The Derby City Better Care Fund: 2016/17 Refresh

Derby City Council

JoinedUpCare in the South of Derbyshire

NHS
Southern Derbyshire
Clinical Commissioning Group

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Introduction, background & progress to date

Background and Context

Just over three-quarters of a million people live in Derbyshire. We have greater numbers of older people and fewer young adults and children and it is projected that by 2033 our population structure will be older still with 28% aged over 65, 15% over 75 and 6% over 85. This has major ramifications for health and wellbeing services and future planning. Generally over the last 10 years the rates of death from all causes and the rates of death from cancer and heart disease and stroke have all improved and are close to the average for England; and on average the health and prosperity of residents is as good as anywhere else, or even a little better. However, there are very significant variations between the most and least deprived areas of Derbyshire and these are reflected in a range of statistics around health outcomes: People in the least deprived areas can expect to live 10 or more years longer than their fellows in the most deprived areas and to be in good health for many more of those years too.

Derbyshire's districts can be broadly divided into two sections: those to the West of the County and those to the East of the County. The western districts are characterised particularly by their rurality, whilst the eastern districts are more urban and are more variable with regard to deprivation and health inequalities.

In summary the key issues for Derbyshire are:

- Ageing population
- Wide variations in health status such as life expectancy
- Rural deprivation and related problems accessing high quality care
- Areas of urban deprivation

More detailed analysis is available in the following documents:

- BCF 2015/16 Part 1
- JSNA
- Health and Wellbeing Board Strategy
- Joined Up Care Board Change Plan (South)
- 21st C plan (North)

The following page shows the Derbyshire area and some of the key health facts.

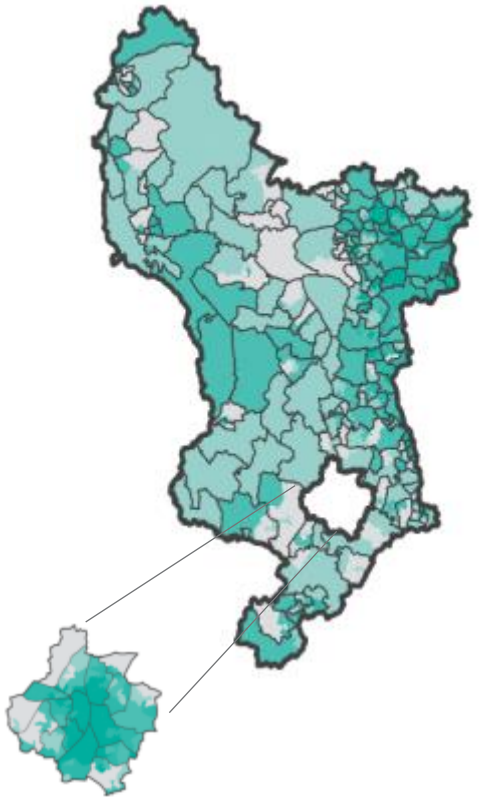
Derbyshire Health Profile

The health of people in Derbyshire is varied.
Life expectancy for men in some areas is 12.2 years lower in the higher deprived areas.

The Derby City and Derbyshire County Health Profiles for 2014 show the following:

- Life expectancy in Derbyshire County (M: 78.9, F: 82.7) is similar to the England average (M: 78.9, F: 82.8), while life expectancy in Derby City (M: 78, F: 82.2) is lower for men and women than the England average
- In the city, life expectancy is 12.4 years lower for men and 8.9 years lower for women in the most deprived areas of the city compared to the least deprived areas
- In the county, the life expectancy is 8.1 years lower for men and 5.9 years lower for women in the most deprived areas of Derbyshire than in the least deprived areas
- In the county approximately 16.6% (22,900) children live in poverty compared to 26.6% (12,100) in the city
- Obesity and being overweight have significant implications for health, social care, the economy and are associated with educational attainment. Being obese increases the risk of developing a range of long term conditions
  - 23.4% of adults are classified as obese in Derby city and 25.3% in the county which is worse than the England average (24.1%)
- Smoking status at time of delivery is an indicator of long term risk to the health of children and the proportion of mothers that smoke at the time of delivery is worse for both the city and the county compared to the England average
- Hospital stays for self harm, and alcohol and drug disorders is worse than the England average for both the city and the county.

Deprivation in Derbyshire: darker wards represent areas of higher deprivation.



Source: Derby City and Derbyshire County 2014 Public Health Profiles

Introduction to our Local Health and Care Economy -

Review of Derby City's BCF in 2015-16 – progress to date

In Derby City, progress against all BCF areas is going well, with almost all schemes reported as being "on track" or in progress.

The BCF is monitored at our Adult Commissioning Board which is the joint forum for SDCCG and Derby City Council to consider strategic and operational issues, with a clear focus on integration opportunities and BCF oversight. The Board in turn reports to the Health & Well Being Board. The NHS system wide transformation agenda is driven through the Joined Up Care Board and programme. This has a number of work streams that deliver and influence BCF performance. For example, there is a focus through the urgent care work stream on understanding the cause of delays within acute settings - having this system wide analysis is improving our understanding of the causes behind DTOCs and is enabling a more focused (and system wide) response to the issues. This Joined Up Care Board is also shaping the future role of community health and social care services, acting as an enabler for integrated service delivery where this is likely to improve outcomes for patients and service users.

