Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to:
NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Derby City**
Clinical Commissioning Groups	**NHS Southern Derbyshire CCG**
Boundary Differences	**Derby City Council is wholly contained within SDCCG Boundaries. CCG is also part of BCF Submission with Derbyshire County Council.**
Date agreed at Health and Well-Being Board:	**13 March 2014**
Date submitted:	**4 April 2014**
Minimum required value of BCF pooled budget: 2014/15	**£957,000**
2015/16	**£17,403,000**
Total agreed value of pooled budget: 2014/15	**£5,264,000**
2015/16	**£17,403,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Southern Derbyshire CCG
By	Sheila Newport
Position	Chair
Date	4 April 2014

Signed on behalf of the Council	Derby City Council
By	Mark Tittley
Position	Cabinet Member for Adults & Health
Date	4 April 2014

Signed on behalf of the Health and Wellbeing Board	Derby City Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Paul Bayliss, Leader of the Council
Date	4 April 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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

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

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

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

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

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

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

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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

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

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

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

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

Voluntary Sector Integration Events:- The CCG ran a specific event to discuss how the CCG and voluntary sector might have collectively work to improve local services, and provide an opportunity for the voluntary sector to share with the CCG what they see to be some of the main issues facing users of services. The event was attended by over 80 people representing a range of local voluntary sector organisation. (Summary available).

e) Related documentation

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

Document or information title	Synopsis and links
Derby City Health & Wellbeing Strategy	
JSNA	
Strategic Outline Business Case for development of integrated care system for frail and elderly (SDCCG)	
Derby City Dementia Strategy (Update)	
Improving Urgent Care Programme (SDCCG)	
Your Life, Your Choice – building sustainable care and support in Derby	Draft Adult Social Care Strategy & Action Plan (2014/16).

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision

The Derby City Health & Wellbeing Board have agreed to work towards services that meet the "National Voices"[1] vision and definition of integrated care which is that:-

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

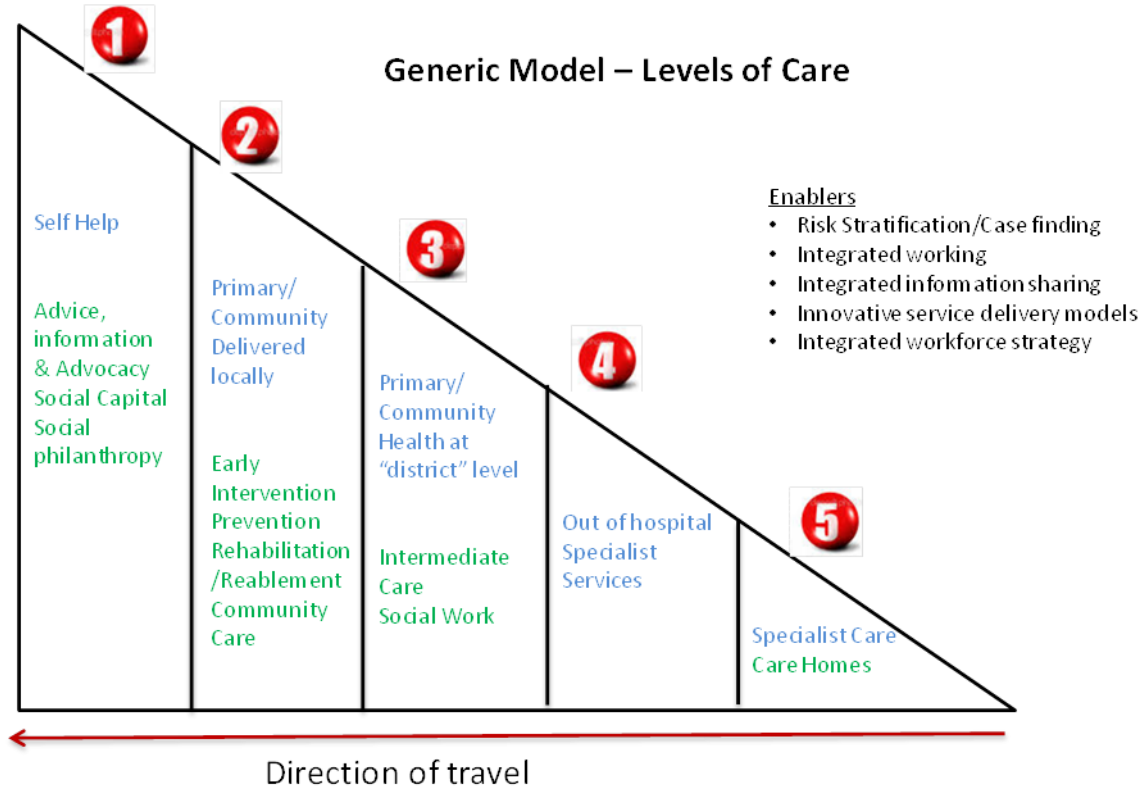
This model is underpinned by the following guiding principles where care must:-

