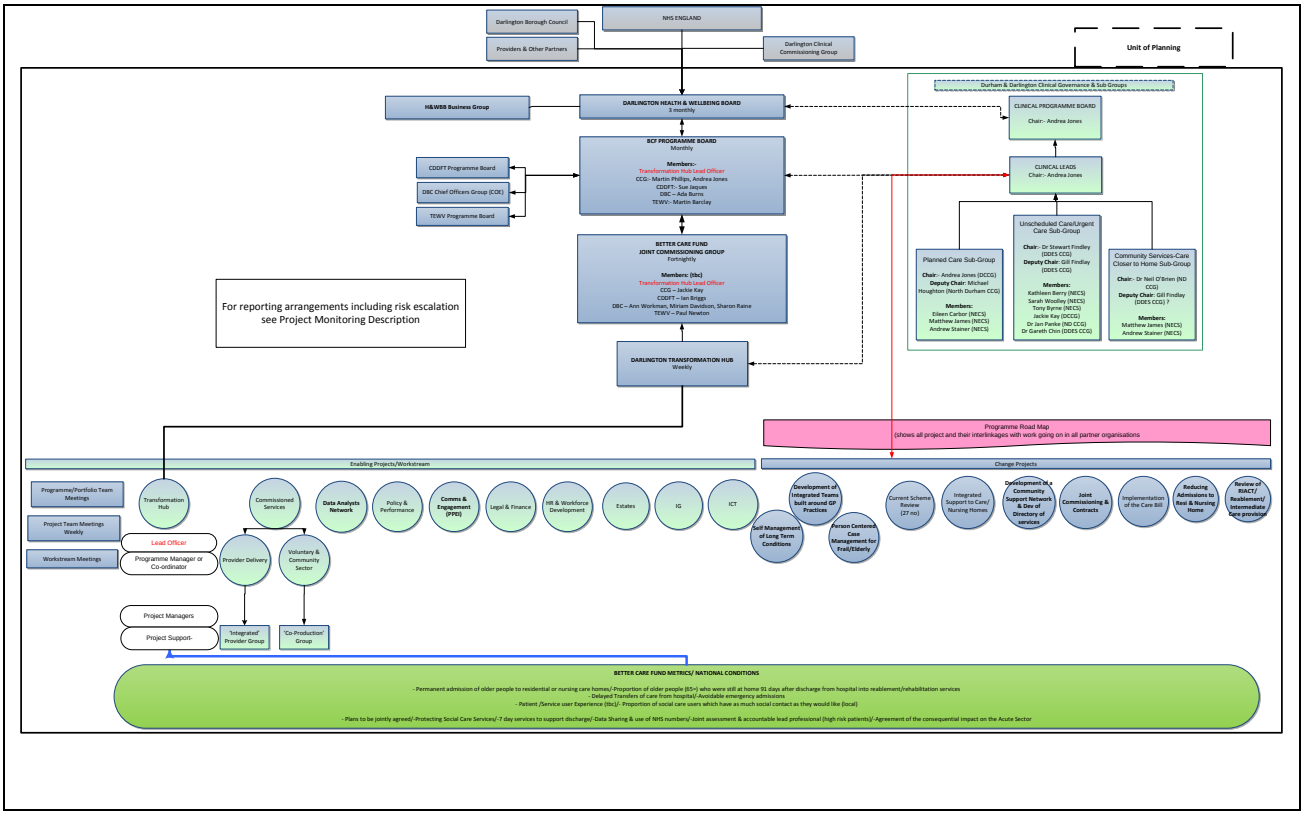
the governance.

The Health and Well Being Board's vision for Darlington's BCF is that -

- We will work collectively as a collaboration of commissioners and providers;
- The interests of the patient are paramount and at the centre of what we do;
- Individual organisational interest will not get in the way of improvements for the patient;
- Where improvements adversely affect our partners, we will manage the impact as well as the improvement;
- Good practice and examples of best care and support will be spread for the benefit of all;
- Our population, patients and staff will be proud of what the Health and Social Care system provides.

