**HEALTH AND PARTNERSHIPS SCRUTINY COMMITTE**
**11 JANUARY 2017**

**ITEM NO.** ……

# DARLINGTON LONG TERM CONDITIONS COLLABORATION

## SUMMARY REPORT

### Purpose of the Report

1. To update Scrutiny on progress at project closure.

### Summary

2. This project was a key element of the Better Care Fund programme, initiated in October 2014, for completion over two years. The project broadly achieved its objectives, with key deliverables including health coach training for professionals working with people with Long Term Conditions; a new algorithm to ensure GP referrals are consistent, and improved patient information. A number of follow-on actions are identified that will be picked up through the Better Care Fund social Prescribing project shortly to be initiated. Long term impact measurement will also be undertaken as part of BCF.

### Recommendation

3. It is recommended that Scrutiny take note of this report

**Suzanne Joyner**
**Director of Children and Adults Services**

### Background Papers

No background papers were used in the preparation of this report.

Dr Andrea Jones 01325 621414. /Elaine Taylor: Extension 6079

| | |
|---|---|
| S17 Crime and Disorder | n/a |
| Health and Well Being | This project is part of Better Care Fund |
| Carbon Impact | None |
| Diversity | N/A |
| Wards Affected | All |
| Groups Affected | People with Long Term Conditions at risk of admission/re-admission to hospital |
| Budget and Policy Framework | Budgets pooled through a s75 agreement between DBC and Darlington CCG |
| Key Decision | No |
| Urgent Decision | No |
| One Darlington: Perfectly Placed | Aligned |
| Efficiency | New ways of delivering care have the capacity to generate efficiency |

## MAIN REPORT

### Background

4. Since the last report to this committee this project has come to a close: there follows a summary of the delivery achieved and follow on actions.

### Achievement of Objectives

| Objective No | Where did we want to be? (OBJECTIVE) | How would we know if we have got there? (MEASURES) | Deliverables that evidence of achievement of objective |
|---|---|---|---|
| Objective 1 | More community support for people living with a LTC including pro-active treatment and care planning to reduce emergency attends at UCC or hospital | 5% Reduction in NEL Admission<br>5% Reduction in the number of A&E Attends<br>2.5% Reduction in the number Ambulance Conveyances/Transfers<br>5% Reduction in the number UCC attends | Care Planning<br>Breathlessness Algorithm<br>Improved patient information<br>Key Worker - Improved Voluntary Sector Support via Social Prescribing<br>Cross skilling of community nurses<br>LTC & MH awareness in Primary Care<br>Health Coach Training |
| Objective 2 | Person centred pathways in place | Documented new process | Breathlessness Algorithm<br>Improved patient |

| Objective No | Where did we want to be? (OBJECTIVE) | How would we know if we have got there? (MEASURES) | Deliverables that evidence of achievement of objective |
|---|---|---|---|
| | | Reduced number Out-patient Appointments:-<br>5% Reduction in OP first appointments<br>5% Reduction in OP Follow ups | information<br>Care Planning<br>Cross skilling of community nurses<br>Systm1 access in Out Patients |
| Objective 3 | Effective community support in place to facilitate as short a stay In hospital as possible | 4% Reduction in the number DTOC days | Removed from scope - already being delivered by other projects:-<br>Hospital to Home & Single point of access for Discharge Management |
| Objective 4 | Holistic pathway, not disease specific | Less professionals involved with the individual<br>Reduced appointments in a reduced number of location for a person living with LCT(s) | Breathlessness Algorithm<br>Care Planning in Primary Care<br>Cross skilling of community nurses<br>Key Worker - Improved Voluntary Sector Support via Social Prescribing<br>LTC & MH awareness in Primary Care |
| Objective 5 | Redesigned process with waste and duplication reduced | Less overall staff effort in the process | Breathlessness Algorithm<br>Care Planning<br>Key Worker - Improved Voluntary Sector Support via Social Prescribing<br>LTC & MH awareness in Primary Care<br>Health coach training |
| Objective 6 | Shorter diagnosis time with more diagnosis happening in Primary Care without referral to hospital (where appropriate) | Shorter pathway with reduced lead times | Breathlessness Algorithm<br>LTC & MH awareness in Primary Care<br>Cross Training of Specialist Nurses |

