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of People Services

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Better Care Fund Update 2022/23

Purpose

- 1.1 To provide the Health and Wellbeing Board with the proposed plan for the Derby Integration and Better Care Fund (BCF) for 2022/23.

Recommendation(s)

- 2.1 To approve the proposed spend and performance objectives for the Better Care Fund for 2022/23 in line with the national expectations for the programme set by the Department of Health and Social Care (DHSC).

Reason(s)

- 3.1 The Health and Wellbeing Board (HWB) has previously received and approved planned activities of the Integration Better Care Fund (BCF). The latest planning round still requires the BCF to be approved and governed through the Health and Wellbeing Board.

Supporting information

- 4.1 The Better Care Fund (BCF) remains one of the government's national vehicles for driving health and social care integration. There are a number of upcoming reforms taking place to the health and social care system, including the Integration White Paper: *Health and social care integration: joining up care people, place and populations*. DHSC require the newly established Integrated Care Boards (ICBs) and local government to agree the Better Care plan, which must still be owned by the Health and Wellbeing Board (HWB) i.e the BCF remains a joint plan for using pooled budgets to support integration between health and care, governed by an agreement under section 75 of the NHS Act (2006). Given the change to legislation, DHSC confirmed that there will be limited change to the 2022 /23 national Better Care Fund policy framework to provide continuity for systems during this transitional period

There remain a number of national conditions that must be satisfied for BCF plans to be assured, and areas must set out how health and social care will work together, and use BCF funding, to improve outcomes for the overall policy objectives (see 4.2 below). The national conditions for the BCF in 2022 to 2023 are that each area has:

- a jointly agreed plan between local health and social care commissioners,

signed off by the HWB

- the NHS contribution to adult social care at HWB level to be maintained in line with the uplift to NHS minimum contribution
- an investment in NHS commissioned out-of-hospital services
- commitment to implementing the BCF policy objectives.

4.2 The overall BCF Policy Objectives are that by furthering health and social care integration and preventing need, BCF plans must be designed to:

- enable people to stay well, safe and independent at home for longer
- provide the right care in the right place at the right time

Appendix 1 provides a summary of the required *Planning Submission* which was submitted to DHSC at the end of September and is awaiting formal approval through the assurance process. **Appendix 2** provides a copy of the *Narrative Plan* which was also required to be submitted. Both of these documents together set out how in Derby and Derbyshire health and care will work together to ensure we:

- work as a health and care system to promote independence, and address health, social care and housing needs of people who are at risk of reduced independence, including admission to residential care or hospital.
- ensure people are discharged from hospital to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes.
- identify expected demand for intermediate care services and the required capacity across the HWB area to meet this.

4.3 **Performance Metrics.**

Beyond the requirement to meet the national conditions, local areas have flexibility in how the fund is spent over health, care and housing schemes or services, but spending must improve performance against the following BCF 202/ 23 metrics:

- avoidable admissions to hospital
- admissions to residential and care homes
- effectiveness of reablement
- hospital discharges that are to the person's usual place of residence

Appendix 1 includes the performance metrics that have been submitted for 2022/23.

Public/stakeholder engagement

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

Other options

- 6.1 The Integration and Better Care Fund is a mandatory national requirement, and all areas must submit a plan to NHSE/I should they wish to make use of the funding flexibilities between Councils and CCGs. This plan is subject to a full assurance process which had not been completed at the time of drafting this report. There is full expectation that the BCF funding and spending arrangements continue, as the integration agenda between health and social care remains a key priority for the government and as set out in recent White Papers and legislation.

Financial and value for money issues

- 7.1 As in previous years, the NHS financial contribution to the BCF will still include funding to support the implementation of the Care Act 2014, as well as funding previously earmarked for the provision of carers' breaks. The BCF must also set out how the fund will maintain investment in community health services and out of hospital interventions. The funding remains subject to an existing pooled budget between Derby City Council and the new Derbyshire ICB and monitoring and reviewing spend against the plan will continue via the BCF Board which remains a sub group of the Health and Wellbeing Board.

Legal implications

- 8.1 The Council and the Derbyshire CCGs must enter into a section 75 agreement as part of the Planning expectations, under section 75 of the NHS Act 2006. This agreement remains in place and covers the Integration and Better Care Fund. As a component of the plan includes direct grants to the Council (the IBCF and Winter Pressures), these must be separately reported to government via the Council's statutory s151 Officer (Strategic Director of Resources).

