Updated Jan2014

Better Care Fund planningtemplate – 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 on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.ukas 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.

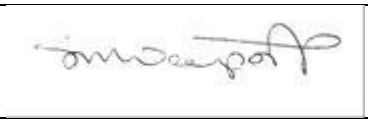
1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Derby City Council**
Clinical Commissioning Groups	
	NHS Southern Derbyshire CCG
Boundary Differences	**Derby City Council is wholly contained within SDCCG boundaries. SDCCG is also part of the BCF submission with Derbyshire Council Council**
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**09/01/15**
Minimum required value of BCF pooled budget: 2014/15	**£957,000**
2015/16	**£17,403,000**

Total agreed value of pooled budget: 2014/15	**£5,264,000**
2015/16	**£17,403,000**

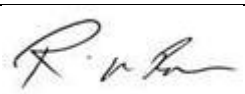
b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Sheila Newport
Position	Chair
Date	09.01.15

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Councillor Martin Repton
Position	Cabinet Member for Adults and Health
Date	09.01.15

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Ranjit Banwait, Leader of the Council
Date	09.01.15

<Insert extra rows for additional Health and Wellbeing Boards as required>

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**
Introductory background documents	
Derby City JSNA	Provides the needs analysis on which the Health and Well-being strategy and BCF is based. http://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/DerbyCityCouncil-JSNA-2011-12-April-2014.pdf

Derby City Health and Well-being Strategy	Articulates the over-arching priorities of the HWBB. http://new.psnc.org.uk/derbyshire/wp-content/uploads/sites/8/2013/07/Derby-City-Health-and-Wellbeing-Strategy-Plan-2012-2014.pdf
Southern Derbyshire CCG Operational Plan	Summary of CCG Plans for 14/15  SDCCG Full Plan FINAL.pptx
Section 6 supporting documents	
Your Life, Your Choice – Adult Social Care Strategy	This is the most recent Adult Social Care strategy which is currently being consulted on http://www.derby.gov.uk/health-and-social-care/your-life-your-choice/

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

The Derby City Health & Wellbeing Board have agreed to work towards services that meet the “National Voices” vision and definition of integrated care which is that:-

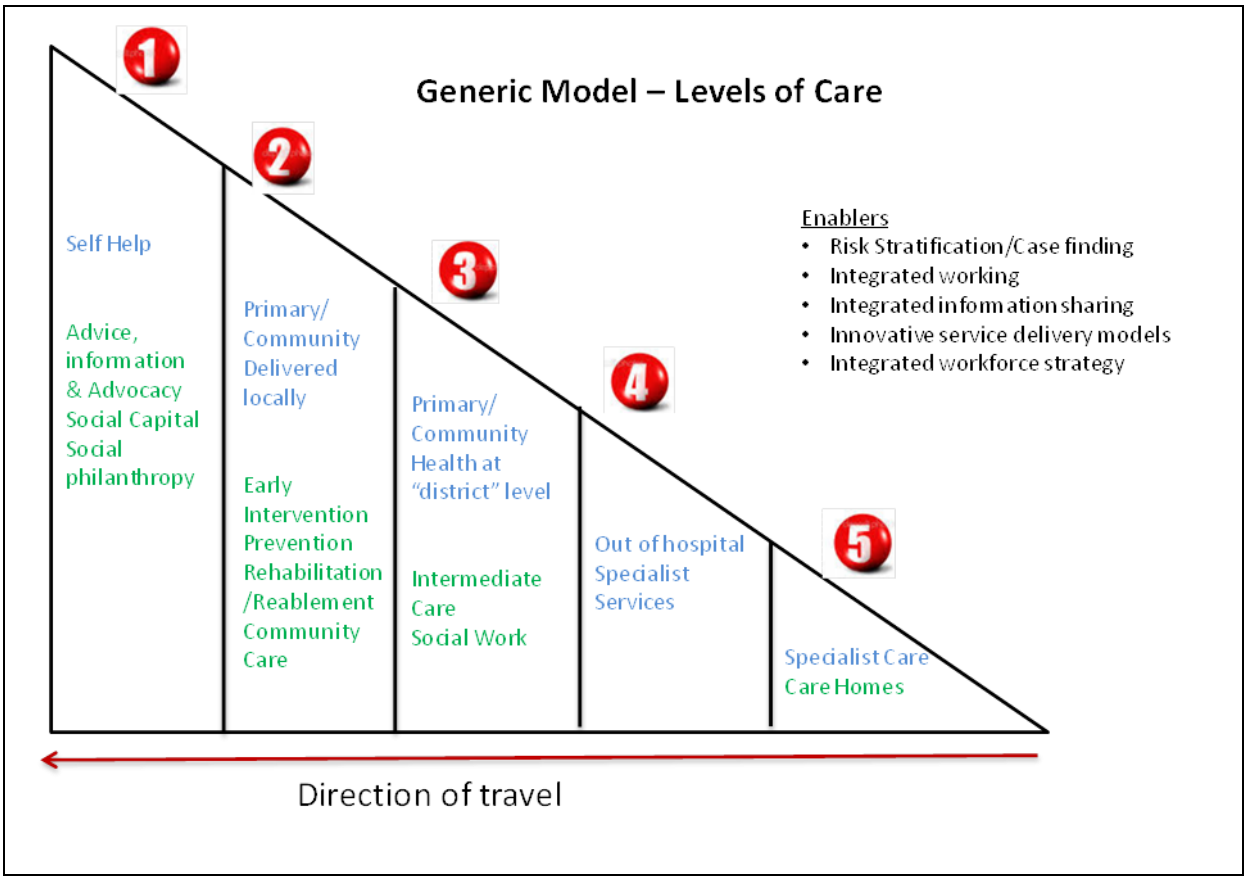
“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”

Our strategic aim to support people to have the best quality of life, within the constraints of their personal circumstances, is at the core of our health and social care system.

This model is underpinned by the following guiding principles where care must:-

- Be organised around the needs of individuals (person-centred)
- Focus always on the goal of benefiting the service user
- Be evaluated by its outcomes, especially those which service users themselves report
- Include community and voluntary sector contributions
- Be fully inclusive of all communities in the locality
- Be designed together with the users of services and their carers
- Deliver a new deal for people with Long Term Conditions (including Mental Health)
- Respond to carers as well as the people they are caring for
- Be driven forward by commissioners
- Be encouraged through incentives in the right place
- Aim to achieve public and social value, not just to save money
- Last over time and allow for innovation

We have created a simple diagram to explain the strategic shift we want to engineer and refer to it as the “Care Wedge”. We are using this with citizens, staff and stakeholdersto explain what we intend to achieve. Over the next five years our aspiration is that, as much as possible, people find the support they need in their community and as close to home as possible (at the left hand side of the wedge). To enable this we will need to change the financial pattern of current investment by moving services and resources closer to the individual, away from institutional forms of care and into the community.



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

Our service transformation will have the following impact on citizens' outcomes. It will mean:

1. More people avoiding formal care and support because they have their needs met through natural community support
2. More people able to remain living in their own home for longer, in greater control of their health and well-being
3. An improved experience of using community-based services as our integrated approach means that:
   - They only have to tell their story once
   - The service offer is consistent across all the days of the week
   - They know the name of the person they need to contact if they need help
4. An increased sense of security because citizens know they can get help quickly – whether it be for social, physical or mental health reasons
5. Fewer people with a long term condition(s) living without an informal network of support
6. More people living well with their long term condition due to an increase in the role of peer support and educators who will help people manage their condition and recover
7. More people in direct control of their support because of increased take up of Health and Care Personal budgets.
8. More people able to access 'a good death' at home, or in a community setting if preferred.

9. Significantly fewer unplanned admissions to hospital and care homes through effective admission avoidance interventions
10. An increase in recovery outcomes across all client groups through increased and improved recovery services
11. Significantly fewer people going into long term care from an acute hospital bed because there is a greater level of support available to help people recover
12. A reduction in delayed discharges through increased community-based services and effective care pathways
13. Timely and effective support to carers

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?

In five years' time we will have empowered citizens, able to access helpful information on a range of subjects that promote their independence and enable them to manage their long term condition/ risk to independence. They will be supported in this through a good network of family, friends and engaged community – perhaps with the help of a peer educator too. The amount of social capital in our communities will have increased through the facilitation of the Local Area Co-ordinators and our voluntary, community and faith sector. Social philanthropy will have increased and contributors will be able to make informed decisions about donating through the *Vital Signs* philanthropic guide. Increased volunteering will make a valuable contribution to tackling social isolation and increasing informal forms of support. Every older person aged 85+ will be offered the opportunity to have an individualised "winter plan".

A more effective involvement of carers at each level will contribute to meeting identified outcomes. Informal carers will be supported to continue their caring role for as long as they feel able or wish to.They will receive a carers assessment and from this support mechanisms to prevent carer breakdown. Increased investment in the carer emergency plan will reduce the 'cared for' being admitted to hospital or institutional care following a carer crisis. Clear pathways of support for the carer will reduce carer stress and the requirement for more dependent funded support from health or local authority.
There will also be an agreement to continue the support to carers who support people with dementia by securing current provision.

The Community Support Teams (created through integrating social work, primary and community health services) will be at the heart of our community offer and will cover both physical and mental ill-health. They will have a close professional relationship with the Local Area Co-ordinators. They will be effectively reducing planned and unplanned admissions to hospital and care homes through rapid action to support frequent attenders and through proactive preventative work with people with long term conditions/ risks to their independence. Working with peer educators and citizen leaders will be a key part of this work as will the maximum usage of health and social care personal budgets. There will be close working between Community Support Teams and Care Homes for any individual who does need a short stay in a care environment.

General practice will be an integral part of Community Support Teams and provide clinical leadership. Practices will be working collaboratively to provide a wider range of services within each geographical area than is currently the case.

These teams will be complemented by a rapid response service obtained through a single point of access that GPs have confidence in because it guarantees it will see someone within two hours of referral and has a comprehensive spectrum of services it can call upon to support people at risk of an admission. The work of the service is ably supported by geriatricians who will spend a significant proportion of their practice time in the community. Health and social care support staff will work together to provide a single source of care for patients.

Recovery capacity and expertise will have increased across physical and mental ill health services. Rather than go to day centres, people with a mental health problem will take part in Recovery and Well-being networks to gain the skills and confidence they need to overcome their illness. Rather than people be assessed in hospital to facilitate discharge, the default position will be to discharge people home to assess, ably supported with intensive support and night sitting if required in the first few days. Only by exception will people receive rehabilitation in a community hospital bed with greater use of care home capacity and people's own beds with peripatetic therapy support and care workers acting as agents of therapy. It is likely that we will need fewer buildings as services will be delivered in people's own homes.

The acute hospital will be free to focus on its core purpose and, as a result of the effectiveness of admission avoidance and supported discharge, will no longer need to expand its capacity to meet demand and may, in fact, be more compact than at present. Community staff will reach in to hospital to provide continuity of care and facilitate discharge; and acute clinicians will provide expert advice and support to community teams and primary care. There will be regular circulation of staff between acute and community settings.