In order to deliver this vision of people at the centre of a model and of no organisational boundaries impacting on their care and support, the BCF programme will ensure that.

- All service development will be based on a good understanding of the needs and wishes of the community
- We will work to embed a true approach to Co-Production, involving partner agencies and users of services
- Our focus will be on enabling people to remain at home or as close to home as possible
- We will identify an agreed set of outcomes, outputs, benefits and improvements for people's social and healthcare in Darlington
- We will develop a set of priorities with identified timescales and investment required.



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

The BCF is managed as one programme in an integrated Transformation portfolio across health and social care, as per the governance structure illustrated above.

Reporting is on a monthly basis via a RAG rating report to ensure that early notification of risk and escalation measures are in place.

d) **List of planned BCF schemes**

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

Ref no.	Scheme
1	Establishing Multi-Disciplinary Teams
2	7 Day working
3	Self-Management of LTC's
4	Integrated Commissioning & Transformation
5	Reduction in Nursing Home Admissions
6	Enabling Strand – ICT, Data Sharing etc
etc	

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**

b) Contingency plan and risk sharing

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

6) ALIGNMENT

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

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

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

The Darlington definition of protecting adult social services is –

- To focus on prevention and early intervention
- Focus on meeting the statutory requirement to meet eligible needs of Darlington Residents (including the new criteria within the forthcoming 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.
- Social Care currently leads on safeguarding adults this will be further developed through the Care Act.
- Local priorities within the Better Care Fund will include Mental Capacity Act Assessments, Deprivation of Liberty Assessments and general multi-disciplinary safeguarding adult's activity.

Protecting social services in Darlington means ensuring that those in need within our local communities continue to receive the support they require, in a time of growing need and budgetary pressures. Our emphasis is on personalisation, prevention and early intervention. Whilst maintaining current eligibility critiera is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible stay within their own homes, our focus is on protecting and enhancing quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Funding is currently used to enable the local authority to provide timely assessment, care management, review and commissioned services to clients who have substantial or critical needs and information, advice and signposting to those who are not eligible. This will need to be sustained and robust plans made for the new Care Bill which will require additional assessments to be undertaken for people who previously did not access social services.

Additional resources will be invested in social care to deliver enhanced reablement

services which will reduce hospital admissions and admissions to residential and nursing homes.

Social Services will also plan for the delivery of 7 day services.

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

Any intended or unintended consequences for social care services will be monitored as part of our plan and is highlighted in our risk log. These will be mitigated by adopting a whole system demand and capacity framework rather than individual organisational demand and capacity planning.

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

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

Funding has been allocated for implementation of the Care Act Duties split down as follows:-

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

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

Carer specific support is already provided with a budget of £XXXX, how will this change with implementation of the Act?

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

b) 7 day services to support discharge

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

We will build on the work to date to provide 7 day services to support discharge. Plans are set out below which will result in 7 day provision being in place across agencies, including primary, community, social and acute services.

A strategic commitment to 7 day services across Darlington health and social care economy is part of the BCF submission. CDDFT is one of thirteen sites who are Early Adopters for 7 Day services. This gives all agencies a focus on the development of Local plans to build upon existing service provision.

The RIACT service in Darlington operates a 7 day service 8 till 8; this prevents admissions and enables planned hospital discharges. This is a joint service with CDDFT Community Health Services (Therapists, Stroke, Falls, Nursing, Social Care, In-house Reablement service) 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. Plans are underway to further develop this service to provide a full 7 day service.

Within the wider social care workforce work will be undertaken with staff, unions and Human Resources to develop a social care approach to 7 day services. This will be developed within the work on further integrated community based multi-disciplinary teams across Darlington.

Social Care staff already work 8 till 8, 7 days a week within the RIACT service in Darlington. Analysis will be undertaken to determine, volume of work, number of staff and arrangements for access to social care seven days will be implemented. This will require consultation with staff, H.R and Unions. Work will be undertaken to understand the Adult Social Care Customer journey, including interfaces with health providers to enable timely assessment and transfer, 7 day services in social care will also be considered as part of this work.