Other significant implications

- 9.1 The Integration and Better Care Fund supports the Council's and the ICB's overall budget as an income stream to allow delivery of key care services to support the overall health and care system in Derby. The loss of this fund would present a significant financial risk to the shared ambition and key performance measures designed to serve patients and citizens well.

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal	n/a	
Finance	Janice Hadfield, Head of Finance	2 nd November 2022
Service Director(s)	Kirsty McMillan, Service Director – Integration & Direct Services	2 nd November 2022
Report sponsor		
Other(s)		

Appendix 1: Extract from Better Care Fund 2022/23 Planning Template

BCF Income for Derby 2022/23:

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution	
Derby	£2,323,304	
Total Minimum LA Contribution (exc iBCF)	£2,323,304	
iBCF Contribution		
Contribution		
Derby	£12,045,014	
Total iBCF Contribution	£12,045,014	
Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes	
Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Derby	£269,682	Community equipment
Total Additional Local Authority Contribution	£269,682	
NHS Minimum Contribution		
Contribution		
NHS Derby and Derbyshire ICB	£20,620,231	
Total NHS Minimum Contribution	£20,620,231	
Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No	
Total Additional NHS Contribution	£0	
Total NHS Contribution	£20,620,231	
Total BCF Pooled Budget	£35,258,231	

Spending Plan 2022/23

Scheme Name	Brief Description of Scheme	Area of Spend	Commissioner	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
Integrated Community Equipment	Provision of equipment to enable people to remain in their homes	Community Health	CCG	Private Sector	Minimum NHS Contribution	£1,997,385	Existing
Integrated Community Equipment	Provision of equipment to enable people to remain in their homes	Community Health	CCG	Private Sector	Additional LA Contribution	£269,682	Existing
Social Care assessments and cost of care	social care assessments and associated costs of care packages - Residential, Nursing and Community Services	Social Care	LA	Local Authority	Minimum NHS Contribution	£6,259,171	Existing
Assessment & Support Planning Teams	social work support and assessments	Social Care	LA	Local Authority	Minimum NHS Contribution	£1,543,769	Existing
Bed Based Respite - Perth House	Bed Based - Step Up/Down	Social Care	LA	Local Authority	Minimum NHS Contribution	£1,389,392	Existing
Carers Support	Support to carers and delivery of the Carers Strategy	Social Care	LA	Local Authority	Minimum NHS Contribution	£779,444	Existing
Healthy Housing/Handy Person	minor repairs, adaptations, home improvements	Social Care	LA	Local Authority	Minimum NHS Contribution	£506,154	Existing
Enablement & Intermediate Care - Home First	Reablement to support discharge -step down (Discharge to Assess pathway 1)	Social Care	LA	Local Authority	Minimum NHS Contribution	£2,391,577	Existing
Local Area Coordinators	In partnership with local communities, support people before their needs escalate and avoid going into crisis	Social Care	LA	Local Authority	Minimum NHS Contribution	£379,615	Existing
Mental Health Enablement Workers x 6	Social model of providing preventative and recovery focussed support to people living with a mental health condition	Mental Health	LA	Local Authority	Minimum NHS Contribution	£284,711	Existing
Out of Hours Emergency Care - Perth House/ Home First	Rapid/Crisis Response	Community Health	LA	Private Sector	Minimum NHS Contribution	£189,808	Existing

Dementia Support	Help people with dementia and their carers to access further information, advice and support	Mental Health	LA	Charity / Voluntary Sector	Minimum NHS Contribution	£297,365	Existing
Social Care Commissioning	Market development (inc Vol sector)	Social Care	LA	Local Authority	Minimum NHS Contribution	£304,958	Existing
Property Adaptions (DFG)	Adaptations, including statutory DFG grants	Social Care	LA	Local Authority	DFG	£2,323,304	Existing
(iBCF) Demographics pressures - residential provision)	Demographic growth, age and complexity	Social Care	LA	Local Authority	iBCF	£4,971,935	Existing
(iBCF) Provider fee pressures - Living Wage, specialist rates, overnight costs	Fee increase to stabilise the care provider market	Social Care	LA	Private Sector	iBCF	£3,652,330	Existing
(iBCF) reviewing team - new cases	social work assessment and support planning	Social Care	LA	Local Authority	iBCF	£317,525	Existing
(iBCF) Transitions team	social work assessment and support planning	Social Care	LA	Local Authority	iBCF	£185,223	Existing
(iBCF) Hospital social work team	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	Social Care	LA	Local Authority	iBCF	£751,476	Existing
(iBCF) DOLS, best interest and mental capacity assessments	Deprivation of Liberty Safeguards (DoLS)	Social Care	LA	Local Authority	iBCF	£309,587	Existing
(iBCF) Arboretum House	Bed Based - Step Up/Down	Social Care	LA	Local Authority	iBCF	£673,575	Existing
Home First Community Night Service	Reablement to support discharge -step down (Discharge to Assess pathway 1)	Social Care	LA	Local Authority	iBCF	£202,590	Existing
Mental Capacity assessments	Deprivation of Liberty Safeguards (DoLS)	Mental Health	LA	Local Authority	iBCF	£25,300	Existing

