HEALTH AND WELLBEING BOARD
Date: 27th July 2023

Derby City Council

ITEM 07

Report sponsor: Andy Smith, Strategic Director of People Services
Report author: Kirsty McMillan, Director, NHS Integration & Prevention

Better Care Fund Update 23/24

Purpose

1.1 To provide the Health and Wellbeing Board with the proposed plan for the Derby Integration and Better Care Fund (BCF) for 2023 – 25.

Recommendation(s)

2.1 To approve the proposed spend and performance objectives for the Better Care Fund for 2023 – 25 in line with the national expectations for the programme set by the Department of Health and Social Care (DHSC).

Reason(s)

3.1 The Health and Wellbeing Board (HWB) is required to receive, consider and approve planned activities of the Integration Better Care Fund (BCF). The latest planning round is underway and covers the period of 2023- 2025.

Supporting information

4.1 The Better Care Fund (BCF) remains one of the government's national vehicles for driving health and social care integration. The requirements and objectives of the BCF are set out in a policy framework for 2023 to 2025 published by the Departments of Health and Social Care (DHSC). Since 2015, the BCF has been a policy objective to enable the NHS and Local Authorities to work together in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. There are two 2 core objectives at the heart of the BCF which are to enable people to stay well, safe and independent at home for longer and to provide people with the right care, at the right place, at the right time. The BCF achieves this by requiring integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWB), governed by an agreement under section 75 of the NHS Act (2006).

DHSC require ICBs and local government to agree the Better Care plan and create a pooled budget to support integration between health and care, governed by an agreement under section 75 of the NHS Act (2006). As with previous BCF Planning rounds, there remain a number of national conditions that must be satisfied for BCF plans to be assured by DHSC. At the time of writing the report, the assurance process was ongoing. The national conditions for the BCF in 2023 to 2025 are:

- There is a jointly agreed plan between local health and social care

commissioners, signed off by the HWB
- The plan implements the BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
- The plan implements the BCF policy objective 2: providing the right care, at the right place, at the right time
- The plan demonstrates maintenance of the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

4.2 **Appendix 1** provides a summary of the required *Planning Submission* which was submitted to DHSC at the end of June and is awaiting formal approval through the assurance process. **Appendix 2** provides a copy of the *Narrative Plan* which was also required to be submitted.

4.3 **Performance Metrics.**

Beyond the national conditions, areas have flexibility in how the fund is spent across health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the BCF 2023 to 2025 metrics set out below. A summary of metrics for both years is included in Appendix 1 and covers:

- A new discharge metric covering discharge to usual places of residence
- A new metric on the proportion of people discharged who are still at home after 91 days after discharge from hospital into reablement or rehabilitation services (new to the BCF but very established in Local Authorities)
- The number of admissions to residential and care homes
- The number of unplanned admissions for ambulatory sensitive chronic conditions
- The number of emergency hospital admissions due to falls in people over 65

Public/stakeholder engagement

5.1 Social Care, Voluntary Sector and NHS providers who are recipients of funding via the Integration and Better Care Fund and are aware how their interventions support the wider health and social care system. Although they are not involved in the detailed planning process, there are a variety of partnership and performance meetings whereby BCF funded initiatives are discussed and improvements agreed and developed. Several of these form part of the Joined Up Care Derbyshire planning meetings, primarily under the Place, Urgent Care and Mental Health work streams.

Other options

6.1 The BCF is a mandatory national requirement, and all areas must submit a plan to DHSC should they wish to make use of the funding flexibilities between Councils and the NHS. This plan is subject to a full assurance process which had not been completed at the time of drafting this report. There is full expectation that the BCF funding and spending arrangements continue, as the integration agenda between health and social care remains a key priority for the government and enshrined in recent legislation.

Financial and value for money issues

7.1 Details for the minimum contributions to the BCF for 2023 to 2025 are set out by government and include the minimum contributions that need to be made by the NHS to the pool. below. The component income lines that make up the fund are:

- Minimum NHS contribution
- Improved Better Care Fund - a direct grant to Councils
- Disabled Facilities Grant (DFG) – also a direct grant to Councils
- New Discharge funding

There has always been flexibility for local areas to pool more funding than the mandatory amounts The funding remains subject to an existing pooled budget between Derby City Council and the Derbyshire ICB and monitoring and reviewing spend against the plan is currently undertaken by the BCF Board which remains a subgroup of the Health and Wellbeing Board.

Legal implications

8.1 The Secretary of State for Health and Social Care has published a direction to NHS England under section 223B of the NHS Act 2006 to ringfence £5,059 million to form the NHS contribution to the BCF in 2023-24. This figure includes additional funding for discharge via ICBs (£300m) in 2023-24. The direction sets a requirement for NHS England to consult with The Secretary of State for Health and Social Care before giving any direction to ICBs under section 223GA(1) of the Act about designated amounts to be used for purposes relating to service integration. The Council and the NHS must enter into a section 75 agreement as part of the Planning expectations, under section 75 of the NHS Act 2006. This agreement remains in place and covers the Integration and Better Care Fund. There are components of the fund that includes direct grants to the Council and these must also be separately reported to government via the Council's statutory s151 Officer.

Climate implications

9.1 There are no significant implications arising from this report.

Socio-Economic implications

10.1 There are no significant implications arising from this report although the Better Care Fund supports a number of services that will be contributing to an individual's health and wellbeing.

Other significant implications

11.1 The Better Care Fund supports the Council's and the ICB's overall budget as an income stream to allow delivery of key interventions, teams and services that support the overall health and care system in Derby. The loss of this fund would present a significant financial risk to the shared ambition and key performance

measures designed to serve patients and citizens well.

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal	Olu Idowu, Head of Legal and Insurance Service, Derby City Council	14/7/23
Finance	Janice Hadfield, Head of Finance, Derby City Council	17/7/23
Service Director(s)	Kirsty McMillan, Service Director – NHS Integration & Prevention, Derby City Council	14/7/23
	Kate Brown, Director of Joint Commissioning and Community Development, Derby and Derbyshire Integrated Care Board	18/7/23
Report sponsor	Andy Smith, Strategic Director – People's Services	14/7/23
	Chris Clayton, Chief Executive, Derby and Derbyshire Integrated Care Board	18/7/23
Other(s)		

Appendix 1 – Summary of the BCF

Income & Expenditure

Income Yr 1		Difference
DFG	£2,323,304	
Minimum NHS Contribution	£21,787,336	
iBCF	£12,045,014	
Additional LA Contribution	£169,682	
Additional ICB Contribution	£0	
Local Authority Discharge Funding	£1,688,692	
ICB Discharge Funding	£1,232,160	£635,471
Total	**£39,246,188**	**£635,471**

	Yr 1
Minimum required spend	£6,401,056
Planned spend	£6,650,523

Adult Social Care services spend from the minimum ICB allocations	Yr 1
Minimum required spend	£13,553,416
Planned spend	£14,321,241

Metrics

Avoidable admissions

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	180.3	186.8	228.1	182.8	Reduction by 1%
	Number of Admissions	476	493	602	-	
	Population	256,814	256,814	256,814	256,814	
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan	
	Indicator value	203.1	203.1	203.1	203.1	

Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,540.3	2,527.6	2,478.1	A Reduction of 4.5% in the City should bring Derby and Derbyshire ICB to the top of the 3rd quartile on 22/23 estimated falls
	Count	1,145	1137	1086	
	Population	43,052	43052	43052	

Discharge to usual place of residence

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	97.2%	97.3%	98.0%	97.0%	0.5% increase
	Numerator	5,595	5,646	5,697	7,996	
	Denominator	5,754	5,800	5,812	8,243	
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan	
	Quarter (%)	98.3%	98.3%	98.3%	98.3%	
	Numerator	6,980	7,157	6,908	7,068	
	Denominator	7,101	7,281	7,027	7,190	

Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	613.8	599.0	587.5	579.6	in line with our ongoing strategy to reduce the number of people admitted into long term institutionalised care, we are estimating that the number of new admissions will be largely similar in 23/24 to 22/23 – however due to demographic changes we are expecting more demand for long term support. We have therefore planned to have 257admissions into permanent care homes per 100,000 population
	Numerator	260	262	257	257	
	Denominator	42,361	43,741	43,741	44,337	

Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	81.5%	84.1%	84.1%	We plan to see more people access the reablement service this year (reflected in the actual number of people) but have planned to maintain the performance in terms of people remaining independent after 91 days
	Numerator	180	831	766	959	
	Denominator	225	1,020	911	1,140	

Detailed Expenditure

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Integrated Community Equipment	Provision of equipment to enable people to remain in their homes	Assistive Technologies and Equipment	Community Health	NHS	Private Sector	Minimum NHS Contribution	Existing	£2,262,160	£2,390,198
Integrated Community Equipment	Provision of equipment to enable people to remain in their homes	Assistive Technologies and Equipment	Community Health	NHS	Private Sector	Additional LA Contribution	Existing	£169,682	£179,286
Social Care assessments and cost of care	social care assessments and associated costs of care packages -	Care Act Implementation Related Duties	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£6,613,440	£6,987,761
Assessment & Support Planning Teams	social work support and assessments	Care Act Implementation Related Duties	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£1,631,146	£1,723,469
Bed Based Respite - Perth House	Bed Based - Step Up/Down	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£1,468,032	£1,551,123
Carers Support	Support to carers / delivery of the Carers Strategy	Carers Services	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£823,560	£870,174