Service reviews have taken place during the year in relation to dementia support services, carers support, equipment and intermediate care and improvements in the way these elements of the BCF are delivered in the future, are now being implemented.

A key achievement in the local health economy this year was the "strategic shift" that took place on the 1st October, whereby NHS intermediate care and therapy services were transferred from our main local Acute provider to one of our community focused providers. This has allowed greater synergies with wider community based and primary care services, and has allowed social care teams to better align their activity to improve the service to individuals and reduce the number of contacts with different agencies. The BCF mechanism will be used in 2016/17 to explore whether a fully integrated service model can de established.

Another achievement in 15/16 has been the continued reduction in non-elective admissions, although our year end performance may not quite meet our originally planned target. As well as improved patient flow, there has been a focus on understanding and improving our performance on DTOCs and developing and embedding 7 day working.

Care Act implementation has gone well in Derby although the impact of increased assessment requests and new safeguarding duties has yet to be fully evaluated. BCF schemes have assisted in bolstering our local preventative offer to support Care Act responsibilities. Local Area Coordination has been expanded via the BCF in 15/16 and an in-year social return on investment evaluation has found that interventions from LAC provide a £4 return for every £1 invested in terms of social value.

Review of 2015-16 (Cont…)

Performance in 2015/16 at Quarter 3

Area	Q3 Position
Residential Admissions per 100,000 population 65+	On track for improved performance, but not to meet full target
reablement – still at home 91 days after discharge	On track to meet target
Diagnosis Rate for people with Dementia.	On track to meet local target
GP Patient Survey: Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?	On track to meet target
Delayed Transfers of Care (DTOC) per 100,000 population 18+	On track for improved performance, but not to meet full target
Non Elective Admissions to hospital – payment for performance	On track for improved performance, but not to meet full target

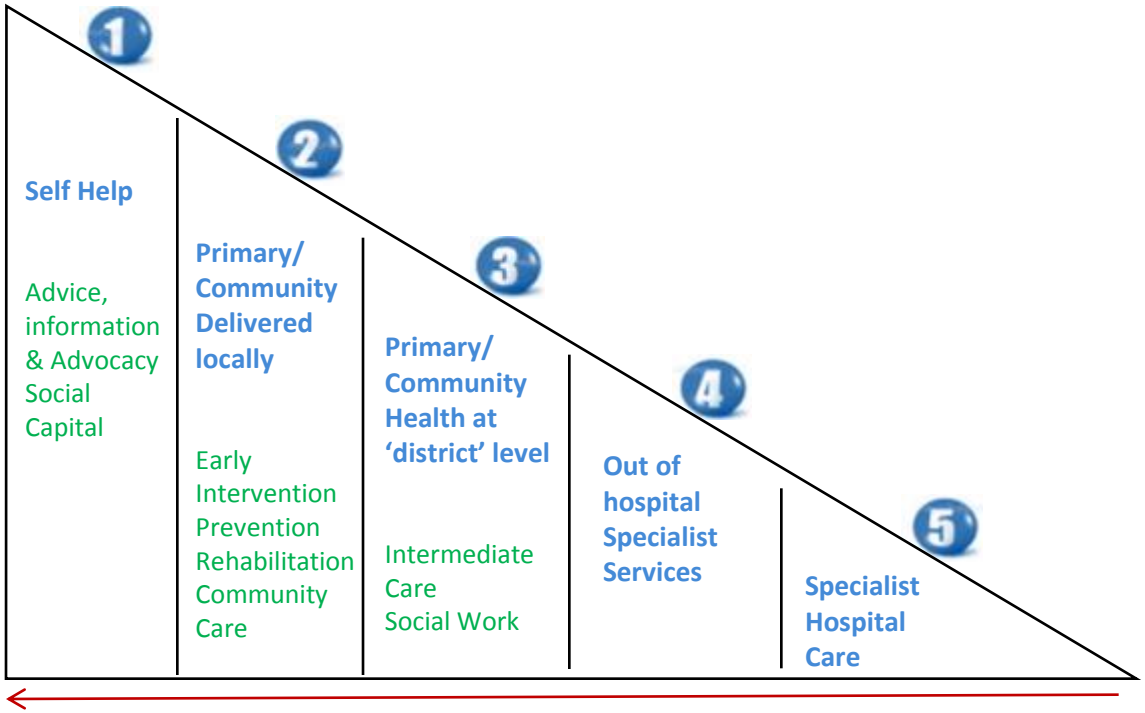
Our Vision for Integration

The Strategic Direction: The Wedge

The overall vision is for the health and social care system in Derby and Derbyshire is summarised as:
"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together the services which will achieve the outcomes important to me."