Track & Triage.	Monitoring and responding to system demand and capacity	Social Care	LA	Local Authority	iBCF	£6,637	Existing
Mental Health Social Worker	Support discharge planning on admission; embed social work input to MDT reviews	Mental Health	LA	Local Authority	iBCF	£50,600	Existing
domiciliary care packages	Domiciliary care packages	Social Care	LA	Private Sector	iBCF	£898,237	Existing
Community Nursing	Delivery of care in patient homes to prevent conditions deteriorating	Community Health	CCG	NHS Community Provider	Minimum NHS Contribution	£941,570	Existing
Integrated Teams (Community Support Teams)	Integration with primary care and other services to co-ordinate proactive care for people who are at risk of dependency due to physical or mental health issues	Community Health	CCG	NHS Community Provider	Minimum NHS Contribution	£1,279,852	Existing
Evening Nursing Services	Nursing care to adults in their own home due to an urgent problem related to a long term chronic disease/condition	Community Health	CCG	NHS Community Provider	Minimum NHS Contribution	£405,648	Existing
Community Matrons	Proactive, holistic approach to manage patients' long term conditions, centred on primary care	Community Health	CCG	NHS Community Provider	Minimum NHS Contribution	£702,426	Existing
Community Therapy	Provision of highly skilled assessment and intervention to patients with physical problems affecting their functional abilities	Community Health	CCG	NHS Community Provider	Minimum NHS Contribution	£310,084	Existing
Clinical Navigation Service	Single point of contact to a multi-professional team to support patients to receive clinically appropriate care at home or as close to home as possible	Community Health	CCG	NHS Community Provider	Minimum NHS Contribution	£491,310	Existing
Surge discharge capacity	resource to provide surge discharge capacity	Community Health	CCG	Private Sector	Minimum NHS Contribution	£165,992	New

Metrics for 2022/23

Avoidable admissions		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	252.9	203.8	210.3	182.8	2020/21 showed a dip in the number of admissions which is a reflection of wider trends for admissions during the COVID19 Pandemic. The unpublished data for 2021/22 provided in the template shows that this has rebounded a little and we are aiming to maintain this level of performance.	Renewed focus on BCF schemes (via the new ICS arrangements) and their role in the urgent community response, Falls recovery pathways and wider prevention interventions. Most of this is contained within the Team Up programme as well as the dedicated Discharge Improvement plan which also has elements that will contribute this.
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	253	204	210	183		
	Denominator						

8.3 Discharge to usual place of residence		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	97.9%	96.3%	96.9%	97.2%	For the 2nd half of 2021/22 a target of 96% was set and exceeded, therefore the aim is to maintain this elevated level of performance achieved in 2021/22 in 2022/23.	Continued focus via existing plans to support discharge planning, integrated discharge hub and overall system improvement plan on Home First. This will continue to enhance our provision of care to people in the community - to reduce need and respond to urgent /crisis need and to bolster the frailty prevention admission at ED front door.
	Numerator	5,691	5,630	5,506	5,333		
	Denominator	5,811	5,848	5,680	5,486		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	97.0%	97.0%	97.0%	97.0%		
	Numerator	9,513	8,761	8,403	7,996		
	Denominator	9,807	9,032	8,663	8,243		
8.4 Residential Admissions							