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Healthy Housing/Handy Person	minor repairs, adaptations, home improvements	Housing Related Schemes	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£534,802	£565,072
Enablement & Intermediate Care - Home First	Provision of integrated services to support discharge	Home-based intermediate care services	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£2,526,940	£2,669,965
Local Area Coordinators	In partnership with local communities, support people before their needs escalate and avoid going into crisis	Prevention / Early Intervention	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£401,101	£423,804
Mental Health Enablement Workers x 6	preventative and recovery support to people living with mental ill health	Prevention / Early Intervention	Mental Health	LA	Local Authority	Minimum NHS Contribution	Existing	£300,826	£317,853
Out of Hours Emergency Care - Perth House/ Home First	Rapid/Crisis Response	Urgent Community Response	Community Health	LA	Private Sector	Minimum NHS Contribution	Existing	£200,551	£211,902
Dementia Support	Help people with dementia and their carers to access further information, advice and support	Carers Services	Mental Health	LA	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£314,196	£331,979

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Social Care Commissioning	Market development (inc Vol sector)	Enablers for Integration	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£322,218	£340,456
Property Adaptions (DFG)	Adaptations, including statutory DFG grants	DFG Related Schemes	Social Care	LA	Local Authority	DFG	Existing	£2,323,304	£2,323,304
Demographics (system pressures - residential provision)	Demographic growth, age and complexity	Residential Placements	Social Care	LA	Local Authority	iBCF	Existing	£4,971,935	£4,971,935
Provider fee pressures - Living Wage, specialist rates, overnight costs	Fee increase to stabilise the care provider market	Personalised Budgeting and Commissioning	Social Care	LA	Private Sector	iBCF	Existing	£3,652,330	£3,652,330
reviewing team - new cases	social work assessment and support planning	Care Act Implementation Related Duties	Social Care	LA	Local Authority	iBCF	Existing	£317,525	£317,525
Transitions team	social work assessment and support planning	Care Act Implementation Related Duties	Social Care	LA	Local Authority	iBCF	Existing	£185,223	£185,223
Hospital social work team	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	iBCF	Existing	£751,476	£751,476
DOLS, best interest and mental	Deprivation of Liberty Safeguards (DoLS)	Care Act Implementation Related Duties	Social Care	LA	Local Authority	iBCF	Existing	£309,587	£309,587

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
capacity assessments									
Perth House	Bed Based - Step Up/Down	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Social Care	LA	Local Authority	iBCF	Existing	£673,575	£673,575
Home First Community Night Service	Reablement to support discharge -step down (Discharge to Assess pathway 1)	Home-based intermediate care services	Social Care	LA	Local Authority	iBCF	Existing	£202,590	£202,590
Mental Capacity assessments	Deprivation of Liberty Safeguards (DoLS)	Care Act Implementation Related Duties	Mental Health	LA	Local Authority	iBCF	Existing	£25,300	£25,300
Track & Triage.	Monitoring and responding to system demand and capacity	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	iBCF	Existing	£6,637	£6,637
Mental Health Social Worker	Support discharge planning on admission; embed social work input to MDT reviews	Integrated Care Planning and Navigation	Mental Health	LA	Local Authority	iBCF	Existing	£50,600	£50,600

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Domicillary care packages	Domiciliary care packages	Home Care or Domiciliary Care	Social Care	LA	Private Sector	iBCF	Existing	£898,237	£898,237
Community Nursing	Delivery of care in patient homes to prevent conditions deteriorating	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£1,106,552	£1,169,183
Integrated Teams (Community Support Teams)	Integration with primary care to co-ordinate proactive care for those at risk of dependency due to physical or mental health issues	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£1,316,968	£1,391,508
Evening Nursing Services	Nursing care to adults due to an urgent problem related to a long term chronic disease/condition	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£417,412	£441,037
Community Matrons	Proactive, holistic approach to manage patients' long term conditions, centred on primary care	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£722,796	£763,707

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Community Therapy	Provision of highly skilled assessment and intervention to patients with physical problems affecting their functional abilities	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£319,077	£337,136
Clinical Navigation Service	Single point of contact to a multi-professional team to support patients to receive clinically appropriate care at home or as close to home as possible	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£505,558	£534,173
Local Area Coordination at Royal Derby hospital	Additional capacity to increase P0 discharge	Prevention / Early Intervention	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£53,959	£53,959
Additional Social Worker/ CCWs to support LRCH ward 5	Additional staffing to support onward flow of patients	High Impact Change Model for Managing Transfer of Care	Acute	LA	Local Authority	Local Authority Discharge Funding	New	£56,450	£56,450
Social Worker/ AHMP to support Radbourne Unit & Cubley Court	Additional staffing to support onward flow of patients	Integrated Care Planning and Navigation	Mental Health	LA	Local Authority	Local Authority Discharge Funding	New	£123,779	£123,779

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Social work development - MH Admission avoidance and D2A Pathways	Additional staff to develop a mental health Discharge to Assess pathway	High Impact Change Model for Managing Transfer of Care	Mental Health	LA	Local Authority	Local Authority Discharge Funding	New	£61,890	£61,890
Social work to support P3 flow and Reviews	Additional staffing to support onward flow of patients	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£56,450	£56,450
Social work support for safeguarding and MCAs for UHDB/DHCFT	Additional staffing to support onward flow of patients	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	Local Authority Discharge Funding	New	£56,450	£56,450
ASCDF Administration, including P3 Brokerage	Additional Brokerage staff to support the P3 Pathway	Other	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£37,599	£37,599
Additional PVI workforce payment	Making funding available to care providers during winter 2023 so that they can provide additional capacity	Workforce recruitment and retention	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£324,127	£324,127
Additional discharge related short-term residential care	Paying for private care capacity to manage P3 demand	Residential Placements	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£201,968	£201,968

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Additional discharge related admissions to short-term residential	Paying for additional private care capacity to provide short term P2a care	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£201,968	£201,968
Additional admissions to PVI short-term homecare	Paying for additional private care capacity to provide short term P1 care	Home Care or Domiciliary Care	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£514,054	£514,054
VCSE P0 discharge home and 6 weeks support	Transport home for up to 10 patients per week with up to 6wks low level support (not care)	Community Based Schemes	Social Care	NHS	Charity / Voluntary Sector	ICB Discharge Funding	New	£97,000	£120,000
Staffing to deliver transformation	Staff to enable transformation of discharge	Enablers for Integration	Other	NHS	NHS Community Provider	ICB Discharge Funding	New	£120,000	£120,000
Mental health discharge transformation	embedding of discharge and review processes for MH beds	High Impact Change Model for Managing Transfer of Care	Mental Health	NHS	NHS Mental Health Provider	ICB Discharge Funding	New	£67,440	£101,760
UHDB staffing to enable discharge	staff to improve 7 day discharges and support coordination of flow	High Impact Change Model for Managing Transfer of Care	Acute	NHS	NHS Acute Provider	ICB Discharge Funding	New	£22,607	£22,607

Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Dementia palliative care scheme	To provide discharge support to patients with dementia in last yr of life	High Impact Change Model for Managing Transfer of Care	Community Health	NHS	NHS Community Provider	ICB Discharge Funding	New	£13,837	£23,721
Transport	to provide increase transport capacity to discharge patients from acute over winter	High Impact Change Model for Managing Transfer of Care	Acute	NHS	NHS	ICB Discharge Funding	New	£117,120	£117,120
Pathway 1 transformation delivery	Schemes to deliver the JUCD pathway 1 transformation strategy	High Impact Change Model for Managing Transfer of Care	Other	NHS	NHS	ICB Discharge Funding	New	£158,685	£1,616,059

Appendix 2

HM Government

NHS England

BCF Derby City 2023-25 narrative plan

Integration and Better Care Fund

Introduction

Health and Wellbeing Board(s).

The Derby City Health and Wellbeing Board (HWB) sits along side the new Integrated Care Partnership which came into existence in 2022. The Derby and Derbyshire Integrated Care System (ICS) published *Joined Up Care Derbyshire (JUCD) Integrated Care Strategy in 2023* which sets out the ambitions for how local Councils, NHS organisations, Healthwatch, and Voluntary Sector partners will work together to improve the health of Derby and Derbyshire citizens Derby and Derbyshire. The document is available on the following link:

Derby and Derbyshire Integrated Care Strategy 2023 » Joined Up Care Derbyshire

Whilst the HWB remains the statutory body for the Better Care Fund, the main partnership with the NHS relates to delivering the Integrated Care Strategy. This sets out step changes that are needed to tackle system health and care challenges and one of the intentions for the ICS in 2023 is to review how the Better Care Fund, and other enablers of integration are aligned to the strategy to look for opportunities to further joined up care delivery to benefit local people. The key strategic ambitions set out in the Integrated Care Strategy are:

- Prioritise prevention and early intervention to avoid ill health and improve outcomes
- Reduce inequalities in outcomes, experience, and access
- Develop care that is strengths based and personalised
- Improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system

This narrative plan, in light of these priorities, will set out how Better Care Fund (BCF) is being used to support these ambitions in Derby City. There are significant overlaps with our neighbouring Derbyshire Health and Wellbeing Board (Derbyshire HWB) within this narrative plan, given we are operating under the same ICS. Many aspects of both BCF narrative plans are therefore aligned. However, there are some local integration developments within the Derby City area that are distinct and are anticipated to be supported by the BCF going forward. This plan will illustrate these developments, as well as those that are supporting the priorities of the Disabled Facilities Grant, how we are supporting unpaid carers, improving discharge and delivering admission avoidance arrangements within our place-based partnership approach known as **Team Up**.