Within the overall national 7 day program as an early adopter , the local health and social care economy across County Durham and Darlington will be looking to make early progress in the following key areas

- Unscheduled care service access
- Frail elderly service development
- LTC support
- Improving access to pharmacy and diagnostics
- Digital health

- Primary care 7 day bid
- Reviewing services against clinical standards and implementing 7 day access improvement plans

See Annex 1 for the details of the schemes.

c) Data sharing

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

98% of Darlington Borough Council's Adult Social Care clients can be identified using their NHS number. This identifier is not currently used in correspondence.

Darlington Borough Council is committed to using the NHS number as the primary identifier for Adult Social Care clients. Work is currently underway to assess the most appropriate way to take this forward based on a number of options:

- Collection of the NHS number at source, i.e. when the client first accesses Adult Social Care services or at review stage;
- Obtaining the NHS number from the client's GP if they do not know it; and/ort
- Using the Demographics Batch Service (Health and Social Care Information Centre) to source the NHS numbers for clients that do not know their NHS number (this requires an N3 connection).

Collection of the NHS number at source has already commenced via Adult Social Care practitioners. Investigation of the feasibility of collecting the NHS number from GP's or using the Demographics Batch Service has commenced.

Pilot work currently underway using NHS number for all referrals through the RIACT service within Darlington. The outcome of this will be used to ensure that the NHS number is recorded for all individuals accessing health and social care. Information and Governance group considering this and review of current IT system within Adult Social Care underway.

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

Health and Social Care settings in Darlington are committed to adopting systems that are based on Open APIs and Open Standards and this is included in the standard requirement for the procurement of all systems.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit

requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The partners in Darlington are committed to ensuring that appropriate information governance controls are in place.

To ensure that Darlington Borough Council's information governance controls are consistent with those implemented in the NHS, the Council is in the course of completing the NHS Information Governance Toolkit, with initial focus on the secondary uses version, for submission by April 2014. The Council already has PSN certification and ICT Services is certified to ISO27001 Information Security Management. Our information governance work programme is based on ISO27001 and the NHS Information Governance Toolkit Level 3 standard.

All of the partners in Darlington are already fully committed to compliance with the Data Protection Act 1998 and the requirements set out in Caldicott 2. In particular, the partners are committed to ensuring that:

1. Client/patient-identifiable information is processed for justified purposes, with advice from the Caldicott Guardian where necessary;

2. Client/patient-identifiable is only used when necessary - anonymised and pseudonymised information will be used wherever possible;

3. Partners only collect the minimum amount of client/patient-identifiable necessary;

4. Client/patient-identifiable is shared and accessed on a strictly 'need to know' basis;

5. All staff are aware of their responsibility to safeguard client/patient-identifiable information;

6. Client/patient-identifiable information is only processed when there is a lawful basis to do so; and

7. Staff are adequately supported to make decisions about the sharing of client/patient-identifiable information.

As the integration progresses in Darlington, the partners will work to ensure that information flows are mapped and to implement information sharing agreements or contractual arrangements where none already exist. This will be a rolling process as the integration will be implemented in a phased manner.

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

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

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

Currently the majority of adult referrals are passed through the RIACT team which is a multi-disciplinary health and social care team which offers a reablement service. DBC have recently merged their intake and RIACT team to offer a single point of contact for all adult social care referrals. This was to improve response time and ensure that a lead professional is allocated as close to point of referral as possible. This lead professional can be either health (nurse, physio or OT) or a social care practitioner and joint care planning is used where necessary. As the needs of the person change through the reablement cycle, the multi-disciplinary team can ensure a seamless transition through the changing needs of the person, ensuring that the right care is delivered at the right time.

We plan to build on our existing joint approaches, such as RIACT to develop a joint approach which will be multi-agency but further expand this good practice by linking the health and social care services to GP practices.