The BCF specifically assists with this service transformation through investment in:

- Local Area Co-ordinators
- Community Support teams
- Increased community-based capacity: home support, equipment services, intermediate care
- Support to carers

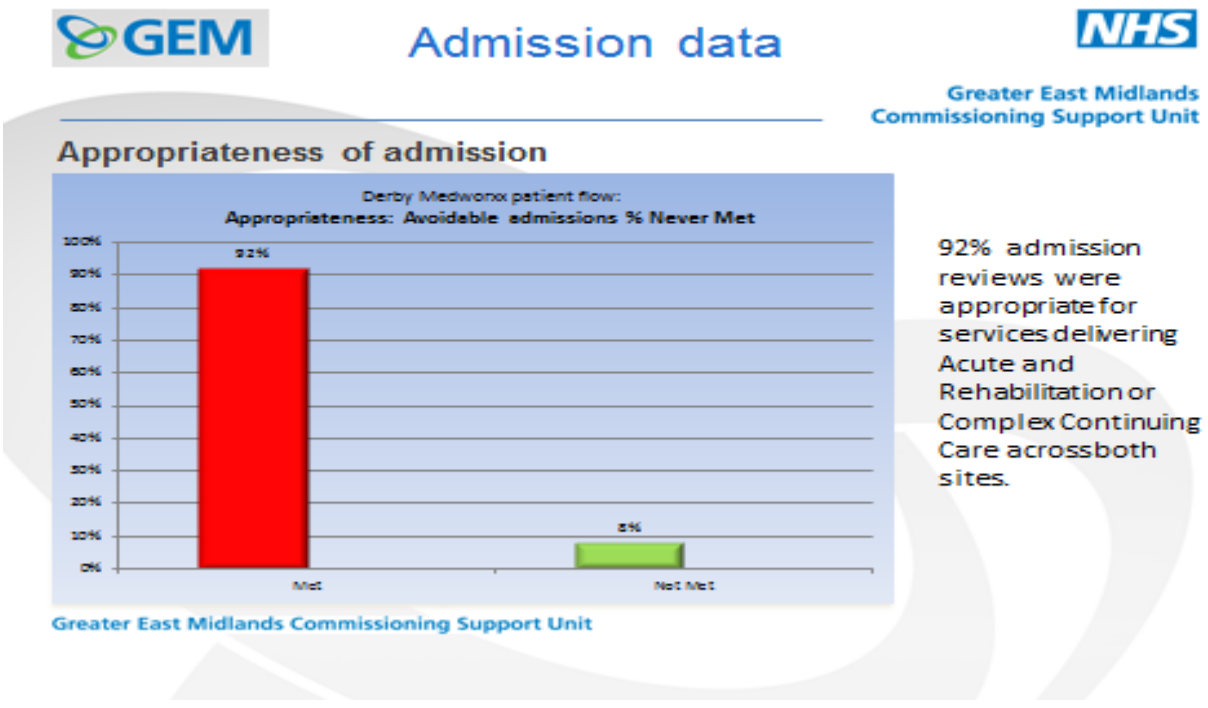
3) CASE FOR CHANGE

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.

Work has been undertaken across the Health and social care community to reduce number of emergency admissions, with work led by a system wide, clinically driven Urgent Care Board.

Much of this work has focussed on streamlining Urgent Care services and has been informed and supported by ECIST. This resulted in major improvements in A&E performance between 12/13 and 13/14.

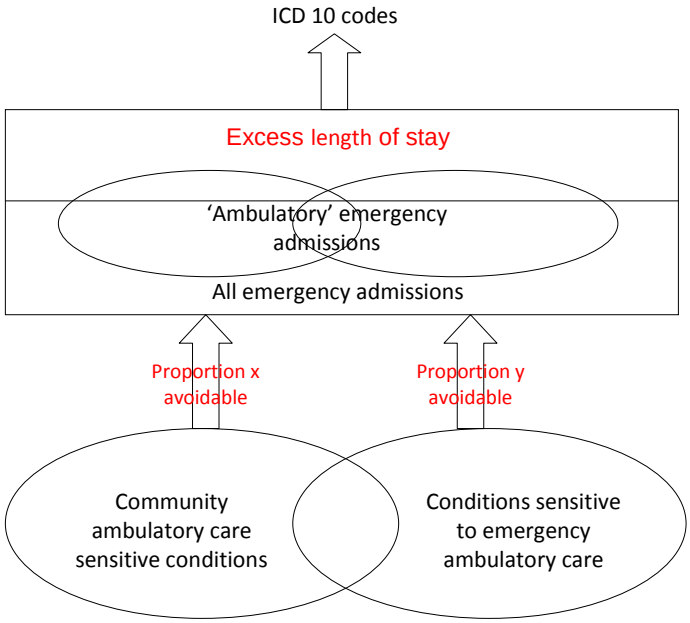
A utilisation review of Derby hospital beds[1] also showed that some admissions were assessed as being for people who did not need to havebeen admitted (8%), but that there is also work to be done in enabling discharge for patients once they are medically fit , with 19% of bed days assessed as being used by people who could be cared for outside of the hospital.



Local modelling of the population need for emergency hospital beds was also undertaken by the Public Health department (Derbyshire County)

[1] "Department of Medicine for the Elderly & Community Facilities Snapshot Utilisation Review – March 2014" :- Greater East Midlands CSU

The model looked at emergency admissions in adults and children of all ages from the four Derbyshire CCGs to Derby Royal Hospital (DRH) or Chesterfield Royal Hospital (CRH) and used data from 1st January to 31st December 2013. Recognising that excess emergency bed use is driven by three factors: too many patients going to hospital from the community, too many patients being admitted through A&E or patients were staying in hospital longer than is clinically indicated. It is on those areas that the model focuses and is presented in diagrammatic form (see below). By combining published evidence with local data and national comparators, the model was aimed at contributing a more accurate picture of need than previous aspirational estimates.



The assumptions and manipulations used in the model are based on the best available evidence and made in good faith; this is borne in mind when interpreting the significance of the outputs

The primary aim of the model was to predict the number of emergency hospital beds needed in Derbyshire. Results for both CRH and DRH are presented to enable decision makers to view Derbyshire as a whole health community. The findings suggest that the number of emergency admissions could change from around 31,000 per year to between 21,000 and 25,000 at CRH and from around 43,500 per year to between 31,000 and 36,000 at DRH as shown in table 1.

Table 1: Reduced Emergency Admissions

	From	To	
		Minimum	Maximum
Chesterfield	30 777 (100%)	21 060 (68%)	25 201 (82%)
Derby	43 499 (100%)	31 022 (71%)	36 362 (84%)

Combining the reduced emergency admissions with the shorter Length of Stay of 3.7

days at CRH (current average LoS for EAs at Wrightington, Wigan and Leigh NHS Foundation Trust) and 3.8 days at DRH (current average LoS for EAs at University Hospital of North Staffordshire NHS Trust) equates to a reduction in emergency beds from 423 to between 213 and 255 at CRH and from 674 to between 323 and 379 at DRH as shown in table2 .

Table 2: Reduced Emergency Beds

	From	To	
		Minimum	Maximum
Chesterfield	423 (100%)	213 (50%)	255 (60%)
Derby	674 (100%)	323 (48%)	379 (56%)

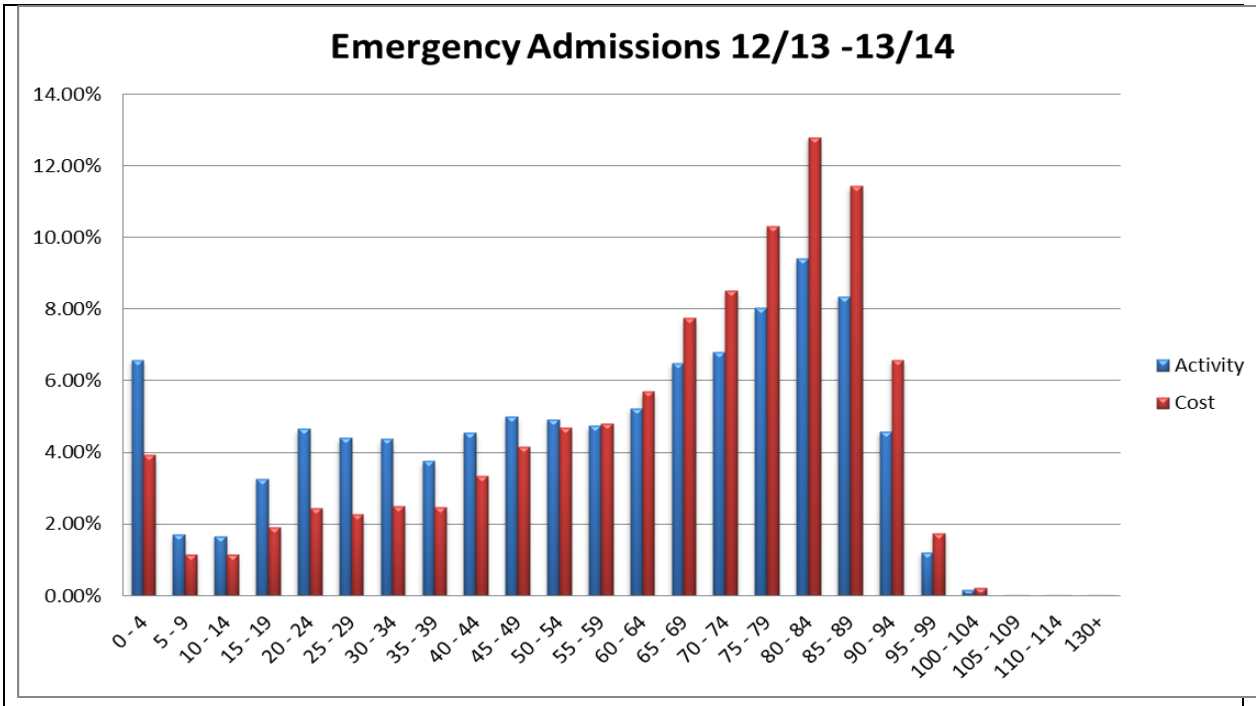
Table 3: Seasonal Variation

	Average beds		Calculated winter average beds			Calculated non-winter average beds		
	Min.	Max.	Min.	Max.	%	Min.	Max.	%
Chesterfield	213	255	240	288	100	199	239	83
Derby	323	379	364	427	100	315	354	83

The above is a “snapshot” of the work undertaken; the modelling suggested that between 168 and 210 emergency acute beds at Chesterfield and between 295 and 351 at Derby may be excess to requirements ***in an optimally resourced and functioning health and social care system***. The aim is to work towards the state where all community capacity is in place and the right contractual and cultural changes ensure that the system works optimally.

It is clear from all the local work undertaken, and confirmed by national studies, that more emergency admissions could be avoided through a **greater focus on pro-active care** and through **improvements in the availability of services for people at home**. This is the focus of the Better Care Fund, however it is essential that a continued focus on the Urgent Care System is maintained if the benefits anticipated are to be seen. (See section 4& 6)

Initial Analysis of Acute admission data has shown that in line with many other areas, the usage and cost of hospital care is highest in the older age groups. The Health and Social care community therefore focussed on Older people and people with Long term conditions in the initial stages of integration work.



Derby adult social care services have also been on a journey since 2010 to redress a balance of care that placed too many people in institutional forms of care and insufficient community-based services. Many of our community-based services were also very traditional with a very low level of personal budget and direct payments taken up. This can be illustrated by the following data:

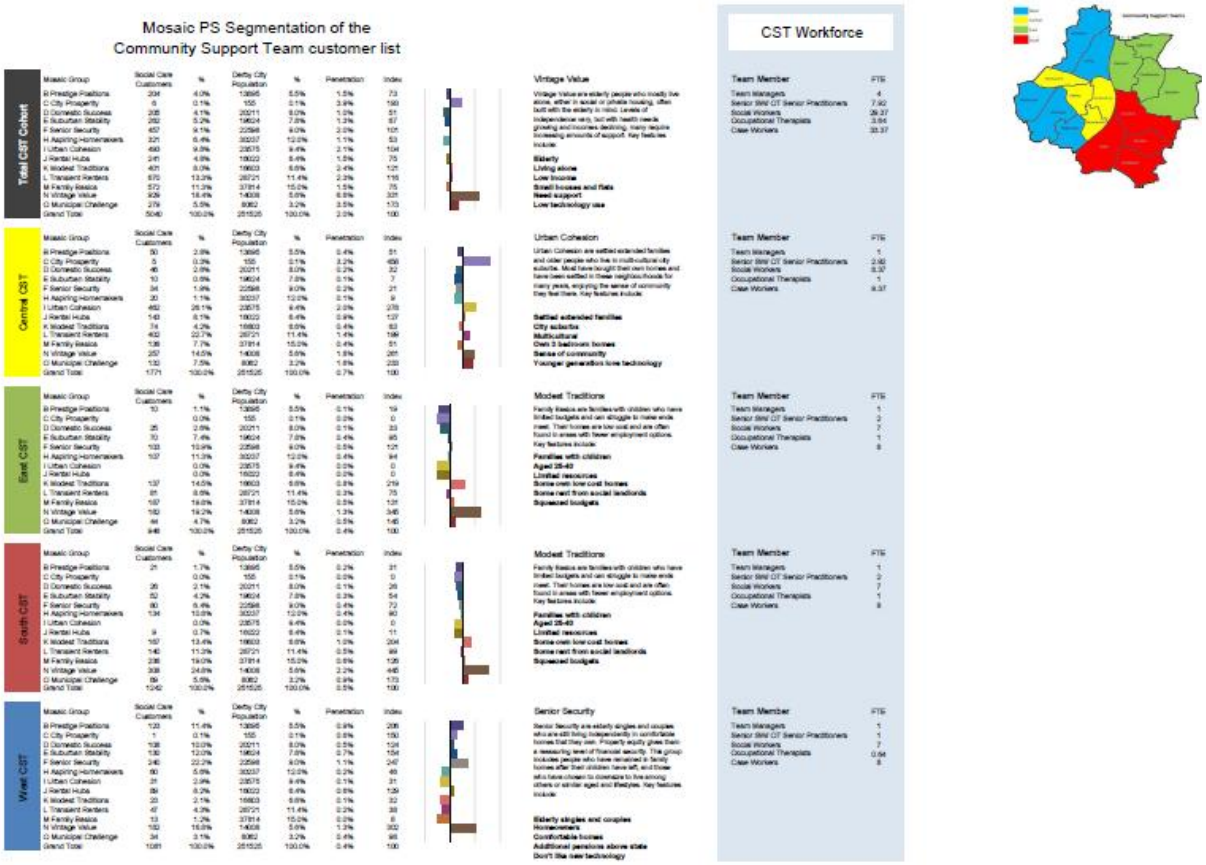
Indicator	2010-11		2012-13	
	Derby	Comp.	Derby	Comp
18-64 in community-based services/ 100,000	1481	1627	1477	13
18-64 in residential care/ 100,000	195	120	152	1
18-64 in nursing care/ 100,000	54	28	54	
18-64 rate of admission to care homes	16.1	16.9	4.5	14
65+ in community-based services/ 100,000	11,212	11,547	8853	93
65+ in residential care/ 100,000	2172	1993	1918	20
65+ in nursing care/ 100,000	1646	809	1623	8
65+ rate of admission to care homes	695	693	583	7
% of 65+ offered re-ablement	2.6	2.7	2.3	3
% of 65+ still at home 91 days+ re-ablement	89.6	80.7	95	83
Delayed discharges attributable to social care	0.8	0.8	0.1	2
Delayed discharges	7.4	7.4	12	9
% of people self-directing their support	26.1	n/a	63	52
%receiving Direct Payments	13.5	n/a	22.4	13