Involving Stakeholders

As part of the development of the Integrated Care Strategy - JUCD looked at what we already knew about 'what matters to people' by looking at the last two years of reports and current insight available. For older people, the key areas of feedback were:

- It can take too long to get a response: “I’m not always confident the right person will come when I need them”
- Health and care are difficult to navigate: “I’m not always sure who to call”

- There are too many people involved and they don't seem to speak to each other: "I have to explain to everyone what has happened to me and when & I don't even know what half my tablets are"

This feedback, along side key policy national objectives plus regional and local reports were pulled together to create an insight document. Alongside other data and sources of evidence the insight document was used to agree the key areas of focus, which were an integral part of the ICS Strategy. These are:

- Start Well
- Stay Well
- Age Well and Die Well

The Better Care Fund is currently positioned to enable delivery of the **Age Well and Die Well** components of the ICS Strategy.

Members of the joint Derby and Derbyshire BCF Programme Board have been the main contributors to the BCF narrative plan, however within the Derby Place Partnership structures, there is wider engagement from NHS ICB and NHS providers, housing representatives and the Voluntary, Community, and Social Enterprise (VCSE) sector. This wider partnership is also reflected within the Derby City Health and Wellbeing Board, the newly established Integrated Care Partnership & the Integrated Place Executive. Housing colleagues have specifically contributed to the planning on the Disabled Facilities Grant.

As in previous years, the BCF plan does not stand as a separate integration programme but is part of a wider system approach to integration and joint working between the NHS, Councils, and partners. The Derby/ Derbyshire BCF Board reports into both HWBs but all integrated care activity (planning and delivery) is largely managed and reported now through the new structures within the Integrated Care System. Many of the schemes and interventions receiving BCF income are also reliant on other income streams, commissioning arrangements and performance measures that reflect the wider nature of their delivery and focus.

Governance of the Better Care Fund in Derby and Derbyshire

Derby Health and Wellbeing Board - The Health and Wellbeing Board for Derby (and the equivalent for Derbyshire) has ultimate oversight of our local BCF plan, signing off planning submissions and receiving regular monitoring updates. In addition to the statutory members, locally represented organisations include Derby University, Derbyshire Constabulary and Derbyshire Fire and Rescue Service, bringing a broader range of insight and perspective, and offering greater opportunity for strategic alignment.

Derby/Derbyshire Better Care Fund Programme Board - This meets monthly and is a formally delegated committee underneath the Health & Wellbeing Board. It has a co-ordinating role ensuring that the BCF investment, metrics and strategies support the approaches agreed within wider system strategies. It is chaired by Derbyshire County Council and includes senior representatives from Derby City Council, Derby and Derbyshire ICB and the Derbyshire district/borough councils. A Finance and Performance Sub-Group also meet monthly and report to the BCF Board.

Place arrangements - Integrated Care Partnership (ICP) & the Integrated Place Executive (IPE) - The Joined-Up Care Derbyshire System has established its structures

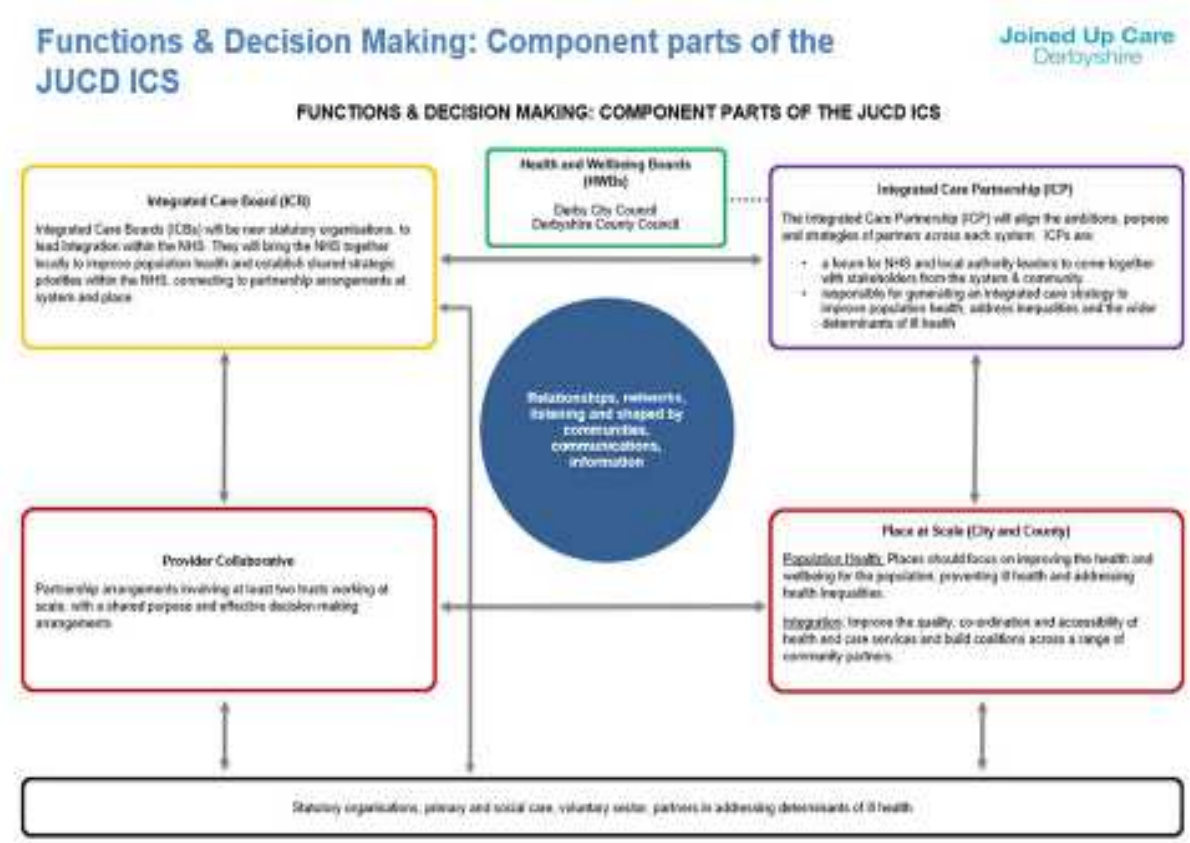
and governance as part of the new ICS. The Derby and Derbyshire Integrated Care Partnership (ICP) brings together NHS, social care, and independent and third sector providers to agree the Integrated Care strategy and direction for the Integrated Care System as a whole.

Although the ICP operated across Derby &Derbyshire, the delivery structure is through two Place Partnerships (one for Derby City & one for Derbyshire – aligned with the Health and Well Being Board / Council / District boundaries). Whilst the local place partnerships are set up to ensure local delivery – overall strategic functions are being co-ordinated on behalf of the partnerships through an Integrated Place Executive (IPE**),** reporting into the ICP.

The IPE brings together senior representatives from local NHS organisations, primary care, Councils, the VCSE and other community partners. The aim is to build on existing progress and deliver the priorities of the Integrated Care System strategy. This includes co-ordinating and enabling the integration of services, supporting developments to integrate our workforce, overseeing performance, and championing distributed leadership. The partnership aims to embed co-production with people who use local services; facilitating accountability to local communities and building broader coalitions with community partners to create health and well-being.

At the time of writing the narrative plan, discussions are at an early stage that may lead to the Integrated Care Partnership, with delegated authority from the two Health and Wellbeing Boards, taking over the Programme Board functionality for the Better Care Programme to enable better synergy with the aims of the Integrated Care Strategy. This will not only raise the profile of the Better Care Fund but also enable us to accelerate integration activity using the BCF as an enabler for change – which is very much the current position with the Derby City Place Partnership.

The diagrammatic representation below shows the current governance linked of the Integrated Care System and the relationship with the Health & Well Being Board.



<u>Other relevant & related system partnerships -</u> The following operational groups also exist with a specific focus on patient flow, discharge and admission avoidance pathways. These groups allow for issues to be escalated for resolution at a senior level across relevant organisations and with a shared focus on achieving the best discharge care and outcomes for individuals. Many of the services overseen by these groups are funded by the Better Care Fund.

System Operational Resilience Group (SORG) - This Group meets weekly (or more frequently when required) to discuss and manage emerging risks to system capacity. It is chaired at Executive level and is particularly focussed on patient "flow" through the system. All local NHS providers and both upper-tier Local Authorities are represented on this group.

Strategic Discharge Group (SDG) - This Group meets monthly to provide strategic oversight at Director level of the local Discharge Improvement Plan. Again, all local NHS trusts and both upper tier LAs participate.

Pathways Operational Group (POG) - This Group exists to deal with day-to-day discharge related issues and has a specific role in relation to daily escalation and winter planning. POG reports to the System Operational Resilience Group (SORG) and the Strategic Discharge Group (SDG).

Pathway Data Group (PDG) - This group has representation from multi-agency data analysts and operational multi agency discharge staff and produces a weekly discharge dashboard to supports demand and capacity analysis. It also carries out deep dive reports on targeted focus areas.