At the heart of our vision for the future is the support and empowerment of the people within Derbyshire, enabling them to manage their long term conditions and, with the support of family, friends and their community, remain independent. Community support teams will bring together social care, primary and community health services within defined 'places' (communities) to reduce admissions to hospitals and care homes. Where people do need to be admitted, close working between hospital and community clinicians will ensure they are supported upon discharge, enabling them to return to their own homes sooner. Increased preventative care and community support will enable hospital providers to focus on providing specialist care.

The delivery of our vision is represented by 'The Wedge' diagram, below, which shows the planned movement of resources from hospital care towards community based preventative services and self-care.



Examples of what the transformation will mean for our citizens

Samantha, 15 years old, is being bullied at school

BEFORE

Samantha has tried to take her own life by jumping from a bridge. She has been admitted to hospital with multiple injuries. The clinicians are taking excellent care of her; focussing on her immediate medical needs. Samantha's family are fearful that she will try to commit suicide again and succeed.

AFTER

Samantha has thought about committing suicide. She has access to an online counselling service via her mobile phone and tablet which enables her to easily obtain confidential and professional support and guidance. Samantha feels safer and is empowered to make positive choices about her future; she no longer contemplates committing suicide.

Jo, 53 years old, is a full time carer with terminal bone cancer

BEFORE

Jo has been admitted to hospital after breaking both her legs in a minor fall. Jo is a full time carer to her son who has a mental health condition and is an alcoholic. Despite the support from her case worker, she is unable to be discharged to her home because it is not deemed safe.

AFTER

Jo has been admitted to hospital. She is a full time carer to her son who has a mental health condition and is an alcoholic. The community team coordinate all the agencies to produce packages of care for both herself and her son. Jo is able to focus on her own health needs and be discharged safely to her home.

Bob, 83 years old, lives alone and has COPD and Heart Failure

BEFORE

Bob is on the Palliative Care Register with a Right Care Plan. He is being well cared for, but there is a long wait for the equipment he needs to enable him to stay at home. His condition is deteriorating and he is repeatedly being admitted to hospital. Bob is anxious about potentially dying in hospital.

AFTER

The community team has coordinated Bob's health and social care needs. He does not visit the hospital for routine appointments; care is delivered in his own home. Equipment is delivered on the same day as the assessment, whilst Telehealth enables healthcare professionals to remotely monitor his vital signs. Bob feels assured and more in control.

Derbyshire (including Derby City) Wide Planning

Developing the Sustainability Transformation Plan

In response to the *NHS Shared Planning Guidance* it was agreed by health and care leaders across both Derby City and Derbyshire County that all parties would contribute to the Sustainability Transformation Plan (STP), making it a truly system wide plan. The 12 organisations (NHS and Local Authority) agreed to create an ambitious local blueprint for accelerating the implementation of the Five Year Forward View (5YFV). The STP will be a place-based, multi-year plan built around the needs of local populations. This plan will be completed by 30th June 2016.

As at the middle of March the following progress has been made:

- the governance arrangements and processes to produce the STP have been agreed and are being implemented. The STP is building on existing relationships between senior leaders across the area. Currently there are two transformation programmes (North and South), which were originally agreed owing to patient flows to the main acute hospitals at Derby and Chesterfield. However, there is a common vision, many common themes and as many organisations are pan county/city it has been agreed that the two programmes will merge under one Transformation Board. Time and resource is being dedicated to the STP, with one nominated leader and a coherent leadership group.
- the scale of the challenge locally for each of the three gaps has been reviewed and initial analysis is underway
- key priorities to address known gaps relating to the three areas are already in place within existing plans. Further plans will be developed once the full gap analysis is completed.

Moving to Place Based Systems of Care

The BCF is a part of the STP and the move towards place based systems of care will enhance the concept of 'the team around the person' leading to a more integrated service, a reduction in duplication and greater efficiency. For a **defined geographical community with similar characteristics** all services – primary care, mental health, community services, social care and third sector sectors will operate as a **single team to wrap care around a person and their family.** There will be an equal focus to **empowering citizens** to self care and participate in shared decision making, and promoting healthy lifestyles and well being, as there is to providing direct care. Links with the local community will be fostered, recognising that communities have a range of complex and inter-related needs, but also have **assets at the social and community level** that can help improve health, and strengthen resilience to health problems. This integrated approach will meet the specific needs of local communities it will be **not one size will fit all** and will recognise that different communities will start with different services and facilities (including general practice).

Workforce

The STP will require a fundamental shift in the way our staff work and the skills they will require. As part of on-going transformational work a Workforce Development Enabling Group has been established to review and develop 6 areas of work:

1. **Workforce plan** - for each work stream review the anticipated numbers, skills and competencies of staff needed now and going forward and how we expect to make the transition. Also to ensure we shape the overall Derbyshire workforce and education commissioning plan. A tool has been developed to model the required community workforce. This is being rolled out across all areas.
2. **Training and retraining** - ensure provisions meet the needs of the workforce plan for each work programme
3. **HR policies, practices, procedures and recruitment** - evolve these to support integrated working for the place based areas
4. **Derbyshire wide talent management** - develop an identification and tracking system and support the system to consider how it develops its leadership talent to think and work system wide
5. **Derbyshire Chief Executives** - work with the senior team to identify the leadership development requirements to support system wide leadership and new team leadership
6. **Managing transition** - help the work programmes to manage the transition.