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

A generic model has been agreed to describe health and social care provision within "levels of care". This model is now being applied to integrated care, urgent care and long term conditions, and has the potential to also be applied to mental health and children's services. The CCG and local authority are currently mapping existing community services against the model with the intention of developing a joint investment profile.

[1] [National Voices – Reference]

Over the next five years our aspiration is that, as much as possible, people find the support they need at the left hand side of this model (see below). To enable this we will need to change the financial profile by moving services and resources closer to the individual. Recovery, or getting people to be the best they can be within the constraints of their personal circumstances, is at the core of our health and social care system.



We want to engineer a step change in the following:

1. Increase the number of people who avoid formal care and support because they have their needs met through natural community support
2. Decrease the number of people with a long term condition(s) living without an informal network of support
3. Increase the role of peer support and educators to help people manage their condition and recover
4. Significantly reduce the number of unplanned admissions to hospital and care homes through effective admission avoidance interventions
5. Increase recovery outcomes across all client groups through increased and improved recovery services
6. Significantly reduce the number of people going into long term care from a hospital bed
7. Reduce delayed discharges through increased community-based services and effective care pathways
8. Timely and effective support to carers

Changes in the pattern and configuration of services:

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

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

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

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

These teams will be complemented by a rapid response service obtained through a single point of access that GPs have confidence in because it guarantees it will see someone within 2 hours of referral and has a comprehensive spectrum of services it can call upon to support people at risk of an admission. The work of the service is ably supported by geriatricians who will spend a significant proportion of their practice time in the community. Health and social care support staff will work together to provide a single source of care for patients.

Recovery capacity and expertise will have increased across physical and mental ill health services. Rather than go to day centres, people with a mental health problem will go to Recovery College to gain the skills and confidence they need to overcome

their illness. Rather than people be assessed in hospital to facilitate discharge, the default position will be to discharge people home to assess, ably supported with intensive support and night sitting if required in the first few days. Only by exception will people receive rehabilitation in a community hospital bed with greater use of care home capacity and people's own beds with peripatetic therapy support and care workers acting as agents of therapy. It is likely that we will need less buildings as services will be delivered in people's own homes.

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

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

It will mean:-

- More people will be able to remain living in their own home for longer in greater control of their health and well-being
- They will have an improved experience of using community-based services as our integrated approach means that:
    - They only have to tell their story once
    - The service offer is consistent across all the days of the week
    - They know the name of the person they need to contact if they need help
- They have an increased sense of security because they know they can get help quickly – whether it be for social, physical or mental health reasons
- Less people go into long term care because there is a greater level of support available to help people recover
- More people are in direct control of their support because of increased take up of Health and Care Personal budgets.
- More people able to access 'a good death' at home, or in a community setting if preferred.
- Less people being admitted to Acute Services where this can be avoided
- A smaller proportion of people being discharged from an acute hospital directly to long term care

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our strategic aim is to achieve at scale and pace a sustainable health and social care system that delivers the right care, in the right place, at the right time for individuals.