Executive summary - Derby City's Better Care Fund, the Integrated Care Strategy and the Place Partnership

As described above, the main vehicle for delivery of the integrated Care Strategy is the Derby City Place Partnership, which is Chaired by the Council, and has all 5 primary care networks encompassed within it. The priorities reflect the national conditions for the BCF and also support the ambitions in our Integrated Care Strategy under **Age Well and Die Well** which states that we will work together:

- to enable older people to live healthy, independent lives at the place they call home for as long as possible.
- to prioritise integrated and strength-based services to support health and wellbeing.
- to help people in a crisis to remain at home where possible.
- to maximise a return to independence following escalations.

These priorities are embodied in the concept of the **Derby City Team Up** which is the Place Partnership's programme of work for improving outcomes by building integrated local planning, service responses and support in the community (including statutory health and care bodies, VCSE, housing, independent care providers, individuals, and communities). How the BCF is being using to deliver the Team Up & the Place Partnership priorities are detailed in the national conditions section of his plan

Key changes since previous BCF plan

Since the previous BCF Plan, the developments of Team Up and the role of the Derby Place Partnership have continued. In June 2023, a Place Partnership development day was held to consider how the ways in which core objectives could best be supported by partnership and collaborative working. Since the last BCF Plan was submitted in the autumn of 2022, the following areas have progressed, and will continue to be a focus following a reset of the Place Partnership after the development day:

- Further development of Team Up service model with specific proposals coming forward about BCF funded activity and opportunities for single a delivery model.
- Further roll out of the urgent community response using health and care organisations, a falls response pilot and further expansion of the home visiting service from within general practice.
- Continued improvements on enhancing the support needed to enable a timely hospital discharge so that individuals can return to a safe, supportive setting, ideally at the place they call home.
- Expanded the range of discharge pathways using the new ASC Discharge Fund including -VCSE engaged with getting people home who have no need for formal paid care or support (known as Pathway 0).
- Established a programme of work to create a Discharge to Assess operating model for people with mental ill-health to coordinate hospital discharges through short-term support services, s.117 funded aftercare or reablement/ rehabilitation.
- Developed a business case for further integration between Derby City Council and Derbyshire Community Health Services – for those interventions funded by the BCF which support admission avoidance and also enable hospital discharges. This could see over 300 staff come under a single management structure to make the most of our shared capacity, better meet demand, retain and recruit staff, and ensure citizens have minimal handoffs and duplication along their care pathway.
- Following challenges around limited homecare capacity, the funding has also supported providers with recruitment and retention initiatives to increase capacity and maintain their ability to accept new referrals.

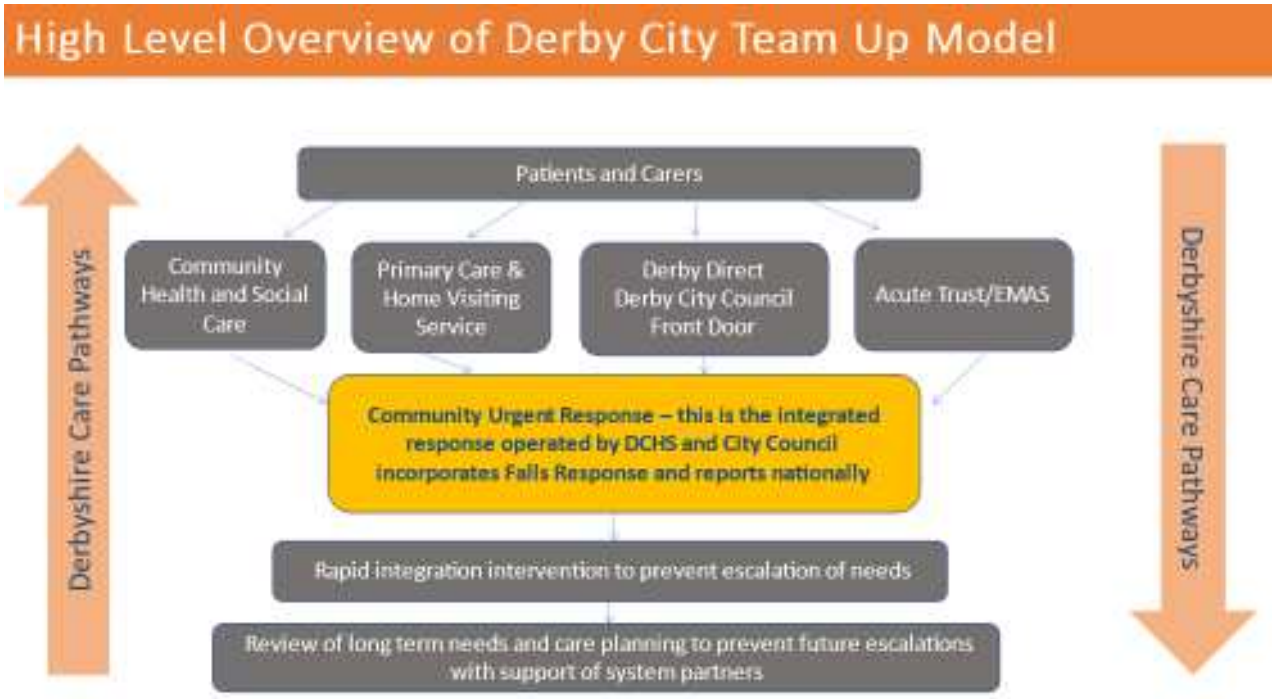
- Developed the Derby Wellbeing collaborative for menta health and co-produced the Derbyshire Joint Health & Social Care All Age Autism Strategy 2023-2028. Both of these developments involve a number of BCF funded activities and interventions.

National Condition 1: Overall BCF plan and approach to integration

Joint priorities & commissioning approaches

As stated above, the key priorities across the City Place Partnership and the focus of BCF Plan for 2023 - 25 is to deliver the key areas of focus from the Integrated Care Strategy and continue to roll out Team Up as the default delivery mechanism. This means looking for opportunities to formally integrate pathways and support wherever possible. The Derby Place Partnership Board is seeking to work with the evidence base that exits, including emerging data sets that aim to measure the impact of our efforts on our key priorities. During 2023, the intention is to review how well the BCF programme is aligned to the Integrated Care Strategy and the priorities of the Derby City Place Partnership.

Whilst the value of more integrated, locally delivered care will benefit many (if not all) groups, it is particularly evident, and therefore targeted, for those living with frailty and at the end of life. Derby City's Team Up approach aims to create one team operating at a Place level whereby everyone involved with vulnerable and frail residents "team up" to integrate the delivery of care and support to provide anticipatory (also known as 'proactive'), planned and urgent care (including discharge support). This *team* is not planned to be a physical new team or 'add on' service – it is a teaming up of existing services – with general practice, community, mental healthcare, adult social care, housing and the voluntary and community sector all working together. The operating model for **Team up in Derby City** is below:



The Team Up approach to integrated working draws upon guidance in national publications, for example, *"Next Steps for Integrating Primary Care: Fuller Stocktake Report* (2022), NHS England *Proactive Care Framework* (2022/23), and the British Geriatrics Society report – "*Joining the Dots (2023): A blueprint for preventing and managing frailty in*

older people" and from national sources of support including the Social Care Institute for Excellence (SCIE). When we ask local people what matters to them, they consistently say being able to stay in their own home for as long as it is safe to do so as the most important thing to help them keep their independence and stay healthy as they get older (Healthwatch Report – 2019). This remains our main outcome that all Team Up partners are working towards.

There are several key interventions under the banner of Team Up that are happening across the Derby Place partnership. These build on the established close working arrangements that have been in place for several years, many part funded by the BCF, and which have already led to:

- A responsive one-team ethos that aims to deliver a seamless journey for individuals wherever possible between health and care organisations
- Multi-agency assessments and shared decisions about people as the default wherever possible
- A clear focus on maximising shared capacity and ensuring that care is not wholly reliant on bedded care i.e Home First is our shared objective
- Flexible use of our joint staffing capacity where this is possible, to meet fluctuating demands
- Joint leadership, escalation, and weekly operational meetings to learn together and problem solve.