The performance highlighted in red is where Derby's performance is out of line with its comparator benchmark. In summary it shows:

- There are still too many younger adults (aged 18-64) in institutional care although the rate of admission has significantly reduced due to a change in practice
- There is still less community-based support for older people

- Derby has virtually double the number of people in nursing care compared to our benchmark group average
- Not enough people are offered re-ablement and when they do the retainment rate looks suspiciously high – are the right cohort of people on this care pathway?
- Delayed discharge performance by adult social care has been consistently good but has deteriorated for the whole system

Use of Mosaic tools has helped us to understand different populations within Derby City and will continue to be used as we further develop the Community Support Teams in each area. (Example below)



The Derbyshire H&SC community are keen to understand better how our whole system works, what the key cost drivers are and to assess how out integration work is making a difference. So in 2013 the Chief Executives of all health and social care publically provided organisations in Derbyshire agreed to pilot an initiative whereby they would share the information on their customers to understand how patients flow through the health and social care system, thus mitigating the burden on services through addressing potential weaknesses in the system within Derbyshire.

Information was shared in accordance with current information governance standards to the data services for commissioning regional offices (DSCRO) within GEMCSU, who carried out the joining of datasets and onward shared a pseudonymised single dataset to the company PI. PI has provided the information back to the organisations

involved via a dual licence to their dashboard software solution, Omniscope, that licence users are able to fully manipulate to produce bespoke dashboards that will help them address the “key questions” facing their organisations in a strive for efficiency in health and social care.

It was clear from local health data that the older population was driving a lot of the emergency activity and cost. it was therefore decided that the initial pilot for PI data would focus on the over 65 age group.

Information from Acute, mental health, Community, 111, Out of Hours health providers and Adult Social Care is currently being combined to help us with stratification of the population.

This work is in relatively early stages, but is already highlighting the areas that we need to focus on and will, for the first time, look at usage of services by individuals across the health and social care system. This will help to target areas where integration of services is likely to provide the most benefit.

Example of PI cross-cutting analysis

More than **12,500** Derbyshire residents over 85 year olds attended the A&E Department at RDH in the study period. Of those:

- Almost **1,500** had attended the department the day before,
- **2,500** the week before,
- **4,000** during the month before
- In addition, **304** had been on a hospital bed having already been admitted to hospital and discharged the day before being taken back to the A&E department.

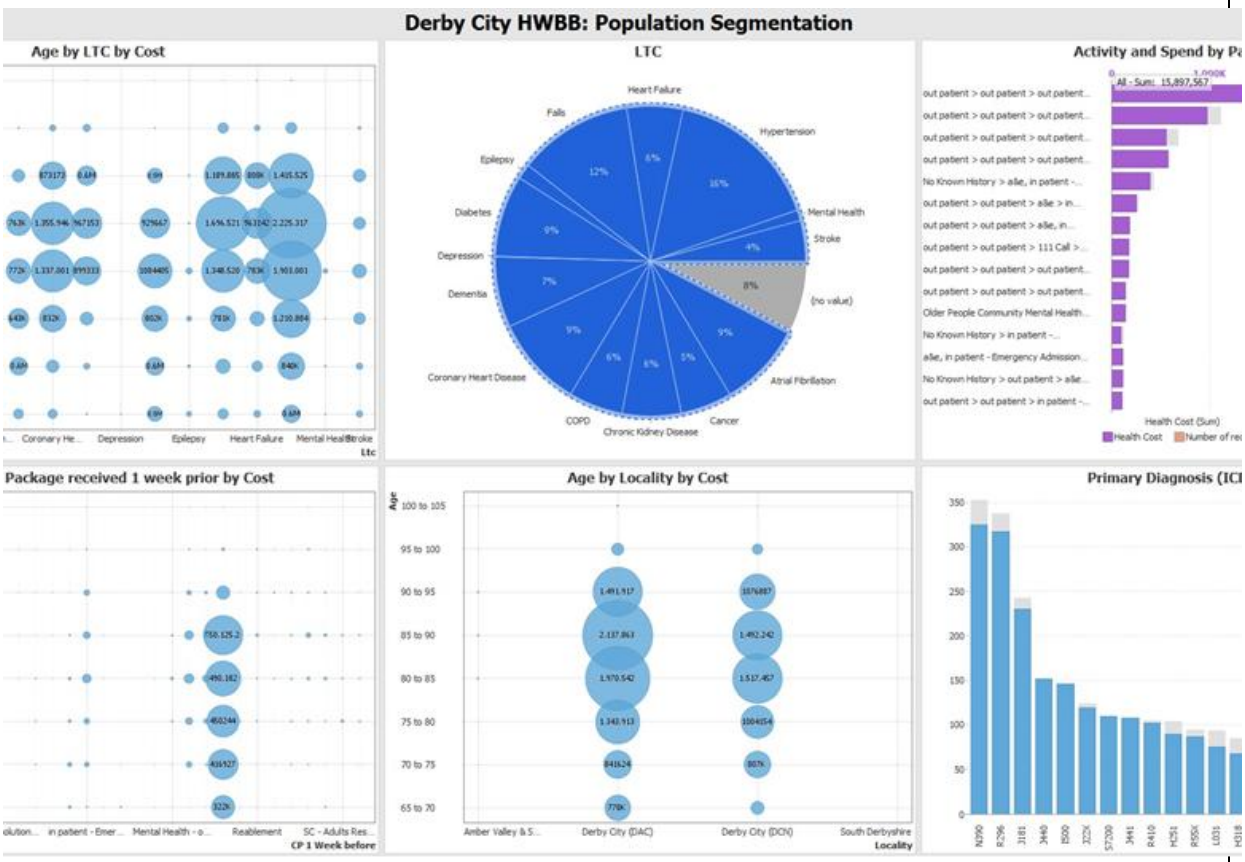
Of **6,011** individuals who were admitted to a bed from A&E:

- **26** had been in a bed the day previous,
- **253** the week previous,
- Over **1,000** in the month previous.

Of the total 12,500 individuals requiring A&E care, contacts with Social Care professionals were made by:

- **384** in the week before attending:
- 164 receiving community care;
- 135 in residential care;
- 96 for assessment;
- 69 for reablement;
- 51 for review;
- 27 for equipment.

A range of interactive ‘dashboards’ are also being developed to help inform the transformation projects. This is still early work in progress, but looks promising. (Example screen shot below)



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

Work has already begun on many of the schemes outlined in the BCF and is being continued during 14/15 and into 15/16.

All of the work is a key part of the overarching 5 year strategy of the CCG and also those of local Health service provider Trusts. A piece of work has been commissioned by the South Derbyshire Unit of Planning to pull this work together to develop a Health and Social care 5 year plan, of which the BCF will be part. This is due to take place during September/October 2014.

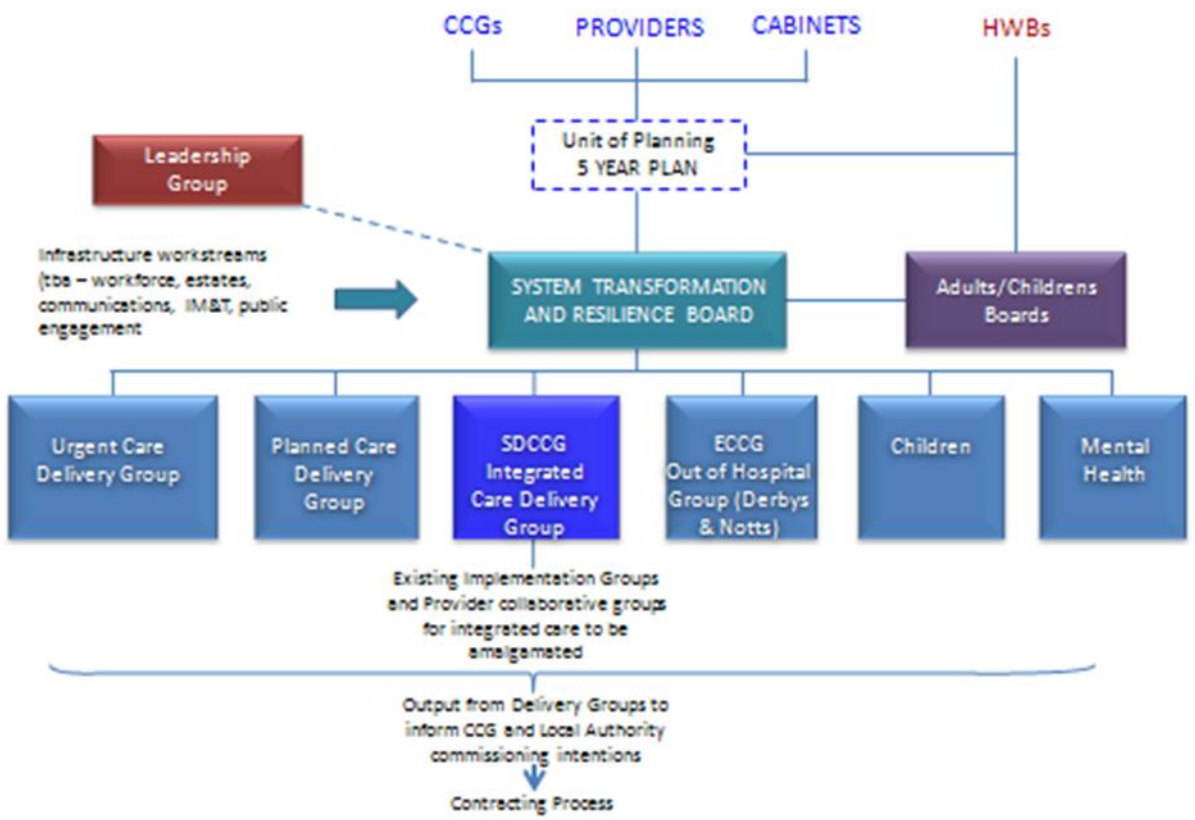
The implementation of this plan will be steered by the 'System Transformation and Resilience' Board, and will be delivered through the clinically led work-streams that report to it. The schemes funded through the BCF will, in the main, be implemented and reported through the Urgent Care or the Out of Hospital work-streams.