Objectives
To achieve our overall vision and aims we have identified a number of key objectives. These are:-

- We will support people to remain independent and in control of their lives
- We will provide co-ordinated personalised support in the community when needed
- We will put recovery at the heart of what we do
- We will reduce the number of unplanned hospital admissions, and where people do need to go to hospital we will ensure they get home as soon as possible
- We will reduce admission to institutional forms of care wherever possible
- We will ensure the Health & Social Care system in Derby is equipped to deliver these service changes to the highest quality

Progress
To measure progress against these objectives we will monitor a core set of metrics linked to our programme of planned changes as this develops. [See section c below]

Health Gain
Improvements in health gain for our population will be measured against the seven key areas highlighted in "Everyone Counts"[2], these are:-

- Securing additional years of life for the people of England with treatable mental and physical health conditions.
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

[2] Everyone Counts [reference]

In this section we described the entire joint work programme to deliver the integrated system outlined above, has already begun. Whilst it is recognised that there will be a requirement to increase the pace and scale of the projects, many are already underway. It is also clear that the programme will develop over the next 5 years and that current plans are primarily based on the first 2 years of this programme.

This programme forms a key part of both the CCG operational plan, and the City Council's Adult Care strategic plan. The continued alignment of projects will be maintained through the cross agency programme groups, the Adult Commissioning Board and ultimately the oversight of the Health and Wellbeing Board.

We recognise that over the next five years there will be an unprecedented amount of change within the system. Health and Social care organisations are committed to working together to ensure that providers are able to continue to provide high quality services whilst this transition takes place.

- **We will support people to remain independent and in control of their lives.**

Planned Change	Year	Process
Roll out of Local Area Co-ordination across Derby	13/14 14/15 15/16	Pilot LAC covering 2 Electoral wards Roll out to further 5 wards (Total =7) Roll out to further 3 wards (Total =10)
Improve information available to the City population to help them make good choices about health & social care needs in appropriate formats	14/15 14/15	Council website development GP Practice website improvement (subject to challenge fund) Improve information available and ensure it is accessible, states what is available and how to access it.
Development of Personal Health & Social Care Budgets	14/15 15/16	Make PHB available for Continuing HealthCare & continue implementation of PB for social care Pilot H&SC Personal Budgets for other care groups.
Increased support to carers	15/16	Support to carers who support people with dementia, will be secured. To provide carers with a carers assessment and a range of support linked to the care and support bill.

We will measure success of this through:-

Measuring people with Long Term Conditions feeling supported to manage their condition.
Number of people with personal health and social care budgets
Number of personal budgets taken as a direct payment
Hits on the relevant Council web page

- **We will provide co-ordinated support in the community when needed**

Planned Change	Year	Process
Full implementation of Community	14/15	All Teams established & operating regular

Support Team Model (CST)	15/16	MDT's Alignment of Mental Health services to CSTs
Development of peer supporters and educators	14/15 15/16	Local Area Co-ordinators will connect to the local community within the Community Support team "patch" to build up a pool of citizen leaders, volunteers and carer champions. The entire city will have a LAC by 2015/16.
Consolidation of the Health Housing Hub	15/16	The Healthy Housing Hub will secure funding that will act as an "Independence Fund" to make appropriate interventions to reduce risk and promote independence.

We will measure success of this through:-

- Reduction in Non-Elective admissions
- Improvement in rate of referral to e of Intermediate Care/Re-ablement services
- Reduction in admissions to care homes
- Reduction in Delayed Transfers of Care

- **We will reduce the number of unplanned hospital admissions, and where people do need to go to hospital we will ensure they get home as soon as possible**