How the BCF is supporting Integration priorities

The **outcomes and outputs** that these priorities are seeking to improve for local people and for partners work more closely together to serve them are illustrated below, with an indication of how these are being taken forward at the Place level, and where the BCF is a current/ potential enabler of change:

Integrated Care Strategy / system priorities for 23-25	Derby City Place developments, including BCF funded/ enabled where relevant
Support people when navigating health and care – **'no wrong door'**. Any point of access to the health and care system should be able to direct the user or carer to the right place.	Development of the Local Access Point for multi-disciplinary triaging of case referrals, with all partners contributing to prevent individuals being re-directed elsewhere BCF activity is included within this via social care and community health teams including community & acute based navigation / triage hubs. Ageing Well income as well as core funding (for all partners) is also being use by the services aligned to the Local Access Point.
Joined-up communication – tackling conflicting information, the need to repeat information and inconsistencies, helping staff understand the wider needs of the service user and carer, beyond the condition for which they are seeking help.	As well as co-locating staff within various triage hubs, the Derbyshire Shared Care Record is being rolled out across partners to enable a single view of essential citizen data & case history to be available to join up our response and to see an individual holistically The BCF co-funds the Council's Social Care Commissioning team who have been supporting this development, as well as part funding a number of the services that hold information about individuals from both health and care organisations.
Staff should access and update a **single record** to support the care of an individual, and to prevent individuals and their carers having to repeat information to many agencies and staff having to waste time updating multiple systems.	The roll out of the Derbyshire Shared Care Record is designed to assist with this, enabling partners agencies to view essential information in a person's health and/or care plan.
We should work together **work together**	There are various integration activities taking place at Place level

Integrated Care Strategy / system priorities for 23-25	Derby City Place developments, including BCF funded/ enabled where relevant
with shared processes to reduce the potential tension regarding organisational sovereignty as demonstrated through individual policies, procedures, cultures etc	and embodied through the Place Partnership Board. A number of teams are now co-located and where joint working improves outcomes, this is being pursued. The BCF funds a number of these co-located teams across social care and community health access points, including within the acute hospital.
We want to improve trust – between groups of staff, and service users' confidence in staff as advocates. Addressing the impact that existing cultures across organisations and teams have on the ability to make this shift will be an important factor to consider.	The Place Partnership is a vehicle for all system partners to contribute and influence local developments and improvements. Some of the BCF funded interventions are breaking down barriers and building trust, such as the BCF Healthy Housing hub and VCSE support for hospital discharges which are both actively working with our acute, community health and social care organisations to help prevent the need for admissions or delayed hospital stays, by offering low-cost home improvements and access to community resources and support. Local Area Coordinators are another example of preventative interventions, funded by the BCF that are an excellent way of building trust between citizens and the ICS structures using strength-based approaches. These are building confidence in the overall systems' ability to work together to keep someone living with frailty at home for longer.
Governance & decision making mechanisms need to drive the shift to improved population health and slow growth in demand. Our current governance structures don't always effectively support 'distributed responsibility' and working across teams. We want to review the form and pace at which **new financial models** and mechanisms for **collaborative commissioning** can be developed and which may need differential allocation. We want to ensure commissioning processes are aligned and reward the right things.	The Place Partnership Board is reviewing its operating effectiveness to be able to demonstrate the impact working together will make. In 2023/24, this will include the integration programme of work between health and care as the Partnership will act as the collaborative commissioner of this work, which includes a variety of BCF funded activity. This will continue the approach to move towards outcome based financial models whereby Place level outcomes are defined in addition to the required inputs and outputs that are more traditionally seen in service specifications.
We should explore **further developments in workforce planning** to better meet the needs of the population who are ageing or at the end of their lives. **Co-location of teams** that are working together/serving the same cohort.	The Place Partnership already has a number of areas where partners are co-located and where there is active collaboration by sharing & planning workforce models and jointly recruiting so that we can make the most of shared capacity as we try and meet the rising demand for care and support. There is a well developed proposal to further integrate health and care (for services funded by the BCF, but also those outside of the BCF) is designed to reduce duplication within separate workforces, making the most of shared skills and positioning the workforce well to manage the changing demand profile.
We want to establish an embedded model for using **Population Health Management** data to plan and target provision. We should further explore the potential that the VCSE sector contributes, particularly their ability to more closely understanding and meeting the needs of our population.	There is a PHM Steering Group that brings together key representatives from across the ICS, including the VCSE sector, to coordinate the development of the overarching direction of travel for PHM in Derby and Derbyshire. The group reports to the IPE as well as both Health and Wellbeing Boards, as required. It is underpinned by the data and digital activities of the ICS led by the Strategic Intelligence Group. Furthermore in Derby specifically, the Derby Health Inequalities Partnership that was established during Covid to coordinate activities across local partners to reduce health inequalities in the city, continues as a venture between Derby City Council and Community Action Derby, representing the VCSE sector. It aims to support a PHM approach through working specifically with some of the city's most

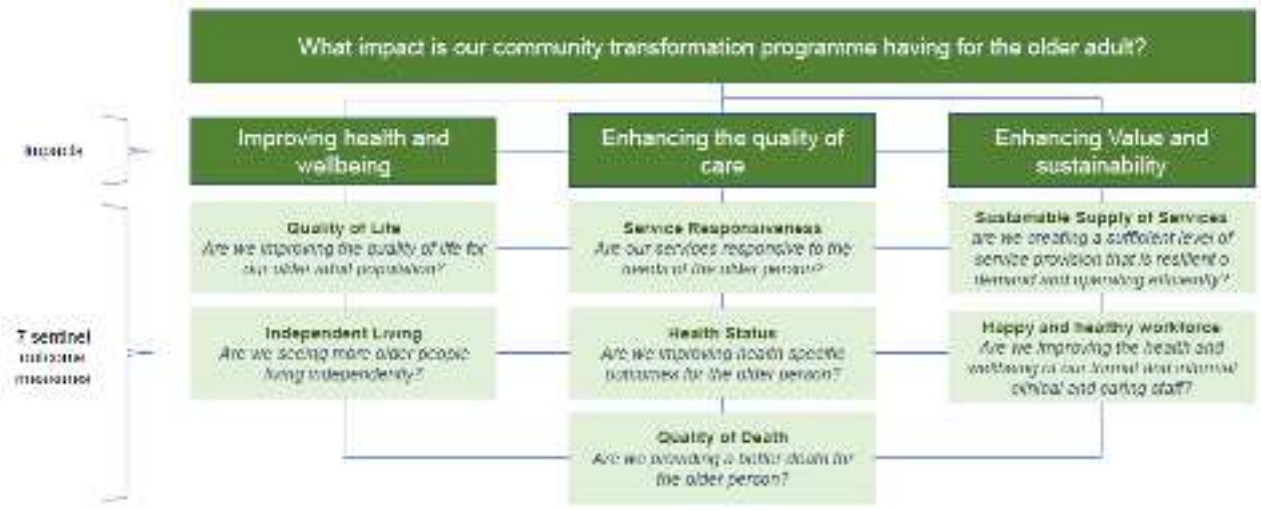
Integrated Care Strategy / system priorities for 23-25	Derby City Place developments, including BCF funded/ enabled where relevant
	vulnerable citizens.

Next steps

Work is already underway to develop a strategic operating framework for organising the System's response to the issues stated above, building on the success of existing local services, including Team Up, with the further development of integrated community teams. External support using Newton Europe is currently underway and a community diagnostic exercise will be concluding in July to present co-produced improvement opportunities. In addition, support will be sought from the Better Care Support Team to assist us with reviewing how well our priorities are aligned to our Integrated Care Strategy, learning from other areas so we make best use of the opportunities already developing.

Suggested measures for improvement

The Integrated Care Strategy proposes that 'measurement activities' for this priority are organised under seven sentinel outcome measures – please see figure below. There is also a National Integration Index planned to be rolled out in 2023 that will help us understand the level of integration and the impact / benefits experienced by citizens. Combined with the Better Care Fund data set, there is likely to emerge a Derby City Place partnership dashboard of key success measures so that we can evidence the impact of the range of Team Up and associated transformation activities underway



National Condition 2 - Enabling people to stay well, safe and independent at home for longer.

There are a number of shared system priorities that align to the priorities of National Condition 2 that are being taken forward with the Place Partnership to enable people to stay well, safe and independent at home for longer. Some of these are funded exclusively by the BCF, others are funding by Ageing Well or system partner's core funding. As stated above, the vehicle at Place level for all of this activity is known as Team Up. Information aimed at citizens about this is detailed on the link below:

Team Up including Ageing Well » Joined Up Care Derbyshire

Urgent Community Response – a key example of the work that is taking place and how the BCF is supporting this national condition, relates to the Team Up **urgent community response (UCR) service**. This aims to provide a crisis response within two hours of referral and reablement care (support to help people live at home) within two days of referral. This is part of the national roll out of urgent community response delivered designed to avoid admissions to acute care and to keep people at home for longer. There are four components of Derby's UCR service.

Home visiting services – whereby people are being visited at home by a range of different health and care professionals – overseen by the primary care networks. This team is co-located with Derby City Council and supports all citizens covered by the 5 Primary care networks and covering 28 GP practices	This service is funded by Ageing Well but is aligned and co-located with social care teams that are funded by the BCF. These teams are involved in any onward referrals and assessments that are needed following a GP / primary care led home visit
Rapid response nursing and therapy services – provided by Derbyshire Community Health Services	This service is core funded by the Integrated Care Board and also part funded by the BCF.
Adult social care rapid response services – provided by local authorities and increasingly being integrated with NHS services	This service is funded as a pilot from Ageing Well and will form part of the integration plans using BCF funded activity between Derbyshire Community Health Services and Derby Cit social care.
Falls prevention and falls recovery services – which are being expanded across the city and county under Team Up.	This service is funded as a pilot from Ageing Well and makes use of the Council's Assistive technology platform known as Carelink.