Risks to the Change Plan – Workforce and OD issues are significant and cannot be underestimated. All risks rated 	Risk	Mitigations
	Identified skills gaps and lack of training places – number of GPs, Advanced Clinical Practitioners, Allied Health Professionals etc.	• Closing the gap on training numbers via Local Education and Training Council allocating 50% of non medical funding to other health professional training (not backfill) • Working with Health Education East Midlands on how we overcome the issue of not enough people in the system to train – capacity, behaviours and values
	Leadership Challenge - working across the whole system and across boundaries	• Working with EMLA on leadership development • System wide working is helping to break down barriers
	Organisational development – cross boundary working; multi-disciplinary working.	• Completing a Derbyshire wide audit to identify specific OD needs at a local level i.e. within geographical areas or across organisations • Identifying specific resources to take this work forward.

Workforce (Cont…)

In order to support staff in moving towards a more integrated way of working across health and social care an organisational development diagnostic was completed. The report was based primarily on interviews and conversations with people involved in the change programmes across the city and county, which includes BCF schemes. In total 53 people were interviewed. In addition some desk top work was carried out in terms of reading the current transformation planning documents and relevant thought pieces around system transformation, place based care and system leadership. The key themes to emerge were:

1. **System leadership -** there is a need for joint commitment to the vision. Leadership development work is being commissioned via EMLA.
2. **Resources and capacity -** A consistent message across North and South is that individuals have struggled to give the transformation work the attention and focus it needs if change is to be achieved to the desired timescales. For the majority, involvement in the transformation programme is on top of another full time role. This is being reviewed by the Transformation Boards and the on-going STP work.
3. **Support and development for people leading workstreams -** It is acknowledged that there is some fantastic work going on, and typically people are full of enthusiasm for what they are doing. However many of them have had little if any development in how to lead change or influence across a health and social care system. This is being reviewed by the Transformation Boards and the on-going STP work.
4. **Development of individuals and groups of staff key to new service models -** Most of the focus around workforce transformation so far has been understanding the impact of new service models on future staffing requirements and the development of new roles. Whilst obviously essential, there is also a need to develop the culture and relationships within e.g. new integrated care teams. There is a view that physical co – location of teams is the answer to this, and while it is a useful enabler of an effective integrated team, it will be the mindset and relationships which have the biggest impact. A pan organisational programme of culture change is needed, and wherever possible this should be incorporated into regular training and work activities
5. **Capacity of general practice to engage and develop -** There is a lot of concern about how general practice can be better engaged with and developed to support and participate in the transformation agenda - This is being reviewed by the Transformation Boards and the on-going STP work.
6. **Raise knowledge and awareness in contracts and commissioning teams -** There is both a need to ensure that contracts for next year support transformation plans, and to develop awareness that change will not happen through transactional processes only. If individuals are not engaged and new processes properly embedded, they will not deliver what is anticipated
7. **Involving and engaging the public –** there is a need to further develop co production and involvement of the public in developing the ideas and making them happen. Currently the focus is more on public consultation about proposed changes, which is a different process.

Evidence Base to Support Change

Understanding our populations

In 2015/16 the JSNA was a key source document. For 2016/17 this is currently under review. However, Public Health are linked into the Transformation Programmes across the city and county, providing invaluable population based information and trends. The move to place based systems means that a great deal of analysis has been completed to review the health needs of populations based around GP practices. An interactive tool has been developed locally to assist detailed analysis across the city and county.

Within the current transformation programmes we have developed an understanding of our populations based on their use of services, for example the top 3% use 40% of GP time. However, it is those that are currently in the next 5% where the most impact can be made. Work is on-going to support the people who most frequently access services to understand how they can be better managed outside of hospital or in a different way. Many citizen's access A&E, by-passing their GP and therefore are not known within the community. We are working with acute providers to identify 'frequent attenders' and to understand their drivers. Access to integrated community teams will be essential in managing people in alternative settings.

The BCF, in-line with the STP is very much about keeping people out of hospital if they do not need to be there or ensuring they do not need to be there when medically fit. We have developed both pro-active and reactive care services in community settings. During 2015/16 'virtual wards' have been established to provide both step-up and step-down services. In reality the emphasis has been on the latter in order to move medically fit patients back to the community. The evidence suggests that this is helping to 'unblock' acute beds and providing a better experience for the patient. Readmission rates have also reduced. 'Pull Teams' within the hospital work pro-actively to identify suitable patients, working with community teams to ensure continuity of care.

Throughout 2015/16 there has been further development of the 'Single Point of Access' (SPA) which in reality has been several access points, causing confusion for hospital providers and ambulance services. As part of winter planning the SPA services have been accessed via one number and this has assisted in streamlining the process. This will be further developed in 2016/17.

2016/17 will also see a greater emphasis on place based systems and further work on pro-active care. BCF schemes have been aligned to take into account both demographic information and the direction of travel within the STP.