Planned Change	Year	Process
Develop an integrated Rapid Response service through the Single Point of Access	2014/15 2015/16	Review current Rapid Response services in Health & Social Care Deliver an integrated service with a 2 hour response standard across 7 days Link this process to the CST teams to ensure longer term support.
Appropriate provision of 'Step up' and 'Step down' services to support CST's & SPA	2014/15 2015/16	Review current provision & model likely demand & options for provision Commission and implement services
Improve 'flow' of patients through acute hospitals	2014/15	Embed discharge planning tools (as appropriate) in acute & community hospitals Develop 'Home first' principles in Discharge planning. Ensure carers are involved at an early stage. as part of the discharge planning arrangements
We will invest further in falls prevention.	2015/16	Further proactive work on falls prevention for older people will reduce unplanned and emergency hospital admissions
To invest in carers having an emergency plan	2015/16	To ensure all services are aware of the emergency plan and how to activate it.

We will measure success of this through:-

Reduction in avoidable Emergency admissions
Reduction in Delayed Discharges

Reduction in hospital Bed Days
Improvement in Patient Experience
Reduction in the rate of falls leading to hospitalisation

- **We will reduce admission to institutional care wherever possible**

Planned Change	Year	Process
We will increase our focus and expertise in supporting disabled adults of working age in the community Offer an ageless option for the 'cared for' to receive respite support	14/15 15/16	The Ordinary Lives team will extend its remit from working with people with learning disabilities to include adults of working age with mental health issues and people with physical disabilities Extend the use of ordinary lives as a respite option to prevent carer breakdown as part of planned support.
We will increase the availability of extra care housing and other retirement housing options	14/15 15/16	70 bed unit to be built at Grange Avenue and 82 units Bath Street Mills
We need to better understand why our rate of placement for nursing care is significantly higher than our comparator average	14/15	Strategic review of utilisation of nursing care across health and social care to be undertaken Action plan formulated based on the outcome of the analysis
We shall ensure the system is equipped to deal with a shift from acute to community care	15/16	Increased investment in health and social care services available in community settings providing care closer to home
Ensure Community Equipment Services are available to ensure new model of care is supported	14/15 15/16	Review current equipment services contract & plan for future needs Commission for appropriate contract & management arrangements
To provide planned opportunities for respite care to support carers	15/16	Consider carers needs to avoid carer breakdown in a preventative approach to respite options. Linking to the 'cared for' assessment and the carer assessment

We will measure success of this through:-

Rates of admission into residential care – adults 18-64
Rates of admission into nursing care – adults 18-64
Rates of admission into residential care – adults 65+
Rates of admission into nursing care – adults 65+
Rate of continuing health care placements per 100,000 population

- **We will ensure the Health & Social Care System in Derby is equipped to deliver these service changes to the highest quality**

Planned Change	Year	Process
We will ensure we have a whole systems management information system in place that provides an evidence base for our work	14/15	Health and CareTrak to be rolled out after pilot is evaluated

We will have in place an electronic care record that is shared across health and social care.	14/15	Identification and evaluation of technical solutions.
We will ensure our multi-disciplinary working achieves good outcomes for people	14/15	The roll out of Community Support Teams will be under-pinned by a cultural change programme
Effective Commissioning	15/16	We shall ensure there is an effective commissioning structure in place to deliver the changes required of the whole system.
Delivery of the 'Care Bill'	14/15	We shall recruit a project manager to plan for the implementation of the Care Bill
Information sharing across Health & Social Care	14/15	We shall update the social care records system and data collection processes to routinely use the NHS no. as the personal identifier for people. We shall use the CareTrak system to target services.

Strategic Enablers

Business intelligence: across the whole of the Derby and Derbyshire both local authorities, all CCGs and all NHS providers (including out of hours) have signed up to using Health and Social CareTrak which is an application that draws data from all our organisations and supports analysis of impact on each other's functions. For example, it showed that referrals to A & E spiked at late afternoon as a consequence of GPs tending to do their home visits in the afternoon. The CCG has now written to all GP practices with this feedback and encouraged GPs to undertake their home visits earlier in the day. Adult social care can now see the pattern of service utilisation leading up to a permanent admission to residential care and are analysing this to see if interventions can be made earlier in the pathway to reduce or delay the likelihood of an admission.