The approach to risk stratification has been to develop low level support with a focus on self-care wellbeing using the “Make Every Contact Count” (MECC) framework. Moderate level of support is available for people at moderate risk consisting of disease specific education programmes and generic self-care and support.

Identification of high risk patients leads to a pathway of care including the self-care tools available to moderate risk group with additional support in care planning and assistive technologies.

The very high risk cohort of patients is met with a very high level of support, intensive professional care with integrated case assessment, planning and management.

Our plans for the local hubs of MDT teams include having an accountable or lead professional where appropriate. The criteria of when an individual will need a named professional will be developed, including how the accountable GP agenda will fit within our plans. However we are committed to ensuring that any individual who will benefit from coordinated supported will have a named professional who will help them co-ordinate their pathways of care and support.

We envisage that all members of the MDT will be a lead professional, and that both the needs and wishes of the patient will, wherever possible, determine who should be that named professional. This will include the voluntary sector who can provide the role for individuals who may have a lower level of presenting need, but without proactive support may not utilise the services in the community and therefore the risk of admission to the acute sector would increase.

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

Darlington is committed to the principles of co-production in the development of our BCF involving patients, service users and the public throughout the design and delivery process.

We have a number of mechanisms across Darlington by which we engage patients, service users and the public in the delivery of services. These mechanisms are co-ordinated by a Joint Communications and Engagement Group which reports to the Health and Wellbeing Board.

Healthwatch Darlington sits on the Health and Wellbeing board and works very closely as part of the Public and Patient Engagement and Involvement Group. They are the key consumer champion in relation to Health and Social Care and have supported engagement work around a range of activity including the Long Term Conditions collaborative and the re structure of Stroke services. They have also held a number of outreach sessions to engage with residents and patients more generally. These sessions are held in community and private sector venues to ensure there are wide-ranging opportunities to have a say about health and social care services. Healthwatch have also undertaken a number of enter and view reviews of health and social care services and have worked to train members of GOLD (the service user group of over 1,000 residents - Growing Older Living in Darlington) in relation to enter and view activities as part of the Gold Standards Framework Programme. Healthwatch acts as a network of networks, bringing

together individual patient groups, voluntary sector groups and individuals including through the support they give to the Learning Disability Network, Mental Health Network, Darlington Ageing Well Network and Darlington Organisations Together.

The engagement carried out to date has not been specific to the Better Care Fund; instead we have used key findings from a number of engagement activities covering a wide range of health and social care issues to shape the initial direction of the Better Care Fund schemes. Engagement through events and activities such as Your Health, Your Town, Your Say, Darlington Clinical Commissioning Group Call to Action, Long Term Conditions Collaborative, Darlington Association on Disability – Stronger Voices, the Frail Elderly Summit and Provider Forums has identified a number of common themes. These themes relate to consistency of support, being supported to remain at home, having more choice and control and more flexible, accessible and responsive services, all of which are guiding principles within our Better Care Fund approach.

HealthWatch are a member of the voluntary sector working group and will be a member of the joint commissioning group from April 2014.

Engagement activity to date has included:

- **Your Health, Your Town, Your Say Event 10th July 2014**
- **Darlington Clinical Commissioning Group Call to Action**
- **Engagement Activity and Case Studies for long Term Conditions Collaborative**
- **Mental Health Network**
- **Learning Disability Network**
- **Growing Older Living in Darlington (GOLD) Health Group**
- **Carers Survey 2012-13**
- **Social Care Users Experience Survey 2012-13**
- **Darlington Association on Disability – Stronger Voices**
- **Provider Forum 29 January 2014**
- **The Elderly Frail Summit – 19 November 2013**

Moving forward we will carry out much more focussed engagement and consultation around the development and implementation of the specific schemes and maintain an on-going dialogue through existing forums such as the Mental Health Network, the Learning Disability Network and Growing Older Living in Darlington (GOLD) Health Group.
This programme of engagement will be co-ordinated by a joint working group of the Health and Wellbeing Board to ensure a systematic approach to user engagement is adopted.