Work is on-going with Derby University Centre for Health and Social Care Research to help us understand the impact of various local schemes , examples are:

- The impact of the implementation of integrated teams – how has care changed as a consequence of changes, both pro-active and reactive
- Variations in care home provision – how can we explain variation and the impacts of links into GP practices
- The introduction of Community Comprehensive Geriatric Assessment – what is the impact on hospital admissions and improved patient experience

Co-ordinated and Integrated Plan of Action for Delivering Changes

BCF 2016/17 - finances and scheme summary grouped into themes that will be used to better monitor performance aligned to integration.

	Enabling Self Care	Social Capital/ Community Development	Proactive Care Mgt	Reactive Services	Diagnostic Services	Enablers/ Infrastructure
	Initiatives in place that enable people to take more control of their lives in their normal place of residence.	Initiatives that enable people to build their own care solutions in their community	Initiatives to proactively identify and manage people at risk of admission to hospital settings	Initiatives to support the flow through the system and to prevent readmissions and permanent admissions to care settings	Services that are provided at a scale above local teams.	
City	£5.2m	£0.9m	£3.6m	£9.2m	£1.3m	£0.9m

BCF 2016/17 - finances and scheme summary grouped into themes that will be used to better monitor performance aligned to integration.

	Enabling Self Care	Social Capital/ Community Development	Proactive Care Mgt	Reactive Services	Diagnostic Services	Enablers/ Infrastructure
	Dementia Support Services, Equipment Services Wheelchair services Property Adaptations Healthy Housing schemes	LAC, VSPA	CSTs, Virtual Hospice, Social Care Support	Re-ablement services, Virtual Ward SPA Intermediate Care Response, Bed Based Re-ablement (Perth House), Home First	Memory Assessment Services Mental Health Liaison (RAID)	Care Act Duties
City	£5.2m	£0.9m	£3.6m	£9.2m	£1.3m	£0.9m

NB – Protection of Social Care funding – for 16/17 the allocation is the same as in 15/16 and this is used to safeguard the and fund social care assessments and the associated costs of care for those with eligible support needs. For 16/17, there will be no risk sharing funding pool in the BCF.