Electronic care record: The CCG and City Council are part of a joint collaboration with providers to develop a real time electronic patient record that can be shared throughout health and social care. A Project Director is being appointed to lead the development of a significant bid for Department of Health funding. Early feedback has been supportive and promising. In the meantime, the City Council and CCG are evaluating the potential to use an existing package that runs on TPP systems (which are used by all but two GP practices in the City) to share health and social care data.

Leadership coalition: as well as our formal decision-making structures we have formed an informal leadership coalition comprising the Chief Officers and Chairs/ Cabinet members of the CCG, both local authorities and NHS provider organisations to create the space to develop our collaborative leadership.

Whole system economics: the work commissioned from Deloittes has given us a starting point but we recognise we need to do more work on developing an in-depth Business case across health and social care which sets out a five year plan with the savings, investment and payback detailed.

Workforce: we recognise we need to develop an integrated workforce plan so we have the staff we need with the right values and skills for our future operating model. Multi-disciplinary working will become the norm and we need to equip staff at all levels in our organisations to accept and thrive in this. We will identify key areas

where we need the workforce to integrate and commission leadership and workforce learning packages to be delivered in an integrated way.

Culture change: We recognise the greatest barrier to integrated work is the pervasiveness of our individual organisational cultures and what we need to create is a one Derby culture. Our starting point for this is to run a collaborative leadership course which is multi-agency and multi-disciplinary. Our workforce plan will include strategies for addressing cultural change.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The great majority of Derby City residents use Derby Hospital as their main acute provider so this plan is primarily addressed as supporting that hospital. The aim of this plan is to ensure that a) people only go to Derby Hospital if they are in need of a hospital services and b) once they are medically fit that people are discharged safely in a timely way.

Modelling work (Deloittes, 2012) commissioned by Southern Derbyshire Integrated Care Programme Board assessed the potential benefits of implementing integrated care for frail and elderly people. The report concluded that:

- Based on InterQual studies at Derby hospitals, 26% of all admissions to DHFT in the over 75 population could be avoided. Of patients who were admitted, 77% no longer needed an acute level of care at a point during their stay
- The need for social care will grow due to the ageing population – and at a greater rate in the County than the City because of the profile of their population
- Southern Derbyshire's performance was compared with value cases in 8 other communities with integrated care solutions to identify the scale of benefits that could be achieved
- Southern Derbyshire currently spends c£185m pa on the over 65 population across acute, community and social care
- If, under a number of different scenarios, care was provided in the community, for patients not needing acute care, there would be significant savings in acute care costs (£2-11m) but these would be offset by re-provision costs *if existing models of care in the community were still being used.*
- Implementing a Single Point of Access was seen to be the first step in reconfiguring the use of community services

Since the Deloittes report, the Integrated care Programme Board has made good progress in configuring community services by:

- Implementing a Single Point of Access to services
- Creating multi-disciplinary Community Support teams (CSTs) that work directly with general practices

- Developed the generic model of delivery for integrated service delivery (the 'wedge') that can be applied to Long Term Conditions, Urgent Care, and Children's services as well as for frail and elderly patients
- Restructured Derby City Adult Social care to directly support CSTs and provide a *Home First* recovery service

There is now a need to update the initial modelling work. Public Health is currently undertaking a project to estimate the number of acute hospital beds required to meet the needs of the current population. This will be based on analysis including hospital discharge information. Using demographic projections this will be extrapolated to provide an estimate of future need which can be triangulated against the Deloittes work.

The CCG, Council and all providers have undertaken detailed work during the last year to manage the increase in A&E attendances and urgent care admissions. This work has fallen in to four work streams:

- Reducing avoidable attendances
- Effective assessment and streaming
- Unblock flow constraints
- Better discharge arrangements

There is a clear synergy between these work streams and the integrated care programme described above. The full impact of both the urgent care and integrated care programmes on acute activity is still being worked through.