| Objective No | Where did we want to be? (OBJECTIVE) | How would we know if we have got there? (MEASURES) | Deliverables that evidence of achievement of objective |
|---|---|---|---|
| Objective 7 | Improved customer satisfaction | GP survey results<br><br>Care Planning Survey | Care Planning<br>Breathlessness Algorithm<br>Improved patient information<br>Key Worker - Improved Voluntary Sector Support via Social Prescribing<br>Cross skilling of community nurses<br>Health Coach Training<br>LTC & MH awareness in Primary Care |
| Objective 8 | Increased number of clients who are able to self-manage and reduce the overall impact on health and social care services | Unable to establish baseline at start of project<br>New measure = no of people receiving health coaching as part of their care planning | Health Coach Training<br>Care Planning<br>Cross skilling of community nurses |
| Objective 9 | Increased employment for people living with one or multiple LTC's | % point gap in the employment rate between those with a LTC and the overall employment rate – current rate is 5.7% - best quartile | *Removed from scope – scope too large and already in best quartile* |
| Objective 10 | Increased quality of life for people living with one or multiple LTC's | Proportion of patients with a long term condition reported to feel supported to manage their condition<br><br>Current Performance 70.2% (In IQ range but recently showed non-significant drop)<br><br>Health related quality of life for people with long term condition(s) | Breathlessness Algorithm<br>Care Planning<br>Key Worker/Navigator via Social Prescribing<br>Improved care via Cross Skilling of community team and specialist nurses<br>Health Coaching approach across all sectors, working to improve self-management |

| Objective No | Where did we want to be? (OBJECTIVE) | How would we know if we have got there? (MEASURES) | Deliverables that evidence of achievement of objective |
|---|---|---|---|
| | | Current Performance 71.5% (In IQ range but recently showed non-significantly increase) | |
| Objective 11 | Increased number of volunteers/CVS helping others to live and manage their LTC(s) | Baseline information not available but commissioning navigator role to provide this service | Key Worker/Navigator via Social Prescribing funding |
| Objective 12 | Increased number of people and professionals using electronic methods of monitoring health | Reduced home visits by professionals<br>(measure via RPIW sample data) | Removed from scope as impossible to measure – no data is recorded |
| Objective 13 | Increased skill level of professionals to be able to manage multiple LTC's<br><br>Increase staff satisfaction | Cross skilling of staff to save duplicate client visits resulting in reduced home visits by professionals<br>(measure via RPIW VSM)<br><br>Increased Staff Satisfaction measured via staff survey. | Cross training of specialist nurses, Community matrons, District Nurses & RIACT<br>Health Coach training |

Baseline figures are reported via the BCF but as with the Frail Elderly work, separating out each of the cohorts for reporting purposes has been difficult. Separate monitoring for Care Planning and Health Coaching has been put in place to give more context to the BCF reporting.

## Conclusions and follow-on actions

5. The main achievements for this project which should have the biggest impact on improving patient care and experience and shortening the pathway are:-

   (a) Cross skilling of the community and specialist nursing teams at CDDFT
   (b) Implementation of the Breathless Algorithm for Primary Care
   (c) Health Coach Training across all sectors

6. There were a number of hand over actions that have been handed over to the subject leads to complete implementation, these are:-

   (a) Primary Care – LTC Care Planning Primary Incentive Scheme – Scheme is designed and funding arranged – needs to be launched with Primary Care

(b) Key Worker – to be implemented as part of the Social Prescribing scheme
(c) LTC and MH awareness for Primary and Secondary Care – still to be delivered
(d) SystmOne access in Outpatients – was still to be rolled out at time of project closure

7. The project had good collaboration at both Project Board and Chief Officer level and had good sponsorship.

8. During the project there were an extensive range of competing change initiatives across all participating organisations which resulted in competing demands on key clinical resources. The LEAN improvement techniques were not bought in to by all organisations so the approach had to be changed part way through the project. It also experienced a number of set-backs during its duration and lack of clinical availability to participate in the project. This coupled with a major restructure within CDDFT during the implementation phase meant a change of management for the effected teams which delayed progress.

9. Additional resources were sourced to enable better engagement but the resources allocated did not have sufficient capacity to enable effective engagement across all sectors.

10. A two year programme, whilst long enough in implement change is not long enough to see any benefits from the implementation so follow up will be required and this will be done via the Better Care Fund monitoring..