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	620.9	620.3	555.5	599.0	Rate at Q1 22/23 is higher than Q1 21/22. Finalised figures will rise given the lag in recording. Ambition is to maintain a rate less than 2020/21.	This years performance may see several potential factors bearing on performance, including capacity gaps in community based care at home services driven by ongoing recruitment and retention issues, that may drive higher than expected use of residential care.
	Numerator	263	268	240	262		
	Denominator	42,361	43,207	43,207	43,741		

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.4%	78.0%	81.5%	81.5%	At 83.5% performance in Q1 22/23 is at the highest levels since 17/18, and over 7 percentage points higher than the 76.2% recorded in 20/21.	Continued efforts to strengthen community services through an integrated 'Teamed Up' provision will continue to give greater scope to maximise peoples independence at home, including through ongoing ambitions for Urgent Community Response and rapid provisions to manage the national 9 clinical conditions.
	Numerator	192	753	801	831		
	Denominator	248	965	983	1,020		

Appendix 2 - Joined Up Care Derby City / Derbyshire Better Care Fund narrative plan 2022-23

This narrative plan provides the context and detailed rationale for the Better Care Fund (BCF) plans submitted by the **Derby Health and Wellbeing Board** and **Derbyshire Health and Wellbeing Board**. In line with national requirements, we have submitted a separate planning template for each Health and Wellbeing Board (HWB) but have chosen to submit our narrative at ICS level as this aligns with our approach to utilising the BCF at a local level.

Members of the BCF Programme Board have been the main contributors of the BCF plan (including NHS ICB and NHS community providers, social care local authorities – Derby City Council and Derbyshire County Council, housing organisations and district/Borough councils). The VCSE sector is involved via the Health and Wellbeing Board, Integrated Care Board, Integrated Place Executive and the Local Place Alliance.

The Better Care Fund (BCF) plans, that are governed by the Derby Health and Wellbeing Board and Derbyshire Health and Wellbeing Board, do not stand as separate integration programmes, but the schemes funded by the BCF are part of a wider system approach to integration and joint working between the NHS, Councils and partners. The Derbyshire Better Care Fund Board reports into both Health and Wellbeing Boards as a statutory requirement, but all integrated care activity (planning and delivery) is largely managed and reported elsewhere in a range of existing system meetings and networks. For many of the schemes and interventions receiving BCF income – there are other income streams, commissioning arrangements and performance measures that reflect the wider nature of their delivery and focus. These cannot be separately attributed to the BCF programme alone, with many developing and evolving prior to, and outside of, the BCF. Some schemes are exclusively funded by the BCF and lend themselves more easily to being seen as dedicated BCF activity.

This approach i.e the BCF being a supporting tool for integration, will be reflected in the narrative plan – as it is not the sole driver of integration within Derbyshire. Our Joined Up Care Derbyshire Integrated Care System is committed to maximise the opportunities that the Health and Care Act 2022 introduced to make joint working easier between the health service, social care, and local government. We are taking a phased and considered approach to establishing the new ways of working. We have the statutory new components of the system in place in the form of the Integrated Care Board and the Integrated Care Partnership and will continue to ensure that this builds on the existing approaches to level up access, experience and outcomes for our population. JUCD recognises that amongst the further guidance and legislation to drive and support this transition will be a policy framework for the BCF from 2023. Our Place Partnership Boards at City and County map the current BCF footprints and will be key in responding to the opportunities within the new legislation. We have therefore aligned the plan to the existing ICS arrangements, governance structure and wider system plans in order to reflect the wider system view: (More details can be seen in the section on governance)

Joined Up Care Derbyshire (JUCD) - Integrated Care System

JUCD is the Derby and Derbyshire health and social care partnership for adults and children. JUCD's priority is to make improvements to the Derby and Derbyshire populations' life expectancy and healthy life expectancy levels in comparison to other parts of the country and reduce the health inequalities that are driving these differences. Further to the boundary changes announced by the government in 2021, we welcomed Glossop into the Derbyshire Integrated Care System from 1 July 2022.

In Derby and Derbyshire, our health and care system has worked in partnership for many years; the duties the Health and Care Bill places on the local NHS and local authorities are welcomed and fit well with the direction we have been taking to improve the health of the local population. Having an

ICS which is now established in law, with a new organisation that reflects the collaborative approach required, is very helpful to what we are aiming to achieve. The BCF supports the existing system architecture and strategy, making a critical contribution to our efforts to keep people in Derby and Derbyshire safe and healthy in their own homes through delivery of a seamless health and social care offer.