Health and Social Care commissioners recognise that to deliver sustainable services in line with the vision described there will need to be some re-shaping of services within the local area. To enable this work has begun in working with providers on redesigning out of hospital care. In addition we are exploring alternative outcome based contractual models which would incentivise the delivery of our service vision. This work will continue during 14/15 and into 15/16.

It is further recognised that Primary Care providers are key to the delivery of the service model and work is underway with the NHS England area team to look at how this can be developed**.**

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

The governance arrangements are set out as below:



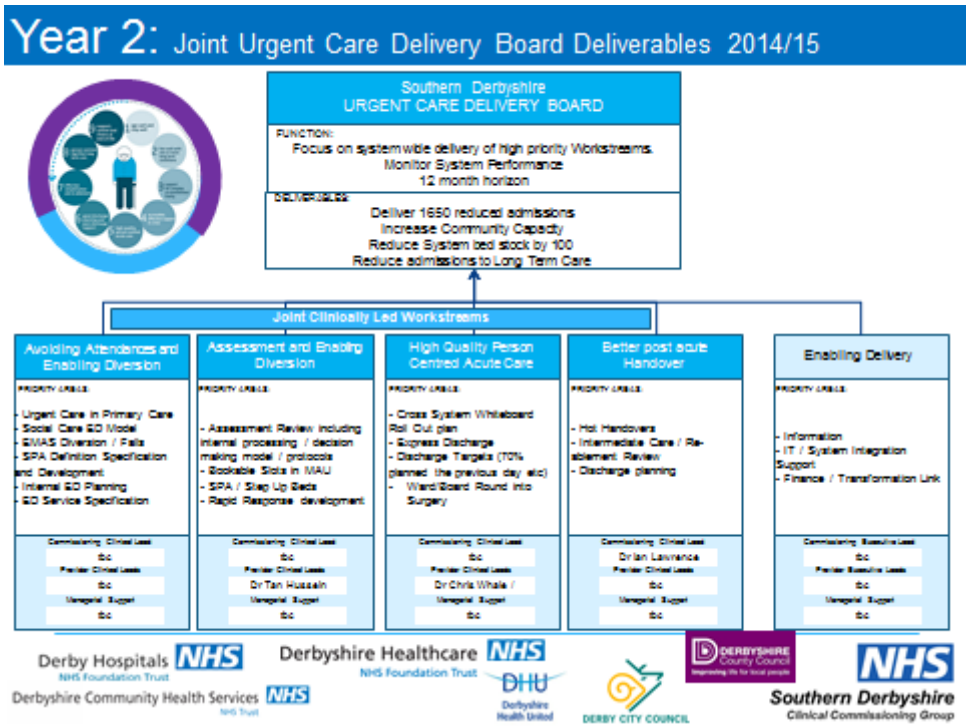
It should be noted that:

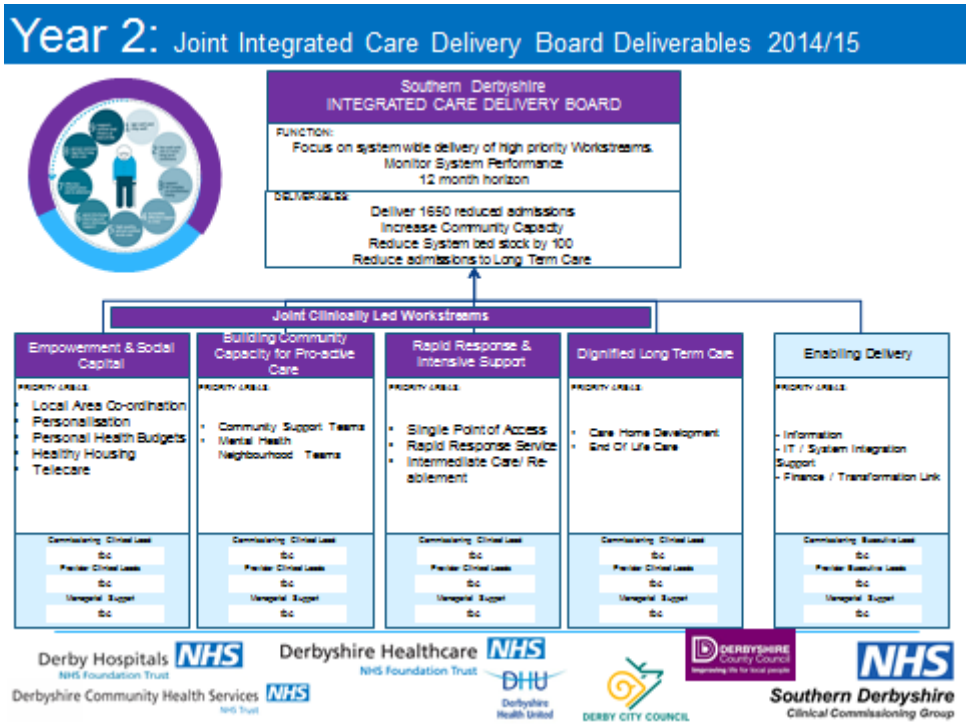
NHS providers are full members of Derby's Health and Well-being Board and have been since its inception.

In order to address the fact that Southern Derbyshire CCG geographically covers both Derby City Council and part of Derbyshire County Council, there is a significant level of collaboration between the three organisations (and the other Derbyshire CCGs). To that end, it has been agreed between the two local authorities that Derby's Health and Well-being Board will be the "lead" board for SDCCG plans with Derbyshire County Council members attending the Derby city board for specific items on integrated care including the BCF plan.

The South Derbyshire System Transformation and Resilience Board is a newly constituted board that covers the unit of planning for SDCCG and Erewash CCG. It is the over-arching strategic board for integrated planning and also addresses the new planning requirements for resilience. It acts as the programme board for BCF and wider transformation plans. Membership is at Chief Officer level.

Tasked out from the South Derbyshire Transformation & Resilience Board are a series of Operational groups that have responsibility for the implementation of planned actions. They are multi-agency groups with senior officer membership.





Note – These projects have been operating from 13/14, Year 2 relates to 14/15 (Year 1 of

BCF)

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

This has been explained in (b) above. Our BCF programme is integrated into our wider transformation programme with the South Derbyshire Transformation Board acting as a programme board with operational groups accountable and reporting progress to it. It is within this mechanism that risk management, oversight and remedial action with be managed.

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	Self help, Prevention & Community Resilience
2	Integrated Community Based Support
3	Reducing avoidable admissions to Hospitals and Care Homes
4	System Enabling Schemes

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.

Introduction:
The risk log below is intentionally high-level as it covers the whole health and social care system in Derbyshire. Each individual project within the BCF has its own project plan and associated risk log which is monitored through either the CCG or Unit of Planning. The BCF Finance and Performance sub-group will receive monthly monitoring reports from individual Units of Planning, CCGs and Adult Care PMOs as appropriate. The reports will include any exceptional risks that have an impact on the totality of the BCF. By exception, risks will be escalated to the BCF Programme Board. The HWB Board will receive quarterly reports of progress, high-level risks and any mitigating actions. It has been agreed, as part of the development of the management of the BCF, to hold a system-wide workshop to ensure that commissioners and providers alike understand the impact of risks on each of the schemes and the overall BCF.

There is a risk that:	**How likely is the risk to materialise?**	**Potential impact**	**Overall risk factor**	**Mitigating Actions**
	Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	*And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	*(likelihood *potential impact)*	
BCF does not achieve the planned reductions in Acute activity at the required rate due to delays in implementation impacting on developments, or unanticipated cost pressures slow down implementation	4	5 Overall activity reductions are forecast at £1.475m in 2015/16. A 20% impact would therefore increase the cost base for commissioners by c£300K	20 High	Monthly monitoring at a senior level through the /STAR Group and Urgent Care Boards, and Ongoing monitoring of emergency care admissions, Reablement Services (beds and community) etc
The existing contractual arrangements with providers not conducive to the commissioning of new models of care	3	4 Commissioner failure to realise financial benefits System failure to	12 Medium	Health and social care community commitment to the development of new models of outcome based contractual models.

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
resulting in the failure to realise the service and financial benefits expected for the BCF schemes		achieve benefits of schemes / programme Financial impact –as above		Monitored through STAR Group and Adult Care Board
Social Care cuts affect delivery of targets and ability to fund preventive services.	4	5 Financial impact on CCG commissioners and Local Authority.	20 High	Current consultation and engagement seeking how to minimise impact. Ongoing leadership from the Adult Care Board /HWBB to ensure that there are sufficient resources to realise our BCF vision and meet targets - reallocation of BCF resources where necessary/appropriate
Quality of care and financial stability of providers across all sectors is adversely affected due to the changes proposed	3	4 Impact on outcomes in Domains 4&5 of NHS Outcomes Framework, and Domains 3&4 of the Social Care Outcomes Framework Impact on service providers which is at this stage not quantifiable	12 Medium	Ongoing leadership from the STAR Group and Integrated Care Board Early engagement of partners with work programmes agreed in partnership at a senior level
Agreement for whole scale change from all partners, including changes to ways of working is not forthcoming	3	4 Change does not happen at the required scale and pace which will impact on achievement of performance metrics. This will then require additional non-recurrent support from commissioners	12 Medium	Ongoing leadership from the STAR Group Workshops in Nov 14 to develop whole system 5 year plan. Followed by system wide transformation plan (to include BCF schemes) Planned change management approach for all organisations involved to communicate these changes to the front line
National changes to Urgent and Emergency Care (primary care, A&E and OOH) and changes to the primary care contract impact on the design of schemes	3	4 Potential impact on commissioners in relation to the value for money from contracts, impact on	12 Medium	NHS England Area Team representation on the STAR Group and Integrated Care Boards

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
		providers implementing the requirements of the contracts (including the potential for financial impact where requirements are not met).		
Insufficient recruitment of qualified and skilled preventive staff	4	5 Staffing and skill shortages for new key front-line staff. While not all new schemes require significant additional staffing, the impact will be on additional costs (locum staff) or non-delivery of savings. This will have to be assessed in due course at individual scheme level	20 High	Monitoring at a senior level through the STAR Group and Integrated Care Boards Identify as a key enabler for service change Early & ongoing engagement with LETC & LETB Workforce development plan in place, including a succession plan Review recruitment and retention plans (annual)
'Sign up' and cultural change from all partner organisations is not achieved resulting in failure to deliver the schemes/programme	2	4 User experience and outcomes remain unchanged / worsen Staff satisfaction remains unchanged / worsens Organisation (health and social care, commissioner and provider) failure / system failure. Financial impact –as described above	8 Medium	Monthly monitoring at a senior level through the STAR Group and Chief Executives/Strategic Directors Leadership Group (Health and Social Care)
Patient/Service User/Carer resistance to schemes requiring behavioural change will	3	3 Decreased user satisfaction Organisations:	9 Medium	Implementation of stakeholder engagement strategy. (NB: stakeholders have already been broadly

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
result in failure to achieve reductions in health and social care activity		Provider activity levels remain unchanged or potentially increase (with potential impact on the delivery of access standards) Commissioners unable to realise financial benefits and potentially have increased cost of additional activity.		engaged in the development of strategic and local plans and have a strong voice from structural i.e. committee level and local/neighbourhood/client group/GP practice level.
Impact on the Voluntary and Community Sector has not been fully scoped.	3	4 The voluntary sector play a key role and any funding changes would adversely impact on the BCF	12 Medium	To utilise the information from the 2014/15 projects and associated BCF activity to provide more detail.
Information Governance: local arrangements contingent upon national agreement	4	4 Difficulties in sharing patient / service user information between health and social care professionals No anticipated financial impact	16 High	Monthly monitoring of situation at a senior level through the System Resilience Group/STAR Group and Integrated Care Boards Informal local systems in place for MDTs and community staff
Primary Care: Increased pressure on Primary Care practices via GMS changes & workload demand in the light of current workforce issues, means they are unable to respond to changes in ways of working	4	4	16 High	CCG /Area Team co-commissioning proposals Engagement of Primary Care in all service developments CCG to sponsor a Pilot for Primary Care involvement in collaborative commissioning.

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

Background

Our BCF plans are factored into 2-year operational and 5-year strategic plans and are in turn reflected in the 5-year strategy of the local acute trust (Derby Hospitals Foundation Trust – that have signed off this plan. These have been considered and signed off by the Governing Body and the H&WB. NHS England, Monitor and the Trust Development Authority (TDA) are currently triangulating commissioner and provider plans including the management of risk and associated mitigations.