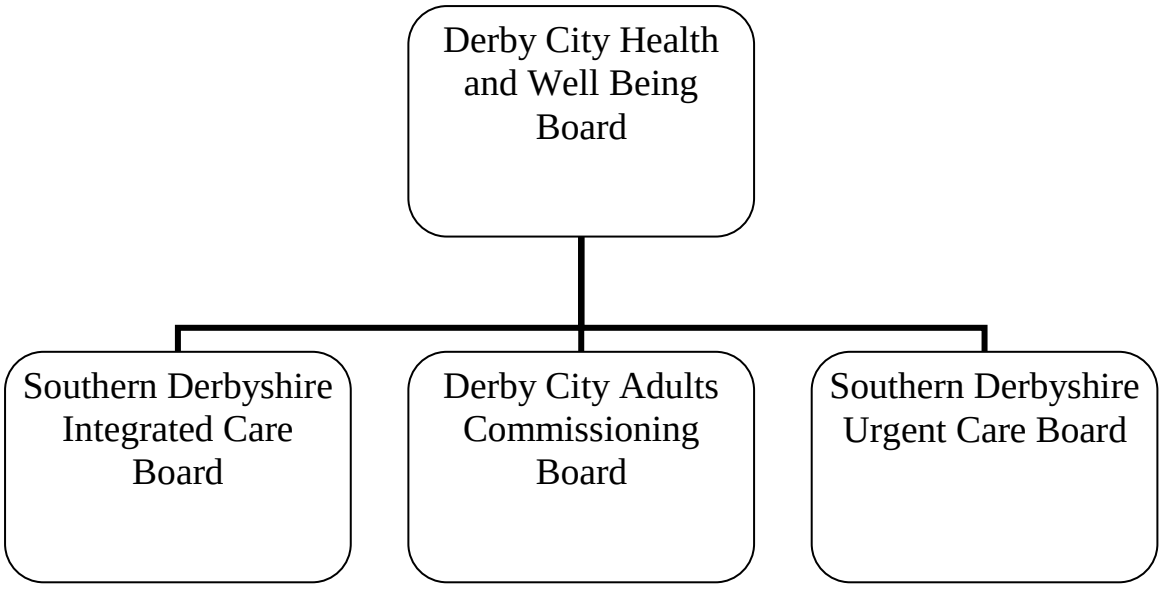
e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Derby City Health & Wellbeing Board retains oversight of the BCF arrangements as they develop, and are supported in this by the Adults Commissioning Board which reports to the Health and Well-being Board. During 2014/15 dedicated resources will be made available to establish the principles and working arrangements for the S75 pooled budget to begin in 2015/16.

The work-streams that will deliver the planned transformational changes will be overseen by the multi-agency Integrated Care Programme Board which has both commissioners and providers on it. This is a strategic group with executive representation. In order to best manage the inter-relationship between integrated care and urgent care plans we will set up a senior operational group that will sit underneath the Integrated Care Programme Board and the Urgent Care Board. This operational group will review delivery plans with exception reporting to the Integrated Care Programme Board.

(See section 1c for description of Governance groups)



f) National Metrics

This additional section has been added to the template to provide some context for the national outcomes and metrics targets identified in the accompanying spread sheet.

Permanent admissions of older people to residential and nursing care; the local authority performs and benchmarks well against this indicator at 568.7 per 100,000 older peoples population. Against the baseline of our comparator average performance for the same period is 698.3 which is similar to the England average performance whilst overall in the East Midlands the average is 759.1. We have made significant in-roads into reducing our rate of admissions to residential care:

Year	2010-11	2011-12	2012-13
Derby	540	486	472
East Midlands	482	568	572
Unitary authorities	550	535	559
CIPFA comparator	524	558	535

It is the rate of admission to nursing care that is our local challenge:

Year	2010-11	2011-12	2012-13
Derby	409	407	399
East Midlands	162	207	224
Unitary authorities	246	244	260
CIPFA comparator	213	225	225

We suspect the reasons for this are multi-faceted but include staff cultures, interpretation of continuing care guidance and the availability of community hospital beds.