Within the JUCD framework, there are several groups whose work continues to shape our system integration.

Health and Wellbeing Boards for Derby and Derbyshire

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

Better Care Fund Programme Board

This meets monthly and has a co-ordinating role ensuring that the BCF investment, metrics and strategies support the approaches agreed within wider system strategies. It is chaired by Derbyshire County Council and includes senior representatives from Derby City Council, Derby and Derbyshire ICB and the Derbyshire district/borough councils. This is a designated sub-group of both Health and Wellbeing Boards.

Executive summary

As stated above, our BCF plans, do not stand as separate integration programmes, but the schemes funded by the BCF are part of a wider system approach to integration and joint working between the NHS, Councils and partners. As a supporting tool for integration, the BCF is not the sole driver of integration within Derbyshire. Under the ICS arrangements, we are taking a phased and considered approach to establishing the new ways of working, this will include the policy framework for the BCF from 2023. However, it is highly likely that incorporating the BCF into existing ICS governance will be the way forward for Derby and Derbyshire.

Key changes since previous BCF plan

We have not made substantive changes to our local BCF plans. For both Derby and Derbyshire, the schemes funded through the BCF have remained largely unchanged. However, although the funding arrangements have not been changed, there have been key changes in the operational delivery of many of these services, with an explicit focus on integrated responses to prevent acute hospital or care home admissions and to ensure that as many people as possible are safely discharged home.

Establishment of the Integrated Care Board

On 1 July 2022, NHS Derby and Derbyshire Integrated Care Board became a statutory authority. This is an important change to partnership working and a wider focus on the Health of the Derbyshire and Derby population and reducing inequalities. The statutory duties are spelt out in the Health and Care Act 2022 and have been further developed and refined in guidance from NHSE. Whilst continuing to recover activity levels and reduce the impact of the pandemic on

waiting times and service resilience our focus has shifted to the opportunities of the legislative changes and becoming an integrated care system.

Changes to Glossop/Derbyshire footprint

From 1 July 2022 Glossop healthcare services became part of the Derbyshire Integrated Care System to improve the way health and care services are delivered through closer joint working. We do not propose to make any changes right now as our immediate priority is to ensure the smooth transition of healthcare services to Derbyshire. Our intentions are that services will continue to be delivered in the same way as they are currently, and we expect this to be the case for the next 12 months. Patient choice will always be at the forefront of the way services are provided and when the potential to change and improve services is identified, we will involve local people in any discussions from the start.

Team Up Derbyshire

The most significant example of change since the last BCF Plan is the **Team Up Derbyshire Programme**, which is our local approach to delivering the asks associated with the national Ageing Well programme in a truly integrated way, building on what already exists locally. Team Up Derbyshire brings together GP practices, community health services, social care, mental health services, the ambulance service and local VCSE organisations, all at PCN level, to ensure a co-ordinated multi-dimensional approach to anticipatory and urgent care. A focus of Team Up is the development of an enhanced multi-disciplinary urgent home visiting service to prevent acute admissions

Work is also underway to integrate falls recovery and to consider how people at the end of their lives could also be supported by the Team up model.

Our focus has continued to be on the health and social care system, both locally and nationally, and the consequences of the COVID-19 pandemic. Because our focus has been on maintaining system resilience and flow throughout an extremely challenging period, we have not made substantive changes to our local BCF plans.

Other key areas of change/achievement in BCF funded services include:

- Wheelchairs – recommissioned with Referral to Treatment timescale performance much improved and over 1400 personal wheelchair budgets created.
- Derbyshire Integrated Community Equipment Service (DICES) continued drive to increase the allocation of more equipment to more people within budget. This has included increased emergency and weekend deliveries. Four-hour deliveries have increased. The Smaller equipment contracts have been added to the wider ICES catalogue to promote cost benefits and ensure better response times for customers. This has included the provision of sensory equipment for the hard of hearing, and smoke alarms for the profoundly deaf, partly funded by the Derbyshire Fire and Rescue Service.
- Healthy Homes Team working closely with Districts and Borough and local health services continued to provide invaluable support to assist with hospital discharge and to offer free warmth and wellbeing solutions for householders living in fuel poverty with long term health conditions made worse by the cold and this year we responded to excessive heat.