HWB Expenditure Plan 2016/17 – compared to 15/16 plan

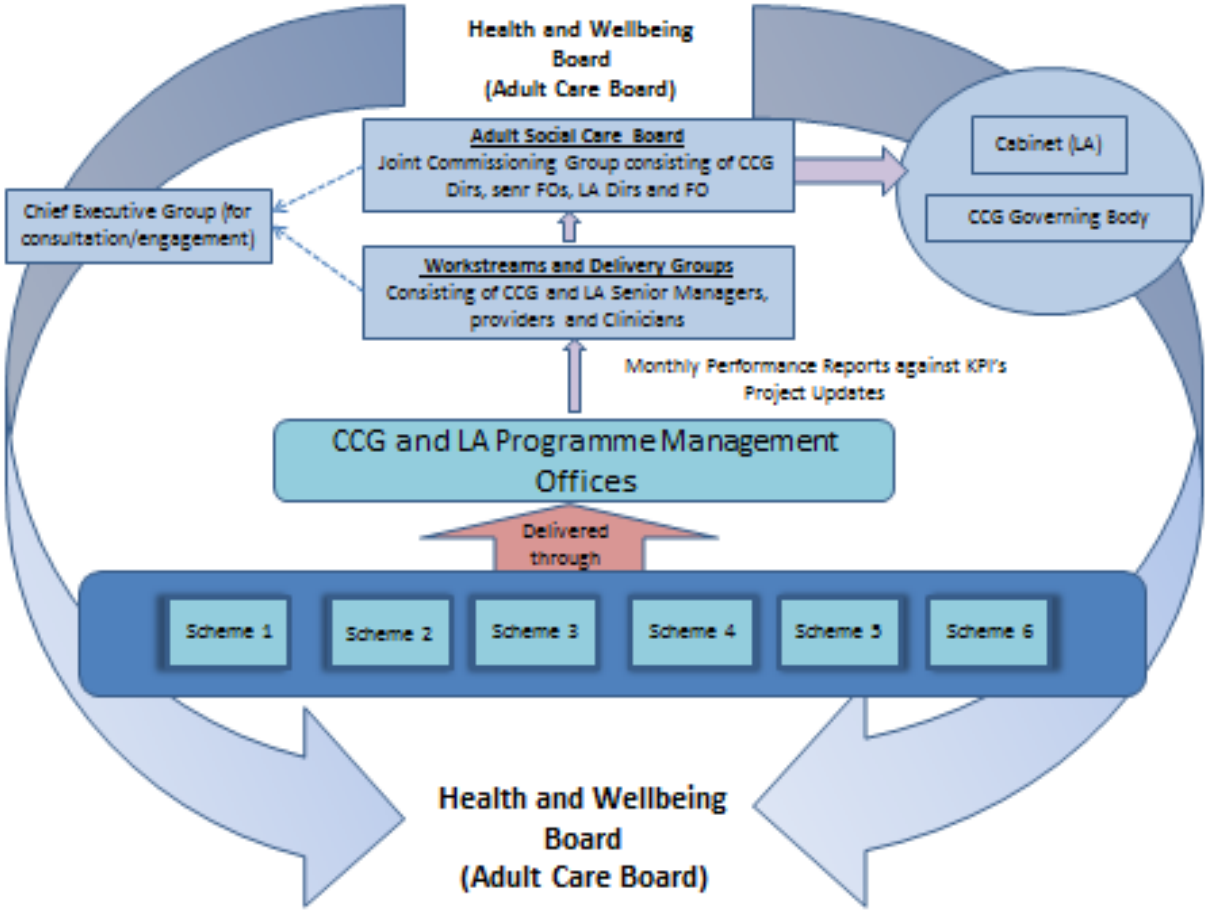
SCHEME NAME	TYPE	LEAD	16/17		15/16
Healthy Housing/Handy Person	Personalised support/ care at home	Local Authority	£400,000.00	Existing	£400,000.00
Local Area Co-Ordinators	Integrated care teams	Local Authority	£300,000.00	Existing	£300,000.00
Carers Support	Support for carers	Local Authority	£616,000.00	Existing	£616,000.00
Dementia Support	Personalised support/ care at home	Local Authority	£235,000.00	Existing	£235,000.00
Property Adaptations	Reablement services	Local Authority	£1,599,000.00	Existing	£897,000.00
Community Support Teams CCG	Integrated care teams	CCG	£1,500,000.00	Existing	£1,500,000.00
Bed Based Respite - Perth House	Reablement services	Local Authority	£1,098,000.00	Existing	£1,098,000.00
Community Equipment CCG	Personalised support/ care at home	CCG	£1,740,000.00	Existing	£611,000.00
Protection of Adult Social Care	Other	Local Authority	£4,287,000.00	Existing	£4,287,000.00
Enablement & Intermediate Care - DCHS	Intermediate care services	CCG	£1,000,000.00	Existing	£1,000,000.00
Enablement & Intermediate Care - Home First	Intermediate care services	Local Authority	£1,890,000.00	Existing	£1,890,000.00
Assessment & Support Planning Teams	Integrated care teams	Local Authority	£1,220,000.00	Existing	£1,220,000.00
Out of Hours Emergency Care	Integrated care teams	Local Authority	£150,000.00	Existing	£150,000.00
Mental Health Enablement	Reablement services	Local Authority	£225,000.00	Existing	£225,000.00
Socail Care Grant	Other	Local Authority	£0.00	Existing	£640,000.00
The Care Act	Support for carers	Local Authority	£660,000.00	Existing	£618,000.00
Social Care Commissioning	Personalised support/ care at home	Local Authority	£241,000.00	Existing	£241,000.00
Performance payment	Other	CCG	£0.00	Existing	£1,475,000.00
Care Home Beds - Step down nursing home capacity	Reablement services	CCG	£275,000.00	New	
Virtual Hospice Beds - Virtual Hospice beds	Personalised support/ care at home	CCG	£270,000.00	New	
Memory Assessment Services	Integrated care teams	CCG	£367,000.00	New	
Virtual Ward	Intermediate care services	CCG	£500,000.00	New	
Self Care/Prevention (formally VSG funding)	Other	CCG	£285,000.00	New	
Wheelchairs	Personalised support/ care at home	CCG	£1,005,000.00	New	
Mental Health Liaison Service	Integrated care teams	CCG	£0.00	New	
Dementia Rapid Response/Reablement	Intermediate care services	CCG	£0.00	New	
DICES Equipment contract	Reablement services	Local Authority	£260,304.00	New	
RAID	Reablement services	CCG	£840,000.00	New	
Autism Diagnosis	Personalised support/ care at home	CCG	£130,000.00	New	
Pull Team	Integrated care teams	CCG	£300,000.00	New	

Planned improvements for 2016/17

- Develop and implement an integrated health and social care intermediate care offer – ideally within one organisation
- Develop and implement an integrated "rapid response" service to manage escalating need within the community, avoiding hospital admissions wherever possible
- Develop and implement an integrated pull team to assist with hospital discharges and improve performance on **DTOCs** - in 15/16 data interrogation exposed that our main acute provider (Royal Derby Hospital) had not been completing DTOC returns in line with the agreed definition and methodology. This means that the data, including trends, cannot be relied upon. The DTOC Plan for 176/17 and beyond is intended to revised the baseline going forward and provide a targeted plan to improve performance – with an overall target reduction of 3.5% being set.
- Review and integrate the provision of wheelchairs with the wider DFG and adaptations approach to maximise efficiencies and improve the customer experience
- Further expand the scope and reach for Personal Health Budgets
- Re-commission dementia support as part of a complete care pathway from Diagnosing Well, to Living Well to Dying Well that supports carers within the home.
- Embed and further improve the carers offer post Care Act
- Expand Local Area Co-ordination where resources permit
- Review the effectiveness of community support teams and further align social care staff and Local Area Coordinators to primary care
- Develop and manage a BCF specific risk log

BCF Governance

The governance of the BCF is described in the original submission - BCF 2015/16 Part 1. However, as the transformation programmes have developed there have been some in year changes to the structure. The current governance arrangements are described in the diagram below. However, it should be noted that as the STP develops and transformation programmes are aligned the governance structure will evolve.