Integrating our discharge and urgent community response workforce – As detailed above, the BCF funds a range of services that support people during an escalation or change in their needs and which may require multi-disciplinary working. A number of these services are delivered by Derby City Council (DCC) and Derbyshire Community Health Services (DCHS) and these are primarily focused on assisting people to return home after a hospital admission, receiving reablement and rehabilitation support, including a rapid response to escalating needs at home to avoid an acute episode or crisis. In 23/24, DCHS and DCC are proposing to further develop the community health and social care offer for the Derby City Place to improve the quality, co-ordination and accessibility of health and care with an emphasis on enablement and prevention of escalating needs. The proposal is

to create a single team to provide discharge to assess and urgent response for the Derby City Place, extending the Team Up model of integrated working, with the potential for including Primary Care, Housing and the VCSE into the design in the future. By creating a single workforce & management structure, the aim is to increase capacity and reduce duplication so that more people can be kept safe and at home - supported by a seamless community health and care team, with as many people as possible avoiding having to go to hospital. This links directly to our demand and capacity model (which will be further detailed below) as not all demand is currently being met by our separate organisations.

It is proposed that the Derby City Place Board becomes the main reference group for the development of this integrated delivery model to align the work to meet the system priorities for Derby, but also to maximise the benefits for individual citizens by harnessing wider partners' contributions and opportunities. This development could be a pathfinder for the Place Partnership as it will see existing BCF funds, pooled between organisations to get the most of their shared resources.

Enhanced health in care homes programme - a further development within Derby City Place is our work on the enhanced health in care homes programme, which aims to develop the workforce skills (including the rollout of digital improvements in care) so that care home staff are better able to look after their residents. The BCF is supporting this through the funding allocated to the Social Care Commissioning Team who are working with care homes to ensure they are engaged with the programme for the benefit of residents.

Anticipatory Care - the BCF is supporting the progression of Derby's anticipatory care programme, aimed at identifying and responding to the health needs of people early, to ensure that they can be looked after at home wherever possible, avoiding the need to go to hospital. The Local Area Coordinators as well as social work function and community health (all funded by the BCF) are involved with a weekly multi-disciplinary team approach to agree interventions to some of our residents who appears to need additional support due to their complex needs and lives.

Carers – Our universally available services for Carers in Derby and the Derby Dementia Support Service are both funded through the BCF. These services offer unpaid carers access to vital information, education and advice as well as providing wellbeing and peer support events which provide unpaid carers valuable respite opportunities from their caring role. In addition, both services facilitate inclusive sessions so that the cared-for and carers can enjoy activities together. Both services put support plans in place for carers, using person-centred approaches to map outcomes. For some carers, a more formal Care Act assessment is required. Both services continue to see an increase in the number of carers accessing the service and feedback from carers regarding the services demonstrates that many see them as a vital resource in supporting their caring role

Supporting people at home with housing improvements – The BCF funds a handyperson service which is focussed on prevention of trip and falls hazards, installation of low level adaptations such as grabrails and key safes. This service is delivered alongside the BCF funded Healthy Housing Service which, combined with the Disabled Facilities Grant enables a comprehensive offer and case work to prevent trips/falls and ensure that homes are suitably heated and adapted. These teams all work closely with social care and the hospital discharge team to ensure that homes are safe on discharge. All of these services are centred around supporting people to remain in their own homes for as long as possible.

National Condition 2 – Demand and Capacity for Intermediate Care

Demand and Capacity for intermediate care to support people at home, and to return home - the ICS has a Pathway Data Group that has representation from multi-agency data analysts from acutes, community Trusts, Councils and those involved in discharge teams. It produces a weekly discharge dashboard, provides demand and capacity models, and carries out deep dive reports. A weekly report is produced to monitor Discharge flow and highlights delays to discharges both from an acute hospital perspective, but also from Discharge to Assess pathways. To support this work, in 2022, the ICS appointed a dedicated 'Discharge Flow Lead' whose remit is looking at all of the pathways and supporting system partners to identify and implement transformation and improvement opportunities. The BCF Demand and Capacity Plan for intermediate care has been produced by the Pathways Data Group and the key areas that have been identified for Derby City are below:

- **Pathway 0** - there is some BCF funded capacity, and non BCF funded community capacity in place to support Pathway 0 discharges and also to avoid admissions into hospital. However, at the time of drafting the plan, there are gaps in our data capture in terms of quantifying all capacity available to match demand. This work will continue in 23/24 to more accurately identify the resources and associated capacity we have at our disposal. This will include identifying more clearly which discharges are likely to need VCSE support from the data held by our acute trust. In summary, this data set needs more work to ensure it is robust.

- **Pathway 1** – this pathway is delivered jointly by the Council and our community trust and using the demand and capacity tool, when rehabilitation and reablement is taken together there appears to be enough capacity to meet demand. However, we know that in 22/23 – not all demand was indeed able to supported using our joint D2A pathways, with only about 75-80% being met; the remainder either having to access non reablement pathways, remain at home without reablement, or remain in hospital for longer. This is because not all staffing capacity is available when needed (due to shift patterns) and fluctuations in demand between discharge and admission avoidance pathways are harder to predict. The workforce is the same for both pathways but is currently delivered by the Council and the community trust separately. Our joint length of stay in this pathway is very positive at approximately less than 14 days per person, and we do not appear to have challenges about onward flow (or stepping off the pathway). This is because we have worked with home care providers so they are able to prioritise the ongoing care we need. However – we are aware that we need to maximise the capacity that we have and so we are no longer reliant on a small number of discharges being facilitated by private care providers. The further integration plans described above between DCHS and City Council will seek to resolve the demand and capacity imbalances by creating a single workforce and operating model that can be responsive to demand fluctuations.

- **Pathway 2** (rehabilitation and reablement) - There is a small gap between demand and capacity for bed based intermediate care as per the model. In 23-24 we will be reviewing the staffing skill mix and workforce model as we believe that the capacity available cannot always support the complexity of the needs of individuals which means some people are delayed in hospital, cannot access the service from home, or we have to reply on private care homes were no reablement is provided. The further integration into a single service planned between DCHS and the Council is designed to improve our overall capacity, reduce duplication and to maximise the use of the available beds.

- **Long term residential/ nursing care (P3)** - There appears to be an oversupply of care homes beds in Derby, which means there is not usually any major difficulties meeting demand for admissions or discharges into permanent care. There are however issues where people need more complex care, and it is more difficult to find a suitable opportunity for them. This has been recognised in the Council's Market Sustainability Plan:

Annex C - Market Sustainability Plan - Derby City Council

There are a number of BCF funded schemes, as well as a large number outside of the BCF that impact on the key metrics that capture how well we are working together to keep people at home for longer:

- The provision of equipment that enables people to stay at home
- Social Care assessments and providing support at home using private home care agencies
- Our D2A services – Perth House and Home First, as well as the therapy services provided by DCHS, whereby we will seek to maximise someone's independence using reablement and rehabilitation.
- The support provided to the VCSE sector to support carers to remain caring for their loved ones at home, for longer
- The Healthy Housing and minor repairs, adaptations, home improvements provide that keep people at home for longer by reducing the risk of housing and warmth related escalations in need, especially during winter months
- Local Area Coordinators and the Mental Health Enablement workers whom work in partnership with local communities, supporting people before their needs escalate and connecting them into community based support
- Community Nursing provide by DCHS which delivers care in patient's homes to prevent conditions deteriorating
- Integrated Community Support Teams provided by DCHS, where together with primary care, teams work to co-ordinate proactive care for people who are at risk of dependency due to physical or mental health issues

The Planning Submission template describes the actual targets set but the BCF specific funded activity that will contribute during 23-25 is summarised below:

Avoidable admissions - the Derby and Derbyshire ICS planning assumptions are that despite demographic challenges, there will be a similar level of hospital admissions this year. Given the BCF alone cannot exclusively impact the metric on how many of these will be avoidable, a modest reduction in this plan is set at 1% which we estimate to equate to 770 avoidable admissions per 100,000 population in 23/24.

Falls –the Derby and Derbyshire ICS planning assumptions are that there will be a 4.5% reduction in the number of people admitted to hospital as a result of falls, however the BCF alone cannot achieve this and there are no dedicated falls interventions funded by the BCF. A modest reduction of 1% is therefore included in the BCF plan which we estimate to equate to 1,123 admissions due to falls in 23/24.

Residential Admissions –in line with our ongoing strategy to reduce the number of people admitted into long term institutionalised care, we are estimating that the number of new

admissions will be largely similar in 23/24 to 22/23 – however due to demographic changes we are expecting more demand for long term support. We have therefore planned to have 257 admissions into permanent care homes per 100,000 population.

Reablement – we are planning to maintain our 22/23 outturn position of 84.1% of people being at home after 91 days, although we are expecting to see more people accessing reablement – up from 766 to 959.

National Condition 3 - Providing the right care, at the right place, at the right time.

Since June 2022, a dedicate Discharge Flow Lead has been supporting the ICS to better understand where discharge improvements need to be targeted. The main focus has been on developing a strategy to expand Pathway 1 in line with the national Home First principles. There has been a series of workshops and engagement events, coupled with deep dive data analyses so that we now have a Discharge Improvement Plan that has been co-produced with all system partners. The agreed vision for Pathway 1 is:

People are supported to receive personalised care, delivered as 'what matters to them' in the right place and right time. Returning home is the aspiration for every person.

To achieve this, there are a set of principles that all partners are signed up to which are set out below:

- People are listened to and an active part of the process
- Assessment of long-term need is in the person's home
- Strength-based discharge planning starts at point of admission to acute/intermediate care
- Strength-based conversations are preferred to referral forms
- Localities provide a multi-agency (place based) approach to P1 which maximises independence through a timely and efficient strength-based approach (66% of people should leave P1 with no onward care needs)
- We have one streamlined process to assess for and access a standardised P1 offer

There are a series of ongoing working groups, that are focused on how the strategy will be embedded and what changes need to take within our acute hospital, the integrated Discharge Hub and with the support needed to discharge and assess people outside of hospital.