- A robust and joined up delivery of Disabled Facility Grants with greater collaboration between different organisations involved.
- Enhanced levels of awareness of energy efficiency which places the system in a better place to respond to the cost-of-living crisis.
- Work is being explored in South Derbyshire with joint working between SDDC and SDCVS using BCF funding on the development of a local home handyperson scheme as a preventative measure that supports hospital discharge that is now being debated for expansion to include Level Access Showers and Wash Dry toilet installations. It is anticipated that this work will commence in the new financial year for 2023-24. The finer details on targets and milestones are being worked up between SDDC and SDCVS.
- Derby Local Area Co-ordination Programme – continues to expand showing positive impact for not only individuals but for communities as has been funded as part of Team Up to work with City PCNS on the proactive care multi-disciplinary team programme.
- Urgent Community response in Derby City Place – as part of the Team Up development, the BCF funded activity around preventative and rapid response services are being incorporated into the City Place's 2 hour urgent community response that is being developed and delivered with PCNs.
- The City's BCF funded mental health enablement workers are now aligned to the new Derby Wellbeing service which is in response to the national Community Mental Health Framework, and fully integrated with our NHS providers and voluntary sector partners.
- District Nursing Service – A rapid response provision has been incorporated into the Team Up – Urgent Community Response model enabling the rapid delivery of community nursing to people's homes to help prevent admission to hospital and to help maintain people's independence.

Priorities for 2022-23

Our approach to locally managing the BCF ensures that it is clearly aligned to our wider system priorities. The system is currently developing its Integrated Care Strategy and Joint Forward Plan and until they are finalised continues to ensure delivery against the previous 5 Year Strategy Delivery Plan. The system has continued to respond to the adapted priorities and requirements utilising the strong partnership approaches being developed through Place based working, Integrated Place Partnerships, Health and Wellbeing Boards, Provider collaboratives and the ICB. The ICB has identified three main challenges:

Health Gap – There are challenges across the country with regards to the overall health of the population and we have been appraised in the previous JUCD infrastructure about the challenges we have with regard to life expectancy and healthy life expectancy.

Care Gap – This is directly linked to the health gap. We have a challenge around the demands for health and social care in our system. There is a care gap in terms of being able to meet all the demands and expectations of the service; and

Resource Gap – The ability for us to respond to points 1 and 2 from the perspective of the people that work for us, the financial resource and the buildings that we work from.

The development of the ICS has supported greater opportunities for integration and joint priorities. Through increased partnership developments key areas of focus for Derby and Derbyshire have informed the 2022-23 BCF Plan including:

- Recovery and resilience of individuals and communities
- Urgent care response and improving system flow
- Shared population outcomes and
- Tackling inequalities through response to Core20Plus5.

The following place-based priorities relate closely to the wider system priorities whilst the BCF Plan acts as an enabler for these priorities.

Place-based care: We are accelerating the pace and scale of the work undertaken by Local Place Alliances and continue to support and enable them to 'join up' primary care, mental health, community services, social care and the third sector.

Derby	Derbyshire
<p>There is a single Local Place Alliance for Derby city, which is co-terminus with the Derby City Council footprint. Specific priorities for Derby City Place Alliance are:</p> <ul style="list-style-type: none"> • To continue the development of a Home Visiting Service, which will provide a multi-disciplinary approach to triaging and intervening in acute health and social care crises for housebound patients, reducing emergency admissions to acute and residential care • To work jointly with the Derby Poverty Commission, to understand the key local wider determinants of health outcomes and develop a seamless strategic approach to tackling poverty related health inequalities • To develop a new model for community mental health services, reducing the need for crisis-based interventions 	<p>Derbyshire is made up of seven Local Place Alliances:</p> <ul style="list-style-type: none"> • Amber Valley • Bolsover and North East Derbyshire • Chesterfield • Derbyshire Dales • Erewash • High Peak • South Derbyshire <p>The Place Alliances, via the Derbyshire Integrated Community Place Board, have agreed a work programme for 2022/23 which prioritises:</p> <ul style="list-style-type: none"> • Development and implementation of the Team Up Derbyshire approach • Implementing a Community Mental Health Framework • Develop implementation plans for a phased delivery programme of an integrated local access point for urgent community response that will ultimately involve DCHS, Social Care, Home visiting and Falls recovery services. • Continue to maintain, support and develop MDT working at scale to support Care homes. • Continue to maintain, support and develop connections across the wider Place between all

	partnerships <ul style="list-style-type: none"> Continue current work on priorities based on local need as identified via local population health needs assessment and other local sources of intel/data/information.
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Prevention and self-management: By preventing physical and mental ill health, intervening early to prevent exacerbation, and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand.