In addition a broader communications strategy is currently being drafted which will cover both the immediate two year delivery plan but also the wider five year vision. The objective of the strategy will be to engage patients, service users, the public, staff and stakeholders in the change by:

- **Informing patients, service users, the public, staff and stakeholders about change and the reasons for change**
- **Setting out the benefits of change**

Addressing concerns / issues / barriers

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

Darlington Borough Council [DBC] and the Darlington Clinical Commissioning Group [DCCG], in partnership with our local providers, have developed a Better Care Fund working group to oversee the initial phase of the Better Care Fund. The membership includes DBC, DCCG, NHS England Commissioning Support [NECS], the County Durham and Darlington NHS Foundation Trust [CDDFT] and Tees, Esk and Wear Valley Foundation Trust [TEWV]. [See Appendix 3]

As part of the working group a Joint Engagement work stream has been established to ensure that the Better Care Fund is communicated to all stakeholders and staff, that effective engagement with stakeholders takes place and that the views of service users and patients is sought to shape developments`.

Goals and objectives of the work stream:

- By the end of November, meet with key voluntary sector organisations to discuss the Better Care agenda and its implications - Complete
- By the end of January, hold a Provider Forum open to all health and social care providers to introduce the Better Care Fund agenda and to begin a journey of co-production. Completed
- By April, through the Health and Well Being Board Joint Communication and Engagement Group, establish current mechanisms for service user and patient involvement and conduct an analysis of engagement carried out to date to help inform the Better Care developments and any future engagement activity required.
- By April, agree through the working group a series of joint staff communications around BCF development
- Develop a high level action plan/project plan - Complete

In anticipation of the health and social care reforms, a ‘co-production’ working group has been established, which includes full representation from the voluntary sector in Darlington, and which has developed an action plan to support the Better Care Fund agenda. Emerging ideas from the group are included in our submission.

All acute providers have been actively engaged from the outset in the development of the Darlington Better Care agenda and are well placed to plan with us, as resources are redirected from acute to community provision.

Prior to the BCF announcement, a number of engagement events had taken place with partners in relation to the key strategic and financial drivers impacting on health and social care costs and service design. Darlington's sustainable community strategy, *One Darlington: Perfectly Placed* [see Appendix 4] and our budget transformation strategy, *Darlington Together* both emphasise the need to ensure that high quality provision, delivered in a context of financial challenge, is done so through integration and person centred care.

In recognition of the importance of delivering fundamental change, all local health service providers (acute, community and mental health/learning disabilities) are directly involved in and signed up to the development of the BCF both via the working group and through regular Chief Executive-level strategic meetings. This BCF submission was approved on the 2 April 2014, by the Darlington Health and Well Being Board which includes both CDDFT and TEWV Foundation Trusts as part of its membership.

In terms of provider engagement it is also important to note that they are already working closely with commissioners on existing transformation plans as a result of work carried out by the Clinical Programme Board. These include work with the frail elderly, Long Term Conditions, diagnostics/7 day working and urgent care). Our clear collective commitment is that the impact of current and future programmes on providers will be fully quantified and managed. We have acknowledged that transformational change projects can be seen as having both a potentially negative impact as well as being an opportunity for providers to develop and deliver services differently.

Health Provider involvement and engagement is assessed via the CCG's assurance meetings with the NHS Local Area Team. The development of the local planning unit which is co terminus with Darlington Borough Council will strengthen this arrangement bringing together the Darlington commissioners and providers across health and social care sectors. A provider event on 29 January brought together for a second time over 30 local providers to secure on going provider input into the BCF planning.

There is on-going engagement with CCG member representatives from each of the 11 GP practices in Darlington. An initial discussion took place on 1 October 2013 to ascertain key areas of work for joint opportunity for integration. This list of priorities areas has been collated with key areas noted as multi-agency community based support, quality of care in care homes; developing intermediate care; improving discharge management; joint commissioning of services from the voluntary and community sector.