Dedicated discharge funding within the BCF for 23-25 - a process is in place to track progress of the BCF interventions against the desired impact and outcomes within our local Improvement plan & the national objectives of the hospital discharge and community support guidance. In Derby, the funding is being prioritised as follows:

- Additional staffing to support the onward flow of patients from D2A pathways, including expanding the staff available to identify where Pathway 0 may be appropriate
- A dedicated VCSE discharge service to get more people home on Pathway 0, without the need for ongoing formalised care
- Additional staff to develop a mental health Discharge to Assess pathway
- Additional Brokerage staff to support the P3 Pathway
- Making funding available to care providers during winter 2023 so that they can provide additional capacity, and also so they can offer rewards and incentives to retain staff during this period
- Paying for additional private care capacity to provider short term care, where are existing D2A Pathways cannot support demand

Demand and Capacity for discharge – as stated above, there appears to be enough capacity for P1, although this is currently only possible by combining NHS rehabilitation support with social care reablement. We plan to further integrate these service in 23/24 t0 ensure that where capacity and demand are not aligned, this can be rectified by combining our workforce and reducing duplication and handoffs. Given this is the same workforce that supports our P2 capacity – we believe this integration will also increase the capacity we have to meet the demands for bedded care on discharge, as all of the beds we have will be available to take people who need them most – rather than us needing to access private care home beds where no reablement is provided. Not only will this mean we are more likely to meet 100% of demand, but the outcomes for individuals will be

consistently better as more people will benefit from reablement after being discharged from hospital.

Discharge to usual place of residence - we are planning to see a 0.5% in 23/24 increase in the number of people discharged from acute hospital to their normal place of residence. This will be achieved by the range of interventions in place using the dedicated BCF Discharge funding, but also due to the further integration of our D2A pathways as described previously which we hope will increase our capacity, maintain our low length of stay and ensure that only those who need to, go into bedded care post hospital.

Progress in implementing the High Impact Change Model

A number of the developments within the Derby City Place are designed to improve the overall experience and outcomes for individuals who need to transfer between the care of separate health and care organisations. Team Up is specifically designed to improve and accelerated integrated care delivery. Our progress against the main areas of the model is listed below:

Population health management approach to identifying those most at risk –

Our ICS recognises that an effective knowledge and intelligence capability, with sufficient capacity, is critical for enabling intelligence-led decision-making, planning and delivery of population health improvements, reducing health inequalities and integrated care. Population health management (PHM) is a key part of the 'data-led toolbox' required to deliver this and embedding PHM as part of a wider shift to data and intelligence-led decision-making, planning and delivery, is essential for the successful delivery of our population outcomes. Other elements of the 'toolbox' include the joint strategic needs assessments, topic-specific needs assessments, equity audits, evidence reviews, use of qualitative data, public and professional experience and insights. Also essential is evaluative capability and capacity to help determine the success of our actions and interventions. A vibrant and collaborative research culture and capability is also key to support the systematic and robust development of new knowledge, in terms of medical and technical advances, but also in the fields of prevention and wider determinants.

Within our ICS, there is a Strategic Intelligence Group (SIG) which gives oversight to developments and implementation of our data and digital strategies, including activities towards implementation of a single linked repository of health, care and wider determinants data to support both operational and strategic decision making. This is not held at Place level currently, nor receives any funding from the BCF. However, it is anticipated that using PHM data and information to identify and understand defined populations and the factors driving their physical and mental health, will be able to help BCF funded interventions be targeted. This is likely to impact those BCF interventions working with people with long term conditions such as the community nursing and therapy teams, social work and preventative approaches such as the mental health enablers and Local Area Coordinators. It is hoped that better understanding through use of PHM data will accelerate proactive care and helps us reduce health inequalities and address the wider determinants of health through the collaborative partnerships that are developing at Place level through Team Up.

Target and tailor interventions and support for those most at risk - as part of the Derby City Place and Team up developments, we have 'local access and co-ordination hubs' that aim to bring together our community teams into one triage process, creating a single, joined-up patient journey. This is allowing a variety of teams to work together to prioritise resources on those citizens who need support most. In our acute hospital – there is an integrated discharge hub that coordinates and makes shared decisions on which

patients would benefit from D2A pathways (including Pathway 0). Outside of hospital, the local access points are coordinating our urgent community response and referring individuals to the range of place-based interventions such as GP home visiting. The PCN holds a weekly multi-disciplinary team meeting to explore which citizens would benefit from a proactive approach to support and care, and all health and care partners take part in this. It is hoped that the PHM data approach described above will enhance this work in the coming years. This will also include targeted action to achieve a reduction in the number of people at risk of falling. The funding mechanism to improve performance on falls is within Aging Well rather than the BCF, and this is funding a number of place-based falls initiatives, including improving the availability and coverage the urgent community 2 hour response for individuals who have fallen, and require physical assistance to recover, but have no or minor injury or illness. Derby City Place Partnership is closely working with Derby's TEC (technology enabled care) service called Carelink to enable responders to complete clinical observations and escalate directly to senior clinical support for triage and onward care.

Practice effective multi-disciplinary working - the developments described above are further improving MDT working and a number of the Place based teams are now located within the Council House and also at Perth House (our main intermediate care hub). There is daily discussion between partners about urgent cases (discharge and community crises), and weekly MDTs about individuals who would benefit from a joined-up approach to support and care. It is early days, but the place-based data set is suggesting that some of our performance indicators are improving, although it is not easy to attribute specific interventions to this.

Educate and empower people to manage their own health and wellbeing – the Team Up programme has a major focus on sstrength based assessments and as a result there are a variety of "quality conversations" training and reflective workshops being delivered. This is leading us to revisit our roles, ways of working and interventions so that we encourage individuals to make better use of the skills and assets that they already have to maintain their wellbeing. The Local Area Coordination model is heavily embedded in Derby and we are using the learning from this to help us work in a way that encourages independence, supports family carers, and genuinely seeks to listen to an individual, rather than prescribing how they should be supported. At Royal Derby hospital, we are rolling out a 'model ward' as a means of testing out new ways of working to support working in a strength-based way to facilitate discharges to normal place of residence. Trusted assessment is an area that we need to improve as we are aware of several 'rechecks' which take place along a variety of transfer of care processes. This work is focused on changing cultures and improving trust between staff and between health and care providers.

Provide a coordinated and rapid response to crises in the community – the development of our Team Up urgent community response is designed to prioritise our resources to deliver a crisis response in a timely way. The narrative plan has explained our plans for further integration within Team Up which is specifically designed to improve our capacity to enable more people to access urgent community responses, reablement and discharge support on the day it is needed, 7 days a week.

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

There are a wide variety of areas that are being funded in the BCF that are supporting delivery of Care Act duties. These are listed below and fund a range of direct social work assessment, advice and care planning as well as paying for the cost of associated care for

individuals. The BCF is also funding a wide range of preventative and supportive functions that are also essential to the delivery of the Care Act.

- Social Care assessments and cost of care social care assessments and associated costs of care packages - Residential, Nursing and Community Services
- Assessment & Support Planning Teams funding social work support and assessments
- Mental Capacity assessments and those under the Deprivation of Liberty Safeguards by funding our safeguarding team
- Integrated Community Equipment providing equipment to enable people to remain in their homes
- Enablement & Intermediate Care - via our Home First model and the bed based assessments and rehabilitation at Perth House, including both the contribution from community health and social care
- Community urgent/ rapid crisis response
- Provision of integrated support in the acute hospital to support discharge, including raft of workers supporting onward discharges
- Mental Health Social Worker specifically supporting discharge planning on admission; embed social work input to MDT reviews
- Carers Support to carers and carers support for people affected by dementia providing access to further information, advice and support
- Healthy Housing/Handy Person service delivering minor repairs, adaptations, home improvements
- Property Adaptations - major adaptations
- Local Area Coordinators working with local communities, supporting people before their needs escalate and avoiding a crisis
- Mental Health Enablement support offering preventative, and recovery focussed support to people living with a mental health condition
- Social Care Commissioning function supporting care providers
- Provider fee pressures where the BCF is paying for increases in care costs to stabilise the care provider market

Supporting unpaid carers

The BCF funds funding of a universally available service for carers and also a dementia support service. Both of these interventions are provided by voluntary sector providers and they offer family and informal carers access to vital information, education and advice as well as providing wellbeing and peer support events which can provide unpaid carers with valuable respite opportunities from their caring role. In addition, both services provide sessions where those being cared-for are also welcome, allowing carers to continue to enjoy activities with their loved ones. All carers are offered a support plan using person-centred approaches to map outcomes& and supported to achieve these outcomes through accessing a wide range of free and low cost community based support, as well as being referred for a formal carers assessments under the Care Act.

For 23-25, our priority is to ensure that the commissioned services funded by the BCF continue to meet demand within the available resources given they have experienced increased referrals. During 2022/23, the dementia support service dealt with 708 referrals from people with dementia, and an additional 576 carer referrals. More than 4,600 support responses were delivered in total. The universal service had 3,212 contacts during 2022/23, including 2,049 contacts for carers, 728 referrals, and 435 professional enquiries.