Therefore it is evident that Derby City is at the top end of performance for residential admissions and further statistically significant stretch would require significantly more

investment and time than the resources and planning time-frame associated with BCF.

The demographics, of particularly the over 85's population in Derby (this cohort is more likely than any other to require residential and nursing care) which is set to increase by 10.3% between 2014 and 2016, means maintaining the current absolute number of admissions shall be a significant achievement.

Proportion of older people still at home 91 days after hospital discharge; whilst Derby has achieved excellent outcome performance on this indicator at 95%.This somewhat masks the underlying issues. Whilst the results for those engaged in re-ablement and rehabilitation services are excellent we feel the cohort of people entering these services are not sufficiently challenging from a reablement/rehabilitation perspective. In addition, the overall volume accessing these services is too low relative to our comparator group as indicated by the rate of offer measure, Derby is at 2.3 relative to a comparator average of 3.1 and England average of 3.2. Our focus is on increasing the offer rate to the point where we are at least reaching the comparator average offer rate. This shall inevitably require the selection of more challenging cases and therefore we expect the success rate to fall back to just above comparator average success rate of 83%.

Delayed Transfers of Care; during the baseline period of December 2012 and November 2013 there has been significant progress in reducing the monthly delayed transfer days from a high in December 2012 of 700 to a low in November 2013 of 284. This has been a result of working closely with the foundation trust to put in place alternative community pathways. A discharge pull team has been set up with the development of intermediate care and reablement services. In addition, there has been significant work on the flow of patients at the Royal Derby Hospital. We are not expecting significant further reductions in delayed discharge days in the short term.

Avoidable Emergency Admissions; during the baseline period the average number of emergency admissions has been fairly constant or at least within a narrow tolerance band, averaging 440. There are a number of initiatives planned such as the community support teams and further development of the single point of access to support a reduction in avoidable emergency admissions. However, with the changing demographic we are not expecting significant change in the rate of emergency admissions in the short term. The new interventions and pathways shall not be fully effective in the first year.

Estimated Diagnosis Rate for Dementia; this is our preferred local measure as it fits in well with our broader strategic plans. Dementia is recognised as a significant challenge nationally for the health and social care system over the coming years. It is also well recognised that an integrated approach to tackling dementia is critical to sustainable delivery of dementia care. Whilst we have submitted some provisional data for this indicator, we are awaiting the new prevalence tool which is due out imminently to finalise our final dementia diagnosis indicator submission.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

We will maintain a focus on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services. In addition we will ensure eligibility remains at substantial and critical for all services where this is applicable.

The BCF contains £5m of funding to protect adult social care services in 2015/16. This will primarily be utilised to protect eligibility criteria and ensure adequate care package sizes and quality of supply in the local care market. A further £618k of funding is also identified to support the introduction of the Care Bill, this is Derby's share of the national £135m allocated for this purpose via BCF. The latter funding shall be deployed to improve information and advice, assessment capability and revised training for the workforce on revised eligibility and charging frameworks.

Please explain how local social care services will be protected within your plans

The local authority budget remains extremely challenged, requiring savings of £77m over the next three years from September 2013. The latest forecast requires savings of £81m to balance the budget. This includes £29m in 2014/15, £31m in 2015/16 and £21m in 2016/17. The total savings required from adult social care equate to approximately 30% of the 2011/12 budget and represent a real term cut of around £7m or 11%.
Funding from the BCF will protect the existing level of resource for personal budgets and care home placements **and** it will fund the required growth in community-based support in order to help deliver savings from acute hospital provision.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We are committed to supporting 7 day discharge facilitated through availability of appropriately scaled seven day health and social care services across the city. The thread for weekend work starts with having an efficient system in operation during the week which ensures maximum discharge activity during the week which reduces pressure on weekends. There will be a seven day presence to facilitate the required discharges at weekends. Routine availability of key services shall be made available on a Saturday and Sunday. A joint approach to this between health and social care systems will be needed to create an efficient and effective model.