A recent CCG survey of the 11 GP practices provided a mandate to take forward the joint working arrangements with DBC for commissioning of services. As part of the wider integration discussion with DBC and Darlington CCG a joint CCG member representatives and DBC Cabinet Members session is planned for May 2014.

Engagement with the acute providers, CDDFT and TEWV, has enabled the organisations to be involved at the very start of the design of new services. This has meant that they have been able to start to plan for the anticipated reductions in bed usage and start to plan with us the community/outside of hospital provision that will be required. Work to detail the risk and reward arrangements is currently being worked out, but there is a clear

commitment from the acute providers to proactively engage , including the CDDFT releasing a senior manager for 3 days a week to be a member of the 'Transformation hub' which will oversee the implementation of the BCF.

ii) primary care providers

The emerging Primary Care Strategy for Darlington and early discussions on a new model for primary care has presented the opportunity to engage with GPs and their practice teams from the outset. The Darlington GP collaborative has been actively engaged and are an integral part in transformation plans for Darlington specifically around

- Multi-disciplinary teams
- Frail elderly
- Accountable GP for 75 years plus
- 7 day services
- LTCs

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

Our work with the voluntary sector has resulted in them being actively involved in the design and planning of the BCF. They have helped identify a number of key schemes to support the Community support network agenda, and the support of people within their own homes. These have included support to GP surgeries, befriending schemes, day provision, and support with personalisation. The work has also resulted in the inclusion of the voluntary sector in our MDT plans.

The voluntary sector representatives are now part of BCF Joint Commissioning Group, with representation on key work streams and on the BCF working group.

Some of the key issues that have arisen include the sector wanting to be recognised as professionals in their own right, e.g. as active members of the MDT, able to undertake the lead professional role and their ability to maintain active engagement with their service users.

The work has also enabled the sector to have an increased understanding of the key priorities of both the CCG and Council, including key performance indicators. Together we have been able to identify where the voluntary sectors skills and approach can help deliver the BCF agenda.

The sector has appreciated and welcomed their involvement in the co-production approach to BCF.

c) Implications for acute providers

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

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

The CCG 2 year operational plan and 5 year strategic plan together with underpinning contract negotiations and agreements with the main provider organisations (CDDFT and TEWV FT) set out how we will secure a strategic shift of activity from acute care to out of hospital care focussed on the needs of patients. System plans, activity trajectories and financial plans are being developed in line with national timelines and involving a range of stakeholders including local authority and other main providers through the emerging unit of planning for Darlington.

Achieving our specified targets for the shift of activity from acute care settings will involve phased disinvestment and redistribution in primary and outside of hospital/community care. This is described in more detail in the CCG strategic plan and financial plans. The aims being to achieve a 15% efficiency target on spend on acute services.

The BCF cost will be covered by:

Holding 0% net growth in Emergency and Elective admissions in 14/15 and meeting the demographic pressure by shifting activity out.

Achieving a 1% net reduction in emergency admissions in 15/16 and a 0% net growth electives in 15/16

Achieving a 1% net reduction in all first OP appointments in 14/15 and 15/16

Achieving a 0.5% net reduction in FU Ops in 14/15 and a 1.5% net reduction in 15/16

Achieving a 1% net reduction in all A&E attendances in 14/15 and 15/16

NB These trajectories are currently being thoroughly tested and will appear in final form in the CCG financial plan (to be finalised in April 2014)

The strategic vision for the configuration of acute hospital resources will be in line with the strategic plans across County Durham, Darlington and Tees. The work to Secure Quality in Health Services [SeQIHS] will continue to drive this in relation to acute hospital services, informed by clinical and public engagement. It is clear from SeQIHS and national work (i.e. Sir Bruce Keogh's plan to drive 7 day services across the NHS) that this will require commissioners to commission care and services differently across the system to meet the quality, financial and workforce challenges whilst maintaining public confidence, and for providers to develop new ways of working in networks, collaboratives or federations that will inevitably lead

to a realignment of services. Commissioners and providers will clearly need to work together closely to take this work forward in a coherent way.