BCF Metrics and Risk Management

Metrics

As outlined in the Section 75 Agreement the Finance and Performance Sub-Group (FPSG) have developed a dashboard which tracks the various metrics. This is produced monthly and scrutinised by the group. Any areas of concern are escalated to the BCF Programme Board where actions are agreed and implemented.

A key action for 2016/17 is to update the scheme level dashboard, making it suitable for in-year reporting to the HWB Board and other audiences.

Risk Management

There is not a separate BCF programme risk log. The Section 75 is clear that risk is the responsibility of the delivery organisations. Each Scheme is represented under a work-stream within the commissioning authority. Delivery risks are escalated to the Adult Commissioning Board, and Health &WellBeing Board. Risks were identified in the original BCF submission (Section 5) and risks within individual schemes are reviewed by the appropriate PMO, workstream or Delivery Board. However, we recognise that this is an area for development and that risk management has been more emergent that robust and structured. For 2016/17 we need to ensure that risks are regularly monitored. One risk identified is the lack of clear and consistent messages to partner organisations and staff on the impact of the BCF. This will be an action point with regular communication, updated websites etc.

2016/17 Metric Targets

In setting new targets for the metrics in 2016/17, year-end performance for 15/16 has been used as the basis for assumptions made, except for the target for NEAs as this was not required to be set in 2016/17.

Residential Admissions

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	593.1	547.3	584.2	540.9
	Numerator	239	223	238	223
	Denominator	40,295	40,743	40,743	41,225

Performance against this metric has proved challenging in 2015/6, with year-end target not likely to be met despite overall trajectory improving. 2016/17 target revised to reflect expected performance based on historic trend.

Reablement

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	90.7%	85.2%	90.0%	90.0%
	Numerator	205	213	207	207
	Denominator	225	250	230	230

Target for 2016/17 based on maintaining the performance expected to be achieved at end of 2015/16.

Delayed Transfers of Care

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Annual rate	2471	2187	3771	3510
	Numerator	4773	4289	7395	7000
	Denominator	193130	196127	196127	199395

The Derby DTOC Plan has set a system target to keep delayed transfers of care at 3.5% of occupied bed days (shown above as bed days delayed per 100,000 for BCF measurement).

This metric is usually reported on a quarterly basis so the above figures are the average across each of the reporting years. The forecast for 15/16 is based on actual outturns for quarters 1 to 3 and planned quarter 4 outturn as provided in the original 2015/16 BCF Plan. More details about analysis of performance and the setting of this target is included in the Derby DTOC Plan 2016/17.

2016/17 Metric Targets (Continued)

Dementia Diagnosis

		Planned 15/16	Planned 16/17
Number of people diagnosed and the prevalence of dementia.	Metric Value	68.0	71.0
	Numerator	78,704.0	83,403.0
	Denominator	117,468.0	117,468.0

Locally determined metric continuing for 2016/17. Target based on CCG operational plans - The methodology for calculating this indicator was changed during 2015/16 from the original plan. Therefore numerator, denominator and plan figures have been amended to reflect this for 15/16 and used to forecast for 2016/17.

Patient Experience

		Planned 15/16	Planned 16/17
GP Patient Survey: Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? (Respondents answering "Yes, definitely" or "Yes, to some extent")	Metric Value	66.2	66.5
	Numerator	4,330.0	4,350.0
	Denominator	6,541.0	6,541.0

Locally determined Patient Experience metric continuing for 2016/17 and aligned to Derby City target.

Key Challenges

The Challenges Faced in 2016/17

As previously stated the BCF is a key part of the system wide STP, therefore challenges to one cannot be isolated from the other. The STP is across the whole of Derbyshire i.e. County and City despite the current BCF's being separate. However, for 2016/17 all efforts are being made to align the two and ensure greater synergy. This is particularly pertinent for Southern Derbyshire CCG which spans both Derby City and Derbyshire County in the south. The following have been highlighted as some of the challenges we face:

- Impact of the CSR locally
- Financial pressures on local authorities and the potential impact on cuts to the voluntary sector
- Increased demand and the increasing complexity of care needs
- The emerging STP and what this will mean for service redesign, organisational form, citizens and staff
- In light of the STP footprint - alignment of City/County BCF plans
- Ensuring that everyone has a common understanding of place based care
- Understanding the data (health needs, activity, patient surveys, etc.) at the place based level, but also work with individuals to understand the outcomes and services that **matter to them** – they may tell different stories
- System leadership – the need for whole system thinking
- Move to different ways of contracting and the changing role of commissioners i.e. from the detail to the strategic overview
- Capacity within the system to make changes
- Transforming primary care at pace and scale
- Supporting local teams need to work across their traditional boundaries – joint messages from organisations, assurance that funding flows will be sorted, clarity as to what is expected to be delivered by place based care
- Workforce issues – skill gaps, recruitment issues and the need to work in different ways

