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 CCG Boundaries. CCG is also part of BCF Submission with Derbyshire County Council.**
Date agreed at Health and Well-Being Board:	**16Jan 2014**
Date submitted:	**14 Feb 2014**
Minimum required value of BCF pooled budget: 2014/15	**£957,000**
2015/16	**£17,324,000**
Total agreed value of pooled budget: 2014/15	**£5,264,000**
2015/16	**£17,324,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Southern Derbyshire CCG
By	Andy Layzell

Position	Chief Operating Officer
Date	14 Feb 2014

Signed on behalf of the Council	Derby City Council
By	Cath Roff
Position	Strategic Director Adults, Health and Housing
Date	14 Feb 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	14 Feb 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

This draft builds upon 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.

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.

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 carer's 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, 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, compliance with essential standards of care, quality, outcomes, staff development and customer satisfaction

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 over a year 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: HealthwatchDerby 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	
The Derby Plan	
Derby City Dementia Strategy (Update)	
21st C Health Care report?	
Your Life, Your Choice – building sustainable care and support in Derby	Draft Adult Social Care Strategy & Action Plan (2014/15).

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"

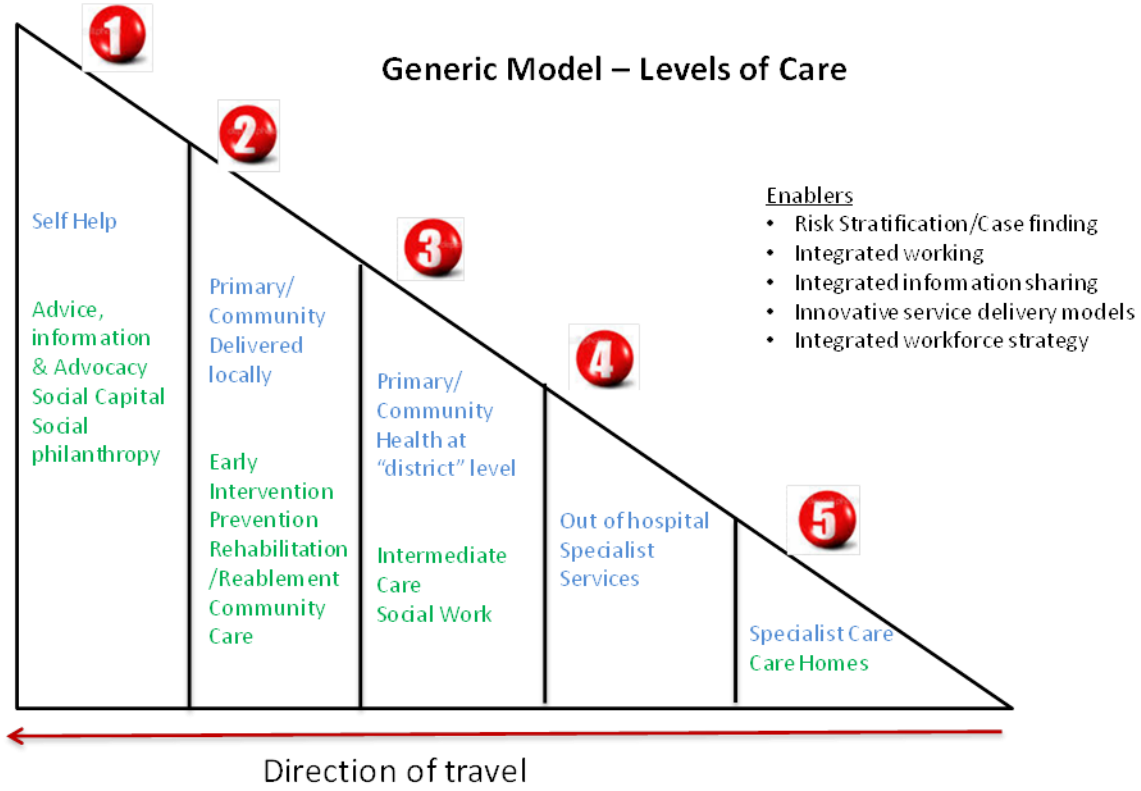
This is underpinned by the following guiding principles where care must:-

- 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 genericmodel 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. This CCG is currently mapping existing community services against the model with the intention of developing a joint investment profile.

Over the nextfive 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.

[1] [National Voices – Reference]



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

This will mean:-

- Better information and more choices for people before they access statutory services
- More people feeling able to stay healthy in their own homes, with the support of formal or informal carers
- A greater proportion of service users accessing Personal Health &/or Social care budgets
- The development of community services based around GP practice populations
- Better availability and usage of Intermediate Care/Re-ablement services
- Improvements in 'Rapid Access Services' to avoid unnecessary hospital admissions

- 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

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 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 fliers" 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 bygeriatricians 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.

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.

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?

Objectives

To achieve our overall vision & 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 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:-

[2] Everyone Counts [reference]

- 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*

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 5 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	14/15 14/15	Council website development GP Practice website improvement (subject to challenge fund) Improve information available

care needs in appropriate formats		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.

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

Planned Change	Year	Process
Full implementation of Community Support Team Model (CST)	14/15 15/16	All Teams established & operating regular 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 'success' 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 shall 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	14/15	Review current equipment services contract & plan for future needs

model of care is supported	15/16	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.

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.

XX% of Derby City residents use Derby Hospital so this plan is primarily addressed as supporting that hospital. The aim of this plan is to ensure that a) people onto 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 – mostly in the County rather than the City
- 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 Childrens services as well as for frail and elderly patients
- Restructured Derby City Adult Social care to directly support CSTs

There is now a need to update this initial 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.

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)

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.

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 works 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 shall 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 shall be needed to create an efficient and effective model.

Some existing work has already successfully taken place with Saturday working as part of 2013/14 winter planning arrangements. The learning form this shall inform our development of the weekend working model.

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.

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 all undertake IG audits each year to ensure they remain compliant with current IG standards

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.

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. Data based on 12/13 for one CCG area would suggest the following numbers across the City:

- Level 1} (78%)
- Level 2} (20%)
- Level 3} (2%)

Currently individual teams are using a set of locally agreed criteria to assess risk, including co-morbidity, number of LTC's, hospitalisation, falls and recent bereavement. The teams are predominantly case managing *Level 3*patients, incorporating joint care planning and accountability. Recent evaluation of existing schemes demonstrates that there will be benefits from extending this to the top of Level 2.

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 models of service	High	Cross Derbyshire workforce planning to be 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.