Our plans will deliver against the 5 NHS outcome domains and 7 measures identified in "Everyone Counts" to achieve the 6 system characteristics of a high quality, sustainable health and care system in 5 years.

We are in the process of developing the schemes through a multi- agency design team approach. These design teams are being actively facilitated to deliver new working arrangements by working to a tight timescale. Whilst recognising the urgency, impact and importance of these proposals, at this stage of the development of new delivery systems, the best we would be able to do would be to make high level estimates the potential impact on finance, bed days & activity. Clearly without more work on impact assessment of similar schemes elsewhere and some early pilot running this is an area of risk (this gap / issue is acknowledged by the LAT).

As identified in the risk update, the partners recognise to ensure we deliver long term sustainable transformation, and provide service continuity to the people of darlington; a core principle of this approach must be ' In changing our current position of acute services 'we can't switch off anything until we are sure alternative works' .

The partners have agreed together to identify and quantify the impact of the proposed schemes both in terms of moving activity out of hospital and into the community, taking a whole system look at the impact as outlined in the proposed metric below. This is a critical component of the overall transformation of darlington and the BCF programme of work and requires detailed implementation planning, impact analysis and risk analysis as well as an assurance of the delivery of credible alternative provision.

	Change / potential impact	Comment
Budget move	**£Xm**	**July 2014**
Activity shift	**X%**	**July 2014**
Ward / Bed number changes	**X Number**	**July 2014**
Medical staff impacted	**X FTE**	**July 2014**
Nursing staff impacted	**X FTE**	**July 2014**
Clinical support service impact	**£Xm/FTE**	**July 2014**
FM / ancillary support	**£Xm/FTE**	**July 2014**
Back office	**£Xm/FTE**	**July 2014**
	£Xm/FTE	**July 2014**
Exploit Redeployment of staff into the community schemes		

Impact on staff

There are some key generic issues around all staff groups that could be potentially issues to address

- **Loss of skills from health community due to uncertainty on future direction / job security Increased turnover due to**
- **If transformation is not well managed and delivered it will be more difficult to attract skills and trainees**
- **Enhanced workforce planning and review of training approaches to meet new skills**

Staff group	Impact	Comment
Medical staff	Redeployment of some medical staff to MDT based delivery Potential loss of key medical staff as there will be less posts than in current models effective workforce planning needed to develop and sustain critical mass of skills in some areas and retain medical staff	Some rationalisation will be possible and some reduction of dependency on agency in skill shortage areas Note as well as the core move from acute the move to 7 day working will also be happening so the medical staff workforce planning is crucial
Nursing staff	Redeployment of some nursing staff may be needed to MDT based delivery Less posts than in current model so potential for loss of key skills Nursing retraining, redeployment may be needed to ensure skills not lost from system	Some rationalisation will be possible and some reduction of dependency on agency in skill shortage areas Note as well as the core move from acute the move to 7 day working will also be happening so the nursing staff workforce planning is crucial
Clinical support – diagnostics / pathology	Likely to need an increase in demand some demand as 7 day access and point of care testing may well be needed	These services are critically balanced to provide sustainable in hospital and primary care support, clear definition and transition mgt will be needed if these key services are not to be disrupted
FM / ancillary support	Less posts Potential redundancy	
Back office	Less posts needed as fewer	Options to rationalise

	hospital services **Potential redundancy**	**back office as a health economy, note transitional planning and implementation will require some of this input**

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

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.
Scheme name MULTI DISCIPLINARY TEAMS
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.
Scheme name JOINT COMMISSIONING & TRANSFORMATION
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.
Scheme name **REDUCTION IN NURSING HOME ADMISSIONS**
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.
Scheme name SELF MANAGEMENT OF LTC
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 2 – Provider commentary

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

Name of Health & Wellbeing Board	

Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	