Within the Derby City Better Care Fund, the financial value of the non-elective admission saving/performance fund is calculated as £1.47 million in 2015/16, representing a 3.5% reduction in Southern Derbyshire CCG responsible activity, in line with national expectations.

The value of the NHS commissioned out of hospital services is greater than the ring-fenced fund of £3.11 million within the BCF; we expect the P4P element to be released by a combination of savings brought about by the out of hospital commissioned services and the schemes within the H&WB element of the BCF.These include a combination of "quick wins" and longer term schemes that will have sustainable benefits beyond the course of the 5-year strategic plan.

Financial risk falls mainly on the CCG as commissioner, in that if the reduction in emergency admissions is not achieved, this would mean that the CCG will bear the cost of these admissions, as well as the cost of the investment in BCF initiatives. This risk is managed primarily through the setting of a QIPP target and a robust QIPP programme that treats BCF as a cost pressure and puts in place a broad range of initiatives to achieve efficiencies to match. We have established robust arrangements with our acute providers to monitor delivery of QIPP plans.

In terms of the risk to providers, if the BCF is successful in reducing emergency admissions, there is a risk to providers that there will be some 'stranded costs', primarily fixed costs that the trusts may not be able to take out of the system immediately. These 'stranded costs' are already recognised in our local acute provider's plans.

Quarterly reconciliation on the P4P element will be signed off by the CCG's Clinical Commissioning Committee and they will be responsible for all over performance within their P4P allocation. Any variation from plan will be analysed and investigated. The CCG will take corrective action and implement appropriate recovery plans. P4P 'at risk' funding will be paid proportionately in line with the split of contribution to the reduction in non-elective admissions, as per Part 2 of the template based on resident population. Work will be on-going during the rest of the year to finalise the detail behind these arrangements.

CCGs have historically managed activity variances, and have a number of process and governance structures in place to identify these early and mitigate. SDCCG hold both contingency and specific risk reserves based on calculated risk at plan stage, so these resources will be utilised should investment be needed for any mitigation or corrective action.

The financial risk to the BCF Plan is the failure to meet the Payment for Performance target and therefore additional non-recurrent investment available via the BCF is reduced. This will affect all commissioners across health and social care. However the Payment for Performance element will not form part of the Adult Care or Health's recurrent expenditure plans. The financial risk remains with commissioners whilst

alternative models of commissioning and contracts are explored.

The total P4P will be subject to the following measures:

- The performance-related funding will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 2015/16, against the trajectory set out in the BCF plan.
- Payments will be made in arrears: May 2015 (based on Q4 2014/15 performance); August 2015 (based on Q1 2015/16 performance); November 2015 (based on Q2 2015/16 performance); February 2016 (based on Q3 2015/16 performance).
- At each 'payment point', SDCCG will release money into the BCF fund on the basis of performance to date, against plan. Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned full-year reduction against the baseline).
- A projection of performance against the trajectory will be made and in utilising this Derby Adult Care and SDCCG will prioritise an agreed schedule of non-recurrent investments in service developments to support the Better Care Fund implementation.

The performance fund remaining for non/reduced performance will be used by SDCCG to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector.

6) ALIGNMENT

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

The Derby Better Care Fund plan is congruent with the Council's Adult Social Care strategy: *Your Life, Your Choice* (see attached). The *Your Life, Your Choice* strategy is complementary to the CCGs 2-5 year strategy with the Better Care Fund plans representing an over-lapping and shared set of priorities.

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

The Derby City BCF and the CCG 5 year plans share a common vision based on the "National Voices" work – that "! can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me"

The table below highlights the links between the 3 Derbyshire County BCF Themes and the South Derbyshire Unit of Planning Objectives as agreed in 14/15 Planning submission. Whilst the BCF and Operational plans are well aligned, these links will be further tested as part of the development of a system wide 5 year plan, which is due to report in November/December 2014.

South Derbyshire Unit of Planning Objective	Linked BCF Theme
Build strong asset based communities	• Self Help, Prevention & Community Resilience
Support people to remain independent & in control of their lives	• Self Help, Prevention & Community Resilience
Provide support in the community when needed & reduce the need for hospitalisation or admission to long term care	• Integrated Community Based Support • Reducing delayed discharges and admissions to hospitals and care homes,
Improve outcomes and the quality of services provided – promote recovery	
Reduce inequalities	

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.

The model for co-commissioning is still under discussion in Southern Derbyshire and has yet to be finalised with the Area Team. However the developing model of services described in our Strategic plan and in this BCF report recognises the central part General Practice has to play.

This is emphasised in, for example, the Kings Fund report Commissioning and Funding General Practice (Addicott and Ham, 2014), general practice needs to be central to the development of community services. At the same time, general practice needs to evolve rapidly to work 'at scale' if it is to play the central role envisaged in the report. We therefore see the main benefits of co-commissioning as providing a greater opportunity to commission in a holistic way fully including primary medical care.

The main benefit of co-commissioning for us therefore is the ability to re-model provision and have the necessary impact through commissioning across the full range services. We have already commissioned and implemented 26 Community Support Teams (through two different providers; City and County) and GP practices are at the heart of a new range of out of hospital services.

To achieve the necessary integration of acute and community services and general practice requires, as a minimum, a comprehensive understanding of the funding,

workforce, estate and incentives that are influencing each part of the system. The scope of co-commissioning sought by SDCCG therefore would include:

- A greater exchange of information about practices as providers to enable SDCCG to better understand and model the pressure points affecting one of its major providers.
- A more direct ability to influence the implementation of the agreed local primary care strategy and ensure its alignment with SDCCG's five year strategy implementation.
- The ability to integrate some fragmented aspects of the current arrangements – for example the development of a premises strategy for primary care which needs to be driven by the strategic direction of the CCG.
- The ability to tailor some national incentive schemes (Directed Enhanced Services), or the way in which they are communicated, to be more consistent with SDCCG's five year strategy
- The ability to pool budgets or for the CCG to take delegated responsibility eg minor surgery DES where CCG is keen to increase to shift activity from hospital to primary care as a more appropriate and cost effective setting.
- To influence the review and future development of PMS practices to achieve greater consistency with the five year strategy and, where possible, to reduce inequalities in service provision.
- To develop closer links between the monitoring and development of the quality agenda in primary care.
- To explore the potential to pilot changes to the Quality and Outcomes Framework to improve patient care
- The ability to align incentives across the whole system and test new models of contracting that support greater integration and better reflect local needs

These are all areas in which there are already good working relationships with the Area Team but which would benefit from clearer definition of responsibilities and which would help SDCCG deliver a more comprehensive and consistent implementation of its strategy.

SDCCG does not seek any involvement in commissioning of the core contract for general practice.

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)

Our definition of protecting adult social care services consists of (a) financial assistance to maintain current levels of support (b) sufficient funds to implement the duties of the Care Act and (c) additional funding to assist in meeting known increases in the number of older and younger adults with increasinglycomplex needs arising from disability and long term conditions.

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

In thecontext of the Better Care Fund,our priorities for protecting social care services are:

- Ensuring the ability to respond to demography/increasing social care needs of youngeradults with disabilities and older people
- Funding the costs of Care Act implementation
- Maintaining essential social care services
- Funding innovation in social care in line with transformation plans to improve social careoutcomes and realise savings and efficiencies in both health and social care budgets

One of the main themes across our BCF plan is the principle of reducing dependence on health and social care services.

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.)

The local authority budget remains extremely challenged, requiring savings of £77m over the next three years from September 2013. The latest forecast requires savings of £81m to balance the budget. This includes £29m in 2014/15, £31m in 2015/16 and £21m in 2016/17. The total savings required from adult social care equate to approximately 30% of the 2011/12 budget and represent a real term cut of around £7m or 11%.

Funding from the BCF will protect the existing level of resource for personal budgets and care home placements **and** it will fund the required growth in community-based support in order to help deliver savings from acute hospital provision.

The BCF contains £4.29m of funding to protect adult social care services in 2015/16. This will primarily be utilised to protect eligibility criteria and ensure adequate care package sizes and quality of supply in the local care market. A further £618k of funding is also identified to support the introduction of the Care Act. This is Derby's share of the national £135m allocated for this purpose via BCF. The latter funding shall be deployed to improve information and advice, assessment capability and revised training for the workforce on revised eligibility and charging frameworks.

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

Oversight of the Care Act implementation is being managed via an internal Transformation Board chaired by the Strategic Director of Adults, Health and Housing services.
The Council has responded to the current Care Act consultation in full. We have completed the recommended financial modelling of the Care Act implications and understand the resource requirement for the Care Act.
The Council has undertaken a gap analysis between the Care Act guidance (consultation document) and current practice/services available in the city. We have broken down the work areas in to the following headings;

- Information and advice
- Support Planning
- Personal Budgets
- Direct Payments
- Prevention
- Safeguarding
- Workforce
- Carers
- Charging for Care
- Market Oversight

There shall be a review of all policies and procedures in the service areas detailed above. We shall develop final actions and projects as part of an overall programme plan to deliver on the required changes, once the Care Act guidance is finalised. This will involve working with key partners in health to ensure policies and service plans align with integrated provision.

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

Carer specific support shall be funded in the amount of £616k. We shall continue to jointly commission our one stop carers drop in centre via Derbyshire Carers Association. Health and Social Care commissioners have a good relationship with carers through the local Carers Strategic Board. Decisions on commissioned services and carer experience is considered in a multi- dimensional meeting
The services provided with the BCF funding shall build on the support we provide for carers on a range of needs;

- Information and Advice
- Carers Assessment
- Carers Direct Payments
- Short breaks provision
- Carer Training
- “Just in Case” Emergency plans
- Support Carers Ambassadors
- Register Carers with GP Practices
- Identify and support carers from hard to reach communities.

Our carers’ strategy recognises the importance and value of family and informal carers to the whole local health and social care system. We understand that the 2011 census returned 9902 people who considered they were providing twenty or more hours of care per week, on an unpaid informal basis. We recognise the priceless contribution these carers make to the whole health and care economy.

Our resource allocation system is one way of putting a value on the benefit of informal care and our experience is that on average a carer’s involvement reduces the level of need that is required to be met by statutory services by 36%.

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

The local authority’s budget remains significantly challenged in the current and next CSR period, subject to any national change. The Council has to save a further £77m (35%) of the Councils budget (excluding schools) over the next three years.
The original BCF plan contributed to the Councils spending power by £11.680m in 2015/16. Thereby contributing 5.6% to the Council’s overall budget. The revised BCF plan shall continue to contribute this level of spending power to the Council’s budget, subject to performance on emergency admissions metric. The performance element maximum pool of £4.586m shall be retained in the plan and released against emergency admissions performance targets as required. This shall adversely impact on the Councils budget by up to £713k should the entire emergency admissions target of 3.5% not be met., This remains a risk to the overall finances of the health and social care locality of Derby. The risk around the performance element of the BCF shall be highlighted and mitigated in the S75 Agreement covering the BCF.

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 are committed to supporting seven day discharge facilitated through availability of appropriately scaled seven day health and social care services across the city. The thread for weekend work starts with having an efficient system in operation during the week which ensures maximum discharge activity during the week which reduces pressure on weekends. There will be a seven day presence to facilitate the required discharges at weekends. Routine availability of key services shall be made available on a Saturday and Sunday. A joint approach to this between health and social care systems will be needed to create an efficient and effective model.

Work during the winter has provided a firm basis for the future development of 7 day working. This has included pilot programmes for:

- The co-location of primary care services in A&E department at Derby Hospital during the weekend
- The extension of the available hours for the Single Point of Access in Derby City to cover weekend working.
- 6 day working in hospital departments to reduce variation in flow through the hospital at weekends
- Use of Care Home beds to enable discharge to assess throughout the week
- Use of Derby City intermediate care beds to facilitate hospital discharge
- Additional funding for social care to provide more cover at weekends

Schemes are still being evaluated, although a key message from this work is the need to strengthen intermediate care services. Additional funding has been identified in the BCF to enable early investment in therapy staff. We will ensure weekend discharge arrangements operate effectively through making available key decision makers and services required to support discharge.

In addition to this Derby Hospitals NHS Trust are participating in an audit of 7 day services within their Trust, following the Keogh review. The plan for this work is highlighted below and will be tracked through Contract arrangements.