Derby	Derbyshire
The specific priority actions for Derby in 2022/23 are: <ul style="list-style-type: none"> To continue to embed Team Up Principles of strength-based working and integrating care by working together in a number of key workstreams To work with the local Place Alliance and PCN to develop proactive care, using the principles of Local Area Coordination for people at risk of poor health and wellbeing. To ensure access to early intervention and preventative services for emotional/mental health, linked to the Community Mental Health Framework To ensure our urgent community response keeps more people at home and connected to their local community 	The specific priority actions for Derbyshire in 2022/23 are: <ul style="list-style-type: none"> To review practical housing related support services and existing independent living services Improve access to information, advice and signposting to different offers in each Place by creating a web-based single point of access that includes aids, adaptations and low level practical preventative housing offers To review the Falls Response Service (FRS), pilot an Enhanced FRS specification in three distinct geographical areas and embed into the wider community based Urgent Care Response system To ensure access to early intervention and preventative services for emotional/mental health, linked to the Community Mental Health Framework implementation under Living Well

Population Outcomes: A population health management approach is key to our strategic intention.

We are focusing on improving the outcomes for the people of Derby and Derbyshire by applying an effective Population Health Management approach (PHM) which is being led by Public Health. The role of the steering group is to bring together key representatives from across the ICS to coordinate the development of the overarching direction of travel for the PHM in Derby and Derbyshire by agreeing the strategic approach and actions that need to be delivered. This outcome-based approach is being used to further shape the priorities of the BCF Plan.

System efficiency: Ongoing efficiency improvements across commissioners and providers are a key component of ensuring that we address the Derbyshire financial challenge.

Work is underway to understand the allocation of community health resources at a Place Alliance level to identify key areas of focus for levelling up. This will link to the Population Health Management work described above to identify what changes are needed to ensure that the skills and specialisms within community health provision are deployed in the most effective way.

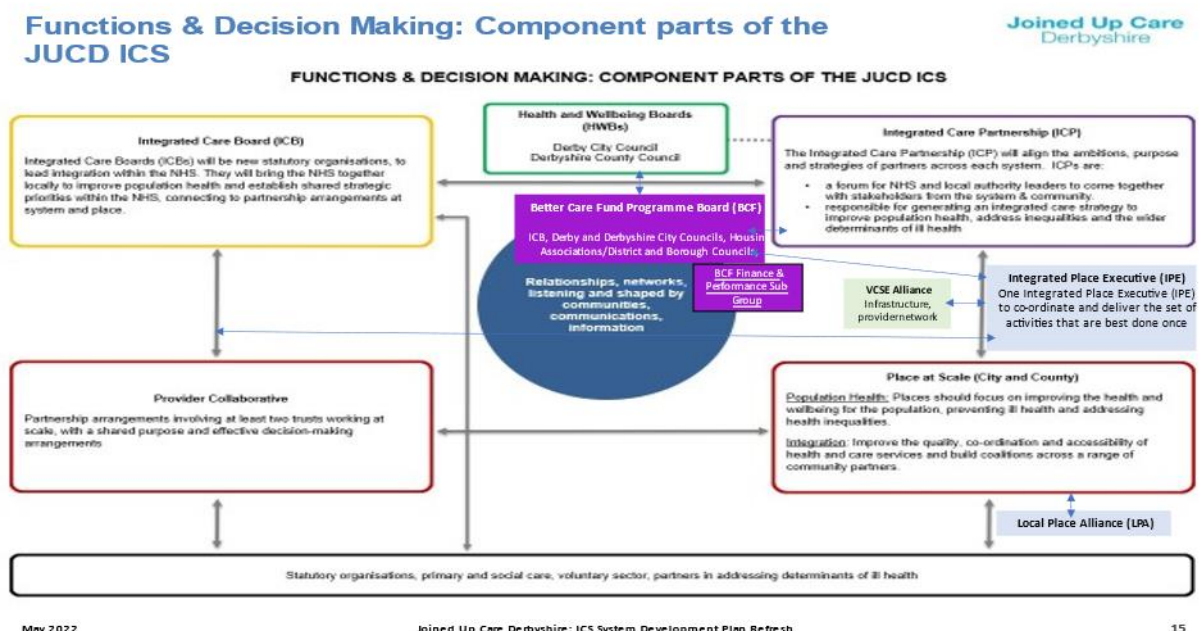
System Development: We will manage the Derbyshire system through an aligned leadership and governance approach, supported by aligned incentives and a single view of system performance.