Review of National Conditions – Position Update

Position Update

National Condition	Update	Actions for 2016/17
Plans to be jointly agreed	• Plans have been developed and agreed by all parties • The BCF minimum spending level is agreed • Additional schemes have been included aligned to potential integration priorities • All stakeholders involved • The BCF is an integral part of the STP • Workforce issues are covered by the Workforce Enabler Group as part of system transformation	• Look at further areas for future pooled budgets e.g. continuing healthcare • Continue to engage with stakeholders as the STP emerges • Continue to work closely with workforce group – quarterly updates as a minimum
Maintain provision of social care services	• All conditions met • All demonstrated within templates • Carer support included	• Demographic information looks at population need for all services • Place based systems will include social care
7 day services	• Plans are in place for 7 day services – links to UECN and SRG • Most services already available 7 days although there remains an inconsistent approach across the city/county • Transformation plans include details of 7 day services related to specific areas of work.	• Work towards equity across the city/county • Continue work with NHSE on implementing 7 day services
Better data sharing	• Derbyshire work well together with a clear vision. • The two Derbyshire Units of Planning can make it difficult to align projects and this can make measurement and comparison difficult. • Informatics Enabler Group to support the two transformation programmes of which the BCF is a part. • IG work stream which has made significant progress. • The technical issues appear to be overcome and the MIG will assist • Cultural and IG issues remain the main problem.	• Continue work on IG issues via the transformation programme enabler group. • Develop a clear county wide data sharing strategy and communications plan. • Continue work on solving cultural issues related to data sharing.

Position Update (Cont…)

National Condition	Update	Actions for 2016/17
Ensure a joint approach to assessments and care planning – accountable professional	• The 2015/16 submission provides the detail	• Continue to progress this area as we move towards place based systems
Agreement on the consequential impact of the changes on providers that are predicted to be substantially affected by plans	• All providers were party to the original submission • Modelling work has taken place as part of the main transformation programmes • Providers are integral to the work of project groups • Finance Enabler Group is assessing impact on all providers with representation from all Directors of Finance	• Move towards capitated budgets • Different contracting methods and risk sharing agreements • System wide agreement to changes via the STP
Agreement to invest in NHS out of hospital services (including social care)	• Community teams are a key area of expenditure • Reablement and intermediate care are included • Both pro-active and reactive services included • All service redesign underpinned by modelling and review of demographic needs	• Further develop co-located and integrated teams • Increase the level of pro-active community care • Move further work into the community as appropriate
Agreement to local action plan to reduce DTOC's	• A DTOC plan has now been drafted - governance of the plan will be within the operational resilience networks already in place, with escalation to the SRG where required.	• Develop and implement plan.

Financial Risks

Risk sharing agreements

It was agreed in 2015/16 that a separate risk share agreement would not be put in place as there were a number of county-wide arrangements already in place, for example around continuing care, high cost placements and high cost drugs. However, much risk sharing is most appropriately administered at an individual CCG level and linked to the unit of planning because of the provider geography.

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

2016/17 – creating a financially sustainable system

The impact of national tariff is increasingly inhibiting system transformation. From a commissioner perspective tariff incentivises income generation at the expense of controlling the cost of service delivery and can be a substitute for CIP delivery, particularly where targets are very challenging. The existence of tariff has resulted in an industry of monitoring and management of activity in both commissioners and providers, none of which effectively supports transformation and improvement in services. 99% of commissioner risk is linked to tariff funded acute contracts and means that commissioners cannot put aside sufficient resources for transformation because they have to plan for significant cost overruns on an annual basis.

The implications of these issues are that the financial challenge is moved around the system and the underlying issues will not be resolved and organisational control totals for individual organisations will not be met. A few years ago commissioners were in deficit. Now that deficit is with providers. It has been ***agreed in principle*** to suspend national tariff on all local (initially this relates to the South of Derbyshire) NHS provider contracts and put in place block contracts.

This could obviously have major impacts on providers and it is essential that providers and commissioners work together, on an open book basis to develop fair and reasonable values for block contracts. Reviewing both historical data and trend analysis. The objective of this approach is to incentivise and stimulate a re-focus on transformational change which starts to put the local system on the path to sustainability. The changes needed to implement such an approach are significant, challenging and most of them affect the acute providers who, in financial terms, are in a very vulnerable position. Such arrangements therefore need to be backed up with very strong, jointly developed, risk mitigation schemes in response to the concerns about demand management and assurances about delivery of their financial control total.

This approach would include:

- A comprehensive review of the Better Care Funds and how they are and can help to mitigate system risk;
- If risks of cost overruns can be significantly minimised this allows the 1% reserves the CCGs are required to hold as risk reserves and invest non-currently to be more confidently allocated towards transformation delivery, potentially controlled through the JUCB board.
- Discussions with regulators about the approach and control total offer which, as it currently stands, does not cover all of the structural deficit that Monitor have identified. Agreeing to this offer now commits the system as a whole to dealing with eliminating the structural deficit at the same time as resolving local productivity issues.

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