	Milestones	**Timescales**	**Update**
Seven Day Working	1. Review of current progress towards implementing the 10 Clinical Standards, to be carried out on behalf of DHFT by Chesterfield Royal Hospital FT.	1. Review to be completed by end of August 2014	A review of the 10 Clinica Standards was requested the East Midlands Acute CEOs which is led by ATOS in respect of 7 d services. Data has been submitted to ATOS by all regional Acute Trusts relevant to the 10 Clinical Standards and the finding of this data will be presen to those participating Trus

			by 22nd August.
	2. Following completion of the review, develop an Action Plan for DHFT. The Action Plan will contain measurable milestones and timescales for implementation in the remainder of 2014/15 and 2015/16.	2. Action Plan to be developed by end of September 2014	Sharing of these outcomes will be presented to Specialities and plans will be produced to review opportunities and share successes which will take place throughout late August and September. A presentation of the final report will be presented to the CEOs in October 2014 which will include potential collaborative working and Trust specific actions.
	3. Further milestones will be described in the Action Plan	3. Timescales will be described in the action plan	Final report to be shared once presented to the CEO's.

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

All Health services use the NHS Number as the primary identifier in its correspondence.

Adult Social Care is in the process of moving to this, routinely using the NHS Number for new clients. Work is on-going to roll this out amongst existing clients (older people pilot) and it is expected that NHS number will be available for all ASC clients by April 2015. Adult Social Care has already undertaken a NHS number matching exercise for all open customers. The identified NHS number shall be populated into the new social care system and be referenced on all correspondence with customers.

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

We are committed to adopting systems based on Open APIs and Open Standards. Currently we use:

- System 1 and EMIS Web in Primary Care practices and increasingly for Community Health Services

Adult Social is implementing Liquid Logic Adult Social Care solution which has open architecture capability to link and interface with health systems as required and authorised through IG controls.

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, and professional clinical practice and in particular requirements set out in Caldicott2.

NHS Organisations and the local authority in Derby fully support the principles of information governance and recognises its public accountability, but equally places importance on the confidentiality of, and the security arrangements to safeguard, both personal confidential information about patients and staff and business sensitive information.

The CCG recognises the need to share patient information with other health organisations and other agencies in a controlled manner consistent with the interests of the patient and, in some circumstances, the public interest.

The CCG believes that accurate, timely and relevant information is essential to deliver the highest quality health care. As such it is the responsibility of all clinicians and managers to ensure and promote the quality of information and to actively use information in decision-making processes.

Accordingly, the CCG sustains robust Information Governance Frameworks which detail the way that the CCG will deliver against the national and legal information governance requirements and includes:

- Demonstrating annual compliance with the key IG toolkit standards through achievement of at least level 2 Performance in the requirement within the NHS IG Toolkit and ensuring plans are in place to progress beyond this minimum where it has been achieved. The requirements of the IGT cover all aspects of information governance including:
    - Information Governance Management
    - Confidentiality and Data Protection Assurance
    - Information Security Assurance
    - Clinical Information Assurance
    - Secondary Use Assurance
    - Corporate Information Assurance
- Mandating all staff to complete basic IG training annually appropriate to their role through the online NHS IG Training Tool or other method approved by the Department of Health;
- Continuing to report on the management of the information risks in statements of internal controls and to include details of data loss and confidentiality breach incidents in annual reports;

Overall accountability across the organisations lies with the Chief Operating Officers who have overall responsibility for establishing and maintaining an effective information governance assurance framework for meeting all statutory requirements

and adhering to guidance issued in respect of procedural documents.

In response to The Caldicott Review 2012, NHS organisations have a nominated Caldicott Guardian whose responsibility is to act as the 'conscience' of the organisation.

The Guardian actively supports work to facilitate and enable information sharing and advice on options for lawful and ethical processing of information as required.

The local authority maintains strategic oversight and management of its information governance duties through a formal Information Governance Board which is chaired by the Strategic Director of Resources. The Strategic Director of Adults, Health and Housing fulfills the duties of the Caldicott Guardian for the Council and sits on this Board.

The Derbyshire Partnership Forum (DPF) signed off the 2013 Information Sharing Protocol at its meeting on December 13th 2013. The DPF brings together a wide number of public sector agencies including those from social care and health sectors. The information Sharing Protocol provides a high-level agreement between agencies on information sharing, covering the principles and minimum standards that need to apply. The document can be found via this link:

http://www.derbyshirepartnership.gov.uk/images/Derbyshire%20Partnership%20Forum%20ISP%20-%20v%203%204_tcm39-112507.pdf

An information sharing agreement has been endorsed by the DPF as the framework for future individual sharing agreements between partner organisations

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

(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

Under the enhanced service 'Avoiding unplanned admissions; proactive case finding and patient review for vulnerable people' GP practices are tasked with identifying patients as high risk, and sets a target of 2% as the number of patients likely to be at high risk.

The enhanced service asks GP practices to use a risk stratification tool. However we continue to await clarification for the Information Governance surrounding the use of risk management tools. In the meantime, local systems are being utilised. Currently

individual teams are using a range of criteria and approaches to assess risk, including co-morbidity, number of Long Term Conditions, hospitalisation, falls and recent bereavement. The comprehensive development of formal liaison/link Social Worker arrangements by district community social work with all GP practices during 2013/14 has strengthened care co-ordination and priority case management.

Further pilot development work to accelerate the development of integrated care teams based on several local communities and working with specific GP practices are part of the PDSA cycle underpinning the implementation of the system plans for the UOPs.Current existing processes will be systematised with the introduction of standardised risk stratification tools (to be rolled out in 2014/15) and formalised approaches to allocating a lead professional and agreeing accountability

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

In ourintegrated care model there is a structured approach to the assignment of the Accountable Lead Professional function, reflecting the multi-disciplinary/professional assessment of each person's care needs and the decision of which care professional is best placed to provide professional leadership and co-ordination; depending on individual circumstances as discussed at the multi-disciplinary team meeting i.e. whether it should be GP, Community Matron, Social Worker or other professional. There is cross-organisational agreement that the Lead Professional should be the care professional best placed to undertake the role for the individual. Teams are predominantly case managing people with highly complex needs, incorporating joint care planning and accountability.

The current default position is often the GP and this looks likely to be strengthened within the GP contract during 2014/15 as well as the outputs from the time-limited Assessment & Lead Professional project.

Recent evaluation of existing national schemes demonstrates that there will be benefits from extending the approach to include people who are at the top of the high risk category i.e. people who are at risk of developing more complex needs.

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

As discussed in section (i) above by the end of September 2014 2% of patients will have a care plan in place. These will have been developed and led by General Practice, however in Derbyshire because of joint working already in place many of these will already in fact be joint care plans. In addition there are a number of other patients (for example those with complex mental health needs) who already have joint care plans. Work is ongoing to quantify this number.

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

Our Vision for an integrated system is based on those things that people have told us are important to them and our analysis of our whole system challenges. We have been working together on Integrated Care for two years and the Better Care Fund projects represent a contribution to agreed wider system change. It is informed through our on-going work as well as some specific engagement programmes described below.

21st Century HealthCare Consultation:- Consultations across Derbyshire have already been held to give members of the public the opportunity to join the debate on finding better ways of delivering healthcare whilst at the same time meeting new and increasing demands for services and managing costs. The first stage was to develop a set of principles on which difficult decisions could be based in the future. The consultations involved 6 public meetings across Derbyshire including the City and a survey. Over 1000 people participated across the City and County

Call to Action & Health Panel Events:-The CCG has run a series of engagement events involving over 200 people to discuss the challenges currently facing the NHS and to help the CCG develop future commissioning priorities. So far 7 events have taken place with staff, members of the public, stakeholders and members of the voluntary sector focusing on what the CCG needs to do to further support patients; what patients can do to support themselves; how can quality in the NHS be improved and how can the CCG build an excellent NHS for now and the future. (Summary available)

The 50+ Forum:-The 50+ Forum is a regular engagement meeting with people aged 50+. The group provide feedback on all aspects of services affecting older people including service gaps. The group is a useful sounding board and co-production platform for commissioners developing or retendering services.

Healthwatch: Healthwatch Derby has a seat on the HWBB and has been party to the draft plan vision and principles. Healthwatch Derby shall be party to sign off of the final plan in March 2014. The expectation is that the local Healthwatch organisation shall engage with local people on the Better Care Fund plan. They shall provide the independent customer experience dimension on delivery of the specific initiatives.

City Carers Forum:-The City Carers Forum is a multi-agency forum chaired by an independent carers' representative. The forum is focussed on supporting carers to continue caring whilst being able to lead their own life. The group makes decisions on spending, carer assessments, commissioning carers services and measuring outcomes for carers.

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

We have been working together for two years to develop an integrated care system for frail and older people (see *Strategic Outline Business Case for Development of Integrated Care System for Frail and Elderly, March 2012) .*This submission upon that strategic work undertaken across the Derby Health and Social Care Community through a number of key commissioner & provider groups described below.

Southern Derbyshire Integrated Care Board: -This strategic Board has clinical & managerial representatives from all Health & Social Care partners across Southern Derbyshire. It is chaired by SDCCG Clinical Chair. It is a board which oversees the implementation of our existing integrated care programme

Southern Derbyshire Urgent Care Executive:-This strategic Board has clinical & managerial representatives from all Health & Social Care partners across Southern Derbyshire. It is chaired by SDCCG Clinical Urgent Care Lead. This board oversees the implementation of our existing Urgent Care Improvement programme.

We also meet monthly as a Chief Executive forum across Derby city and Derbyshire – both commissioners and providers where the BCF plans for both Derby and Derbyshire have been circulated and discussed.

ii) primary care providers

Southern Derbyshire CCG Membership Forums:-The membership forums are open to all GPs from its 57 membership practices. The sessions are used to consult with members on CCG strategy as well as to steer implementation.

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

Residential & Home Care Forum:-Senior Council commissioning staff meet regularly with Independent and voluntary sector care home and home care representatives operating in Derby city. The forums address commissioning intentions, safeguarding, personalisation, capacity issues, compliance with essential standards of care, quality, outcomes, staff development and customer satisfaction

Voluntary Sector Integration Events:- The CCG ran a specific event to discuss how the CCG and voluntary sector might have collectively work to improve local

services, and provide an opportunity for the voluntary sector to share with the CCG what they see to be some of the main issues facing users of services. The event was attended by over 80 people representing a range of local voluntary sector organisation. (Summary available).

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?

Derby Hospitals FT is the Acute provider that serves the needs of the Derby City population. Southern Derbyshire CCG have been working with the Trust to ensure that there is a shared view of activity changes on service delivery targets.

Much joint work has taken place over the last two years to develop Urgent Care services in the City, which has resulted in great improvements in A&E performance and improved flow through the hospital. This work continues through the Joint Urgent Care work-streams.

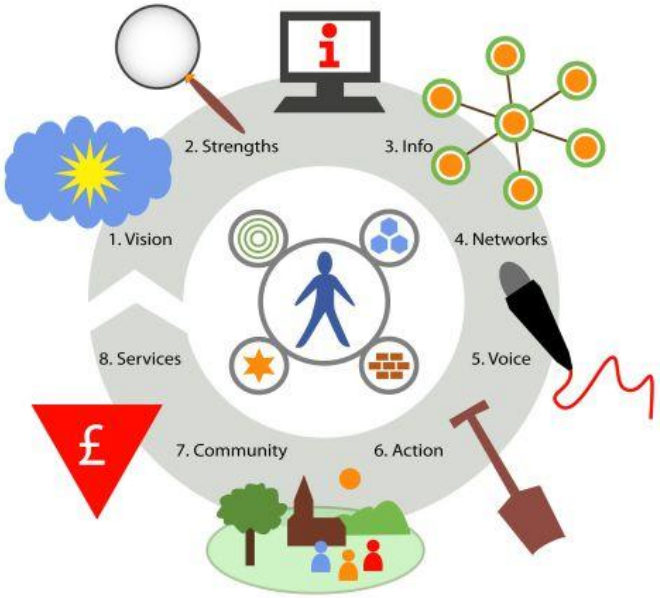
The need to focus on greater transformation of Out of Hospital services is recognised and consequently the CCG, the City Council and all local NHS providers have agreed to develop a joint 5 year plan detailing the key Transformation schemes and the impact they are expected to have. BCF schemes will be an integral part of this plan.