Of those supported by the voluntary sector or peers, the Council supported 842 individuals via formal Care Act assessments during 22/23 and allocated 470 cares personal budgets.

Disabled Facilities Grant (DFG) and wider services

The strategic approach to housing is set out in the Council's Housing Strategy 2020-2029 which outlines our ambitions for investment in good quality and well managed housing to support health and wellbeing, and enhance the quality of life of adults and the life-chances of young people. The strategy recognises that access to housing enables people to access the services they need and maintain independence, contributing to stability and a sense of identity. A recently concluded housing stock condition survey of both the privately owned and rented sectors, and an accompanying health impact assessment, produced by Derby's Public Health Intelligence team, have provided an unprecedented level of insight to ensure we target some of the most vulnerable citizens in the city. Aligned to this is the local Place Partnership which is also focused on ensuring individuals can stay in their own home for as long as possible, rather than moving into an institutionalised care setting. Housing is seen as one of the key priorities in this collaboration and therefore housing is a key contributor to Team Up.

In addition, the health needs are periodically analysed through a Joint Strategic Needs Assessment, produced by the Public Health Department in collaboration with key partners, and implemented by Derby City Council and the NHS Derby and Derbyshire ICB through Derby's Health and Wellbeing Board. Our HWB recognises the role housing plays, stressing that living in poor quality or otherwise unsuitable housing is a potential major factor in ill-health, accidents and wellbeing. In contrast, availability of good, suitable housing is identified as a driver for better health and enhanced wellbeing. The BCF supports this using not only the DFG as a mechanism to improve homes for disabled people, but also by the funded Healthy Housing Hub which continues to bring together a range of local partner agencies and organisations to offer information, advice and practical housing assistance to vulnerable residents where their housing conditions are impacting upon their health and wellbeing. The aim of the service is to achieve better health and wellbeing through ensuring individuals live in a safe, affordable and suitably adapted home. 1,100 referrals were completed in 2022/23 for the handy person element of the service – largely delivering preventative measures to limit trips and falls hazards, installation of low-level adaptations such as grabrails and key safes. The Healthy Housing hub also dealt with an additional 800 referrals completed 2022/23 with interventions dealing with measure designed to keep homes safe and warm. The main DFG offer provided 270 adaptations in 2022/23) in close conjunction with social care and health colleagues, including the hospital discharge pathway to ensure that homes are safe on discharge.

Additional information (not assured)

The Council's Housing Renewal Policies have used the flexibilities enabled by the RRO since approximately 2004. As examples, the Council have been able to provide a discretionary top-up to the mandatory £30k grant of £20k, removed means testing for works below £2k and have been able to offer Relocation Assistance where it is impracticable to adapt the clients current home. Derby is committed to continue to use the financial flexibilities offered by RROs to provide assistance, directly or indirectly, for a range of housing interventions. These include adaptations for disabled people, improvement grants, and other assistance to help owners, landlords, and tenants to repair and improve their homes.

We do not separately set out a budget for top-ups at the beginning of the year, but in 2022/23 we spent a total of approximately £253k on top-up grants over the mandatory £30k limit. The gross expenditure for cases above the mandatory limit was approximately £940k (i.e the total of mandatory and discretionary expenditure on cases costing above £30k). We

also supported 3 discretionary Relocation Grants to help people move from unadaptable properties at a cost of £27k. In percentage terms, 8.5% of the overall budget was spent on Discretionary DFG supporting £20k top-ups and relocation.

Equality and health inequalities

The main changes since the last BCF Plan is that publication of the Integrated Care Strategy which sets out how health and care partners are aiming to increase life expectancy and healthy life expectancy and reduce the inequalities experienced, by tackling the conditions that cause these and their primary drivers. Although not referenced explicitly, the BCF investment will be critical to supporting longevity of life and independence at home, including in delivering upon our Care Act duties, implementing assistive technologies and equipment, prioritising housing related schemes and property adaptations, carers support services, and in areas of prevention and early intervention. Where citizens do require hospitalisation or more formal care arrangements, the BCF and associated discharge fund are being used to ensure safe and timely discharge from hospital, and appropriate packages and placements of care to manage demand associated with demographic growth, age and complexity of cases. In all instances, support is delivered equitably and where appropriate, is targeted to ensure we are maximising outcomes for our most vulnerable residents, for example through our Healthy Housing Hub and Local Area Coordination approaches.

Life expectancy and healthy life expectancy within Derby and Derbyshire - the health of a population is described using healthy life expectancy and life expectancy statistics, and health inequalities can be starkly demonstrated by illustrating the difference in length of life, and how many of those years are spent in good health. Please see **Table 1** below for a summary of the differences in Derby and Derbyshire.

Table 1

	Derby	Derbyshire
Life Expectancy at Birth [inequality gap*], in years		
Female	82.1 [10.1]	83.0 [7.4]
Male	78.6 [10.2]	79.6 [8.3]
Healthy Life Expectancy At birth, 2017-19 [inequality gap, 2009-13*], in years		
Female	62.0 [19.2]	61.3 [13.5]
Male	59.9 [18.7]	61.1 [13.7]

** The inequality gap describes the difference between the least and most deprived populations. Life Expectancy at Birth statistical measures estimate the average number of years a new-born baby would survive if they experienced the age-specific mortality rates in this area throughout life. Healthy life expectancy measures reported years in good health.*

The inequalities illustrated in **Table 1** are distributed differently across the area. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from Black, Asian, and minority ethnic backgrounds, those with serious mental illness, people living with disabilities, LGBTQ+ people and people currently homeless.

How the BCF is contributing to improving health inequalities - The BCF is likely to impact most in relation to health inequalities affecting older people, those in poor housing and those with mental health. For older people, the support accessed via reablement is clearly designed to increase the likelihood of someone living at home for longer, and during the life of the plan (23-25) – the integration plans between the Council and DCHS should see an increase in the numbers of older people who can access and benefit from reablement.

For people living in poor housing, the Healthy Housing Hub and the DFG already offer a route to improve the physical condition of the home as a key determinant impacting on good health. As stated above, as the PHM intelligence become available, this will be used to further target these areas to make the most in roads into housing related health inequalities.

For people affected by mental health, the BCF is funding a range of social work, support and physical health interventions that will be either universally available or targeted at people with mental ill health. The BCF funded mental health enablement and discharge support workers will form part of the overall Derby Wellbeing collaborative between health, social care, housing and voluntary sector partners Living Well Derby approach:

Derby Wellbeing | Health & Wellbeing (livingwellderbyshire.org.uk)

Derby Wellbeing has evolved following work in 2021 in Derby City to co-produce a new vision for mental health services to bring together a Living Well team of mental health nurses, occupational therapists, voluntary sector workers, peer workers and social care support. The Derby Wellbeing
Collaborative is aiming to support people experiencing ill health using stories and data and by
supporting the community (citizens, peer networks and community based support) to grow their connections so Derby City feels alive and connected to each other as a means of reducing the impacts of poor mental health.

Other funding from the BCF that is paying for Local Area Coordinators and support for carers are also both directly contributing to reducing the inequalities gap. In 23/24 – through the mechanism of Team up – these interventions will be enhanced once the wider population health management approach becomes more developed as this will help us to target these interventions even further to those who would benefit most.

Wider interventions and developments in the ICS, beyond the BCF

Within the ICS, there are existing and emerging approaches for prevention, health inequalities and population health management and a data set is emerging about the desired population outcomes and priority indictors affecting health and inequalities. These priority population outcomes and key indicators (known as Turning the Curve indicators) will be based upon the JSNAs and will focus on increasing life expectancy, increasing

healthy life expectancy, and reducing inequalities. The new Integrated Care Strategy has built outcomes based on improving the overall health of Derby and Derbyshire's population and these are set out in the strategy under the areas of focus:

- **Start Well** – People have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care, and education. Children thrive and develop positive and healthy relationships.

- **Stay well** - All citizens live a healthy life, can make healthy choices, and are protected from harm. They maintain quality of life and recover well from ill health or injury.

- **Age well and die well** - Citizens thrive and stay fit, safe, and secure into older age. They maintain independence and actively participate in society. They have a personalised, comfortable, and supported end of life.

The latest iteration of our 'Turning the Curve' indicators have been agreed as important 'markers' on the way to improving high-level outcomes and therefore require focussed activity. They address direct risk factors for the main causes of death (biggest causes being cancer, respiratory and circulatory disease), illness, and inequalities, including mental health.

1. Reduce smoking prevalence
2. Increase the proportion of children and adults who are a healthy weight
3. Reduce harmful alcohol consumption
4. Improve participation in physical activity
5. Reduce the number of children living in low-income households
6. Improve mental health and emotional wellbeing
7. Improve access to suitable, affordable, and safe housing.
8. Improve air quality

The ICS has also identified indicators to reduce specific inequalities for adults drawing on local data and NHS recommendations known as "Plus 5" indicators and these will require accelerated improvement:

- **Maternity:** ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups**.**
- **Severe mental illness (SMI) and learning disabilities:** ensuring annual health checks for 60% of those living with SMI or learning disabilities**.**
- **Improving vaccination uptake:** reducing inequalities in uptake of life course, COVID, flu and pneumonia vaccines
- **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
- **Hypertension case-finding:** to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

** https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/*