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

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

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

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

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

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

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

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

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott 2.

There is full commitment from Adult Care to making sure appropriate IG controls are in place.

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

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

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

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

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

internal controls and to include details of data loss and confidentiality breach incidents in annual reports;

Overall accountability across the organisations lies with the Chief Operating Officers who have overall responsibility for establishing and maintaining an effective information governance assurance framework for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

In response to The Caldicott Review 2012, NHS organisations have a nominated Caldicott Guardian whose responsibility is to act as the 'conscience' of the organisation. The Guardian actively supports work to facilitate and enable information sharing and advice on options for lawful and ethical processing of information as required.

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

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

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The agreed model of care for Derby community services is designed to deliver joint assessment and accountability which centre health and social care on individual patients. Within this model cross organisational agreement is that the Lead Professional should be the person best placed to undertake the role for the individual. The lead professional shall Identify key support networks including carers and informal support from the VCF sectors.

There is a structured approach to agreeing who is the best person to be the Accountable Lead Professional; depending on individual circumstances as discussed at the multi-disciplinary team meeting i.e. whether it should be GP, Community Matron, Social Worker or other professional. There is cross-organisational

agreement that the Lead Professional should be the person best placed to undertake the role for the individual. Teams are predominantly case managing people with highly complex needs, incorporating joint care planning and accountability

Governance and accountability will be strengthened during 14/15 with emerging national guidance and changes e.g. GP contracts.

We continue to await clarification for the Information Governance surrounding the use of risk management tools. However, in the meantime, local systems are being utilised. Currently individual teams are using a range of criteria to assess risk, including co-morbidity, number of Long Term Conditions, hospitalisation, falls and recent bereavement. Current existing processes will be systematised with the introduction of standardised risk stratification tools (to be rolled out in 2014/15) and formalised approaches to allocating a lead professional and agreeing accountability.

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

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

We have extrapolated data for one CCG area (2012/13) to provide an initial level of need on which to base planning assumptions for Derby City, which will continue to be refined during 2014/15:

- Self-Care/ Support Management: 15 % of Derby population
- High Risk: 4 % of Derby population
- High Complexity/ Case Management: 0.4 % of Derby population

4) RISKS

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

Risk	**Risk rating**	**Mitigating Actions**
Shifting resources around the Health & Social Care system	High	Close monitoring of changes through governance structure
Destabilising existing good relationship with providers & partners	Medium	Early involvement in changes
Destabilisation of providers	Low	Work with providers to adapt to changes
Workforce – lack of appropriate numbers and skills in time for new	High	Cross Derbyshire workforce planning to be

Risk	Risk rating	Mitigating Actions
models of service		undertaken, linking with local education bodies
Workforce and cost implications of 7 day working	Medium	Strategic sign up to 7 day working, but impact not yet quantified in all areas
Availability of appropriate IT solutions	High	Local 'work arounds' will enable progress to be made.
Information Governance concerns re: sharing data & records	Medium	National work expected to mitigate some of current issues being faced
Public Engagement	Medium	Consultation work to be undertaken, specifically where key service changes proposed
Savings in the Acute sector not achieved	High	PH needs assessments being undertaken and Finnamore provider economic work.
Social Care cuts affect delivery of targets and ability to fund preventive services	High	Current consultation and engagement seeking how to minimise impact.
Provider non compliance	Medium	Providers on-board but perverse incentives in the system may/will hinder progress e.g. tariff, targets, different national bodies such as Monitor and TDA.
GP and primary care response patchy	Medium	New Primary Care Strategies and new GP contract will assist.
Introduction of Care Bill will result in an increase in the cost of care provision from April 2016 that is not fully quantifiable and will impact on the sustainability of current social care funding and plans	High	Local work on costing will inform decisions about how requirements will be implemented. New national funding expected.
Competition Policy	High	Issues with collaborative work being seen as anti-competitive – discussions with NHSE.