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

Scheme ref no.
1
Scheme name
Self-help, Prevention and Community Resilience
What is the strategic objective of this scheme?
This scheme relates to segment one of the “care wedge”. Its strategic objectives are to: • Help people help themselves as much as possible • Delay/ negate the necessity of approaching statutory services for support. • Facilitate people finding solutions within their own community • Build up community resilience and social capital
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?
This scheme comprises a suite of services which support and develop the strategic objectives detailed above. In detail they are: **(a) Local Area Co-ordinators**: Local Area Co-ordination is a unique and innovative approach to supporting people who are vulnerable through age, learning disability, physical disability, sensory impairment or mental health issues to identify and pursue their vision for a “good life”, to strengthen the capacity of communities to welcome and include people and to make services more personal, flexible and accountable. Local Area Coordination aims are to: • help people to stay strong and safe • nurture valued and supportive relationships • build individual and family leadership • support local or non-service solutions wherever possible • build more welcoming inclusive and mutually supportive communities • Contribute to making services more personal, flexible, accountable and efficient. As a single, local accessible point of contact for local citizens, it becomes the new “front end”, the place where relationships are formed and expectations set for the pathways and partnerships that follow it also offers the opportunity to simplify and integrate the service system(s) for local people. Originally developed in Western Australia in 1988 and subsequently developed across Australia. LAC projects are now starting in multiple sites across England. In supporting citizens to articulate their vision for a good life, recognising and making best use of the individual and community resources around them the LAC approach begins to "push back" the more formal services approaches. This doesn't ignore the

crucial role that specialist services have to play in supporting the people we serve, but recognises that this offer should be the last resort as opposed to the first, **a good life is a community life not a service life.**



LAC has been piloted in two of the most deprived wards of Derby and evaluated. On the basis of the Derby University led evaluation we are now rolling out LAC across the whole of the city over the next two years expanding into a further four wards in 2014/15 and the remaining three wards in 2015/16.

The investment in the scheme shall be £300k in 2015/16 consisting predominantly of staffing costs for six additional staff with a minor spending budget to facilitate LAC's and communities to create opportunities to build social capital.

The short term expected benefits are to avoid 30 packages of care through self help and community support. The build up of social capital shall have the longer term benefit of creating sustainable asset based community approaches to avoid isolation and deterioration requiring statutory service intervention.

A database of interventions is already in existance through the pilot, this shall be used to capture the work of the additional LAC's to monitor activity and capture outcomes. The BCF investment shall create the opportunity to establish a LAC in each community to support the approach identified above. Based upon the success further consideration shall be given to additional investment.

The LAC's shall be an integral part of the community support teams resource to support people in the community. The Reablement indicator shall be used as a partial proxy measure to evidence the success of the LAC team.

a) **Handyperson scheme**: this service provides free and low cost repairs and

minor works to vulnerable households. The service is targeted at over 65's living in the community. The annual adult social care survey has highlighted older people's support and need for this service. They often comment on the inability to obtain trades people to undertake minor work that they can no longer do themselves. Fear of mis-selling, poor quality of work and exposure to unregistered trades people are all barriers older people face when faced with requiring this type of work.

We shall invest £200k of the BCF fund in to this scheme to cover staffing and materials to support people with minor repairs and works to enable people tocontinue to live in the community. The scheme combined with the Healthy Housing Hub shall deliver a conservative number (seven) of avoidances to residential care. However, the scheme shall have a significant beneficial impact on approximately an additional 150 households, throughout the course of 2015/16. The activity levels and outcomes are already recorded and have informed the BCF investment decision.

b) Healthy Housing Hub: this is an award winning service that recognises the link between poor housing and poor health. The service case finds in the community and delivers housing solutions to vulnerable people. It does a considerable amount of work installing safe and effective heating. The service operates effectively with the handy person service and targets the most vulnerable people using funding from national schemes on winter warmth, energy efficiency and climate change to improve housing environments to maintain people's independence in the community and improve their levels of safety and quality of life. A BCF investment of £200k shall be targeted at the Healthy Housing Hub to support its continued operation and links to the handy-person service and the community support team activities.

c) **Carers support :We are aware the 2011 census recorded 25000 carers in Derby with over 9900 providing 20 or more hours of care per week.**We shall continue to jointly commission our one stop carers drop in centre via Derbyshire Carers Association. Health and Social Care commissioners have a good relationship with carers through the local Carers Strategic Board. Decisions on commissioned services and carer experience is considered in a multi- dimensional meeting.

The services provided with the BCF funding shall build on the support we provide for carers on a range of needs;

- Information and Advice
- Carers Assessment
- Carers Direct Payments
- Short breaks provision
- Carer Training
- "Just in Case" Emergency plans
- Support Carers Ambassadors
- Register Carers with GP Practices
- Identify and support carers from hard to reach communities.

The value of carers support to the health and social care economy is well understood and the support offer to carers is appropriately scaled.

The BCF shall invest all of the allocated Carers grant into carers services in 2015/16 amounting to £616k. The carers service outcomes are measured through the carers survey and provider monitoring. The local authority is aware through its resource allocation methodology that each package of care with a carer's involvement costs £2178 per annum less than packages without carer involvement. We estimate that we can apply this assumption to at least 50 new packages of care each year. The benefit of those packages where the person would not be able to remain in the community without a carer has not been quantified for this purpose, to avoid any double counting.

d) **Dementia Support Service**: This is a dedicated service that people are referred to on receipt of a diagnosis from the memory assessment service. It offers advice, information, training and practical help to the person with dementia and their family. It also offers social contact and support amongst fellow dementia sufferers. This service links directly to the local metric, diagnosis rate for people with dementia as a critical part of the diagnosis experience. The service is well established and shall be funded through the BCF in 2015/16 £235k. The availability of this service provides confidence to GP's that following diagnosis of dementia, a support services offer shall be available to direct people and their carers into, particularly for those people living in the community.

The dementia support service provided direct one to one support to 573 people in the first six months of 2014, with a further 1120 people benefitting through group activities and befriending sessions over the same period.As this service has already been operating in the city we estimate there shall be a marginal impact on further residential admission avoidance. We have estimated the benefit at fifteen people over the course of 2015/16.

From the local metric information we are aiming to diagnose 514 more people than the current baseline at the end of March 2014. This represents 24.2% more people than in the baseline and has a 16.7% impact on the diagnosis rate by 2015/16.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

(a) The service is commissioned and provided by Derby City Council.
(b) This service is commissioned and provided by Derby City Council
(c) This service is commissioned and provided by Derby City Council
(d) These services are commissioned by DCC in a lead commissioning arrangement with the CCG and provided by a range of organisations including the VCF and independent sector.
(e) This service is commissioned by DCC and provided by Making Space, a voluntary sector organisation

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

Local Area Co-ordination:

From Service Users to Citizens by Ralph Boroad, Centre for Welfare reform, 2012

Derby Local Area Co-ordination, Evaluation report by University of Derby, September 2013

Building the capacity of individuals, families and communities by Lesley Chenoweth and Daniela Stehlik, 2002

Review of the LAC Program in Western Australia, Disability Services Commission, March 2003

Housing interventions:

Association of Directors of Adult Social Services, Housing Learning and Information Network (2012).

Strategic housing for older people: planning, designing and delivering housing that older people want. Resource pack. London: Housing Learning and Improvement Network. Available at: www.housinglin.org.uk/_library/Resources/Housing/SHOP/SHOPResourcePack.pdf (accessed on 17 December 2013).

Carers:

A national strategy for carers, London, Department of Health, 2013

Allen K, Glasby J (2010). *The billion dollar question: embedding prevention in older people's services –*

10 high impact changes. HSMC policy paper 8. Birmingham: HSMC.

Dementia:

Dementia: supporting people with dementia and their carers in health and social care. Nice clinical guideline 24. London: National Institute for Health and Clinical Excellence, 2014.

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

All of the above schemes will have additional, non-financial benefits or non-measurable benefits. Outcomes include:

- Increased self-esteem
- Greater opportunity for patient choice regarding location of care
- Patients feeling well supported with high satisfaction levels
- Reduced demand on Statutory services

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?

This scheme reports to the Integrated Care Programme Board. Each project has its benefits described and a methodology for measuring them which is monitored over the year.

What are the key success factors for implementation of this scheme?

Many of the services in this theme are tried and tested with a well-established evidence base for their efficacy.

The most pioneering aspect of this scheme is taking the Local Area Co-ordination model from Western Australia and applying it to all client groups (in Australia it was focused on people with disabilities). We have set up a country-wide action learning set to share the learning from other areas as they also roll out LAC. We have also managed to get Eddie Bartnik, the founder of LAC in Australia, to be the ALS "patron". One of the key success factors in rolling out LAC is to
(a) involve the community
(b) recruit the right people and
(c) Extend your LAC areas by building out from an established LAC neighbourhood rather than "pepper pot" development.

Engaging with older people and Carers. The CCG and Council has engagement groups to support dialogue and service development with older people and carers.

The dementia support service is reliant upon good engagement with people suffering from dementia and their families. The service offer to these people is important as it should reflect their needs and wishes and demonstratively improve their outcomes and quality of life.

Scheme ref no.
2
Scheme name
Integrated Community-based Support
What is the strategic objective of this scheme?

This scheme covers segment two of the "care wedge", focusing on care delivered in the home or close to home and based on blocks of population of 20,000. Its strategic aims are:

- to provide person-centred care that promotes independence and recovery
- through an integrated approach reduce hand-offs and duplication
- improve the experience of the individual when accessing care

- focus on the top percentage of people with complex needs who frequently attend hospital

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?

We have recently created **Community Support Teams** which are based on clusters of GP practices and based on populations of approximately 20,000. The teams are made up of General Practitioners, social workers, primary and community health services staff. They are supported by a new type of worker: care co-ordinators who help to identify patientsat high risk of deterioration, arrange multi-disciplinary team meetings and provide practical support chasing up of key information relating to a persons case. The teams are designed around the evidence base provided by Torbay and NE Lincolnshire.

The work of the CSTs is supported by key community-based services such as enablement and recovery services, home support, day services, aids and adaptations. Where appropriate these are accessed via a personal budget and taken as a direct payment. One of our ambitions is to increase the number of direct payments used by older people and to increase the number of personal health budgets as we believe this approach will improve the quality of care and achieve efficiencies.

As stated in Scheme 1 the CSTs are an integral part of the delivery plan and many of the services identified in the BCF shall support the teams to be able to deliver the required level of emergency admission reductions. There is an investment of £1.5m in the community support teams in 2015/16. This spending predominantly relates to dedicated multi-disciplinary staff to operate in a collaborative way with each other and other services to avoid hospital admissions. A target of 450 admission avoidances has been assumed for the CST's and other community services in 2015/16.

The CST investment accounts for 45% of the required 990 emergency admission avoidances to hit the 3.5% nationally prescribed target reduction figure. The availability of the services below shall support the CST's to achieve their target figure.

To support these Teams in keeping people at home wherever possible, we are also working to maintain and develop out of hospital services they can call on. In particular:-

Bed Based Respite services:-

Short stay beds are available across all Council Care Homes to support step up and step down intermediate care. These beds can be used to facilitate discharge whilst longer tem decisions about the individual can be made, when they are not well enough to be discharged to their home environment.

Bed based respite care is also available for older people across all of the Council operated care homes. The service provides breaks for carers which allow them to continue caring and support the cared for to take a break from their normal environment.

Respite services shall receive approximately £1.1m of funding fromt eh BCF. This funding is not new and and has been funded through the S256 funding transfer that has taken place prior to the formation of the BCF. Whilst the benefits plan indicates a reduction of 35 residential admissions this is already reflected in the baseline figure for residential admissions, due to this being existing funding.

Integrated Community Equipment Services:-

The community equipment service is jointly commissioned between the CCG and the Council. Equipment services are free at point of delivery and are an important enabler to support people to live safely and independently in their own home. As such the hospital discharge teams rely heavily on equipment services to facilitate timely discharge. In addition, many of the care homes in the city utilise the equipment service to support people in residential and nursing care, these people may otherwise be admitted to hospital.

The provider as well as being commissioned to provide equipment ordered by professionals, was also commissioned to provide a central retail facility in order for people to be able to purchase equipment privately. This facility has been widely marketed to people with low level needs who wish to purchase equipment and small aids directly.

As we seek to keep more people out of hospital and in the community the need for equipment services shall grow. Hence there is funding in the BCF to support this growth of £611k. The majority of prescribing for community equipment is undertaken by hospital staff to facilitate discharge and we expect this to increase. We expect the additional resource which equates to approximately 50% of current health spend to have an impact of reducing by 40 nights delayed transfer bed nights.

Social Care Services:-

Social Care provides a range of services to the elderly and disabled people to keep them safe and independent in their own homes wherever possible. The ethos of social care services is that all individuals have the capacity to be enabled or re-enabled to live an independent a life as possible. To this end the model of care will have a focus on re-ablement and review to ensure people's independence is maximised.

Our social care services will cover a person's needs for;

- Personal Care
- Nutrition
- Running their Home

- Social Needs
- Learning opportunities
- Keeping Safe

A range of services have been commissioned to support the above needs, where they cannot be met through other means available to the person. These services will operate in a wrap around the individual dovetailing with health and natural supports available to the person.

The BCF shall protect social care services in the city by injecting £4.287m of funding from the BCF. This will ensure that the eligibility threshold shall be maintained at the current level. In addition, the benfits plan details the impact of this additional social care funding on delayed transfer of care, reducing residential admissions andavoiding hospital admissions. The requirement to support more people in the community shall require adult social care to commission a greater volume of packages and more intensive packages of care.
The commissioning framework in place for adult social care shall ensure there is sufficient provider capacity to deliver the additional requirements at cost effective rates.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These services are jointly commissioned by the Area Team, SDCCG and DCC.

They are provided by General Practice, Derby Hospitals Foundation Trust, Derbyshire Healthcare Foundation Trust, Derby City Council, voluntary and independent sector providers.

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

Does clinical co-ordination improve quality and save money, a review of the evidence, Health Foundation, 2013

*Managing people with long-term conditions. An inquiry into the quality of general practice in England.*Goodwin N, Curry N, Naylor C, Ross S, Duldig W, The King's Fund, 2014

The most well-known and successful example of integrated care is that of Kaiser Permanente in the U.S. which focuses on integrating services and removing distinctions between primary and secondary care for people at all stages of the risk pyramid. Multi-disciplinary teams operate out of specialist centres and people with Long Term Conditions are stratified and appropriate interventions delivered dependent on their risk levels.

- The DH funded a programme of integrated care pilots involving 16 areas in England all trialling various degrees of integration from disease specific integrated care pathways to organisational integration across health and social care services. The Torbay ICP which focused on delivering a locality based service, aligned with general practices and comprising integrated health and social care teams, for the care of older people, has demonstrated measurable progress in reducing reliance on acute hospital services and a reduction in emergency bed days used**.**

The Primary Care Foundation in 2009 undertook some detailed research supported by the Department of Health resulting in the publication of a practical guide for Practices outlining key lessons for improving urgent care. This work suggested that high quality urgent care depended on four factors:
- Access
- Speed of initial response
- Capacity
- Assessment

Recent research by Imperial College found that General Practices providing more timely access to primary care had fewer self-referred discharged A&E visits per registered patient (for the most accessible quintile of practices, RR = 0.898; P<0.001). The research concluded that policy makers should consider improving timely access to primary care when developing plans to reduce A&E utilisation.

Institute of Public Care, Oxford Brookes University: Evidence Base for Carer Support 2013

Carers at the heart of 21st Century Families and Communities; (Department of Health, 2008)

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

All of the above schemes will have additional, non-financial benefits or non-measurable benefits. Outcomes include:

- Increased number of people who receive Wrap around MDT delivery of support and maintenance within the community setting from Nurses and Physiotherapists
- Rapid access to services
- Increased satisfaction with service provision
- Increase in number of people feeling supported to live with a Long Term Condition
- Reduction in “Avoidable Emergency admissions” particularly for –
    - chronic ambulatory care conditions
    - acute conditions that should not usually require hospital admission

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?
This scheme reports to the Integrated Care Programme Board. Each project has its benefits described and a methodology for measuring them which is monitored over the year.
What are the key success factors for implementation of this scheme?
Recruitment of Community Support Teams (where additional staff) Agreed methodology for identification of high risk patients (in line with IG regulations) Implementation of regular MDT's at practice level **Availability of community services capacity e.g. intermediate care , equipment etc.**

Scheme ref no.
3
Scheme name
Reducing Admissions to Hospital and Care Homes and Delayed Discharges
What is the strategic objective of this scheme?
This scheme covers segment three of the "Care Wedge". The strategic objectives of this scheme is to: • Reduce avoidable admissions to hospital • Reduce avoidable admissions to care homes • Reduce the number of delayed discharges
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?
This scheme has a number of components which may be summarised as follows: (a) Enablement and Intermediate Care services Supporting people to recover from an acute event or loss of capability over time to make them as independent as possible. This involves mutli agency multi disciplinary staff working together to support individuals in community and bed based settings. The focus is on maximising the individuals capacity and capability to live independently for as long as possible, with wrap around on going support to ensure they are safe and can enjoy a reasonable quality of life in the community.The BCF shall invest £2.89m in intermediate care services which shall deliver 200 reduced hospital admissions through working closely with the community support teams and other community based services. Whilst the benefits plan details the reduction in residential

admissions similar to bed based respite this funding is not new as it is already in previous years s256 funding. Therefore the baseline residential admission indicator already reflects the expected level of decrease in residential admissions.

(b) "Ordinary Lives" team – assessment and support planning team that works with people with complex needs who are currently in institutional forms of care but can move into independent living in the community. A sum of £1.22m is already invested in this team through s256 funding. Working more closely with the CST's this shall yield a positive impact on hospital admissions, to contribute to the 3.5% reduction target.

(c) Out of Hours Emergency Social Care Packages
Our out of hours emergency social care response services faced with an emergency situation can end up admitting people to hospital where there is no carer or family to help an individual through the night. These people often need personal care rather than medical attention. If this service was available on a call out basis to out of hours staff this would avoid inappropriate hospital admissions.

A small of funding of £150k has been allocated to this initiative from BCF. The befits plan outlines a modest twenty hospital admissions that can be avoided through this investment. Depending on the success of the scheme we shall review scale. The out of hours team shall record when the service has been utilised to inform assessment of the effectiveness and decision to scale up.

(d) Mental Health Enablement workers
Community enablement workers to support people with MH needs in the community to maintain secure tenancy and acquire skills to gain employment. These six staff members will work with people on the mental health recovery pathway to support them to reintegrate into the community. This will help reduce the demand on social care and reliance on NHS mental ill health services. A relatively small BCF investment of £225k shall fund the six staff to support approximately 150 people to live in the community rather than a proportion be admitted to residential care. The cost and nature of mental health residential admissions means it is extremely difficult to reintegrate people in the community if they have had apro longed spell in residential care, as this can be debilitating for the individual concerned.

These supplement an increased range of projects that are being managed through the Urgent Care and Integrated Care board – these include 'Home to Assess',' Single Point of Access'. These schemes are interdependent.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

a) Commissioned by CCG and Social Care, Provided by NHS, Social care and private sector care providers.

b) Commissioned by Social Care, Provided by Social Care

c) Commissioned by Social Care, Provided by Independent Sector

d) Commissioned by CCG and Social Care Provided by Social Care

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

Interventions to reduce unplanned hospital admission: a series of systematic reviews. , National Institute for Health, 2013.

The MACE model (Mobile Acute Care of the Elderly) developed in Canada, which integrates primary and secondary care by utilising a multi-disciplinary team working both in hospital and out in the community has improved outcomes for patients and reduced hospital costs and LOS (Farber et al, 2011).

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

Many of the impacts will be measured e.g. reduced admissions, reduced A&E attendance, reduced readmissions etc. together with the financial impact. However, change to reflect same as others there will also be benefits such as:

- Easier and better co-ordinated care
- Reduced burden on GPs i.e. one call will assist in arranging care
- Patient satisfaction and quality of experience
- Less time spent in hospital i.e. care in the right place

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?

This scheme reports to the Integrated Care Programme Board. Each project has its benefits described and a methodology for measuring them which is monitored over the year.

What are the key success factors for implementation of this scheme?

Development of more integrated re-ablement/ intermediate care teams
Reducing duplication of visits/ input
Individuals feeling more supported post hospital discharge
GP's and other professionals having easy access to support and advice, to prevent hospital admissions unless necessary.

Scheme ref no.
4
Scheme name
System Enabling Scheme
What is the strategic objective of this scheme?
This scheme covers a range of projects that will need to be undertaken to ensure the BCF is successful.
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?
This scheme has a number of components which may be summarised as follows: a) Social Care Capital Grant b) This funding is utilised in the Council's capital programme. The programme contributes towards the upkeep of social care buildings such as day centres and care homes for older people. In addition, the capital programme has significantly funded the development of two new extra care facilities in the city, comprising of 150 units at a cost of £18m. These facilities provide services to people in need of care and support who would otherwise require greater health service intervention and admission to residential care.Care Bill Requirements To enable the City Council to meet the statutory Care Act requirements from April 2015. Including closer integration with health commissioners and housing. The Care Act provides a new legal framework for the whole of social care with new statutory regulations and guidance. This introduces new duties and extends existing responsibilities for social care and partners. It also provides a framework for closer integration with health and other health related services, such as housing. This framework includes the following areas: - Strategic commissioning and planning, including developing a diverse, sustainable and high quality market place to buy social care and health support - Access, assessment and planning for care and support, including integrated personal health budgets - Integrated advice and information across health, and other partners - Joined up service delivery Detailed financial modelling and analysis is currently being undertaken to calculate the anticipated additional costs arising from implementation of the Care

Act, both in relation to the social care reforms to be implemented from April 2015 and the funding reforms that are due to come into effect in April 2016. Initial modelling suggests that the funding earmarked in the BCF for the implementation of the Care Act may not be sufficient to meet the anticipated full costs of Part one of the Care Act, the social care reforms and the related new and extended duties.

c) Social Care Commissioning
Commissioning is a key aspect of social care at a macro and micro level. In order to create additional social care capacity at a micro commissioning level to keep people in the community additional investment is required. The brokerage function between support planners and service providers is undertaken by micro commissioning specialists. They will have a key role in working with the community support teams to procure services on behalf of the teams to facilitate hospital avoidance and facilitate timely discharge.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

a) Commissioned by social care and delivered by Independent contractors

b) Commissioned by social care and delivered by a range of independent and voluntary sector providers

c) Commissioned and provided by social care

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

Dilnot Commission's recommendations on funding care and support to protect people from very high care costs
Law Commission review of adult social care law to modernise the legislation and to replace over 65 years of piecemeal legislation into one single Act
Failures at Mid-Staffordshire hospital
The Caring for Our Future White Paper
Department of Health Information Strategy
Better Connected (SOCITM 2013)
Digital by Default – Government Digital Service
Department of Health Strategy – the power of information
Derby City Council New Homes for Old Strategy

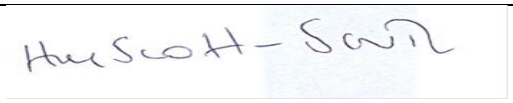
Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

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
These projects are enablers to support the whole system change. The requirements of the Care Act are mandatory and we are not expecting the small amount of funding associated with part one of the Care Act via the BCF to yield any significant benefit to the system change as a whole.
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?
Social Care Survey for older people Carers Survey
What are the key success factors for implementation of this scheme?
Development of more community options for health and social care Better information and advice Engagement with Carers

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	Derby City Health and Well-being Board
Name of Provider organisation	Derby Hospitals NHS Foundation Trust
Name of Provider CEO	Sue James
Signature (electronic or typed)	pp 

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	28884 (All Providers)
	2014/15 Plan	27899 (All Providers)
	2015/16 Plan	26921 (All Providers)
	14/15 Change compared to 13/14 outturn	-3.4%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	260 (this is he BCF for Quarter 4 14/15)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	730 (this is the BCF for Quarter 1-3 15/16)

(*) please note that the figures do not match part 2 of the BCF template due to annex 2 requiring financial periods. Part 2 of the BCF template requires calendar periods

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?**	The BCF strategy for Derby City describes an approach which resonates with the Trust's vision of integrated care in an out of hospital setting. It is important that the modelling takes account of demographic growth and changes in non- elective flows such as vascular surgery and hyper acute stroke. DHFT is fully committed to work collaboratively to develop the detailed plans to deliver the BCF strategy
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?**	No