Derby	Derbyshire
Plans are developing to support the evolution of Derby City Local Place Alliance to the Derby City Place Partnership Board. This will be a formal statutory body of the ICS.	<p>A key focus for 2022/23 will be to migrate the existing multi-agency infrastructure for place-based working in Derbyshire into the ICS.</p> <p>As with Derby City, strategic development work is underway to support the development of Derbyshire Place Partnership Board. This PPB will be supported by a network of the existing seven Local Place Alliances in Derbyshire County.</p> <p>There has also been a significant change in the overall place footprint for Derbyshire as Glossop healthcare services became part of the Derbyshire ICB from 1 July 2022. The priority is to ensure the smooth transition of healthcare services to Derbyshire and therefore no immediate service changes are planned.</p>

All the above priorities shape our BCF work programme with a particular emphasis on developing population health management approaches at place level and embedding prevention and self-management.

Governance

In Derby and Derbyshire, we see our local populations as key partners and their views are systemically captured and utilised through our JUCD governance structure.



CONTROLLED

As stated above, our BCF plans, do not stand as separate integration programmes, but the schemes funded by the BCF are part of a wider system approach to integration and joint working between the NHS, Councils and partners. As a supporting tool for integration, the BCF is not the sole driver of integration within Derbyshire. Both Derby and Derbyshire's Health and Wellbeing

Boards have retained a joint BCF Programme Board as a delegated sub-group. This is likely to continue until the final arrangements under the new Integrated Care System are established, at which point we will review how best to reflect specific BCF governance requirements within our ICS infrastructure.

The BCF Programme Board continues to meet monthly to oversee the management and monitoring of the Derby and Derbyshire BCF programmes. The joint Board continues to comprise representatives from the two Councils and Derby and Derbyshire ICB. A representative of District Council also attends, and guest members may attend where there is a focus on specific areas e.g. carers' support, DFG delivery, Discharge to Assess Pathways, Integrated Community Equipment Services (DICES (Derbyshire) and ICES (Derby)).

As previously, all BCF national returns (planning and monitoring) are reported at least annually to both Health and Wellbeing Boards, but the oversight monthly is carried out by the multi-agency dedicated Finance and Performance Sub-Group.

Newly Established Integrated Care Partnerships and Derbyshire Integrated Place Executive (IPE)

The Joined-Up Care Derbyshire System is establishing and reviewing its structures and governance as part of the Integrated Care System Transformation. The formal structure will be through two Place Partnerships (one for Derby City – aligned with the unitary authority) and one Derbyshire County (aligned with the upper tier authority and with representation from the local place alliances which are largely co-terminus with districts and boroughs). Whilst the mechanisms are set up and to ensure continuity functions are being co-ordinated on behalf of the partnerships through an Integrated Place Executive (IPE), and there will always be a need for mechanisms to co-ordinate activities that are best done once across the ICS. Reporting will be into the **Integrated Care Partnership**.

The IPE brings together senior representatives from local NHS organisations, primary care, local government, the VCSE and other community partners. The aim is to build on existing good work and lead the development of an Integrated Care System strategy in Autumn 2022 – for co-ordinating and integrating services, supporting integrated workforce, overseeing performance and championing distributed leadership.

We aim to balance subsidiarity with only doing once those functions that can best be planned and developed at a system level to maximise efficiency of effort and consistency of outcome.

We aim to embed co-production with people who use our local services; facilitating accountability to local communities and building broader coalitions with community partners to create health and well-being. The redesign of the next service specification and model for carer support will be co-produced through planning workshops and quality-assessment sessions across Autumn 2023 to Spring 2023.

The IPE will also lead the development of and deliver the Integrated Care Partnership Strategy on behalf of the ICP.

The following groups have also been established to oversee delivery and to jointly manage issues which need to be escalated for resolution at a senior level across relevant organisations and with a shared focus on achieving the best care and outcomes for individuals.

System Operational Resilience Group (SORG)

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

Pathways Operational Group (POG)

This Group exists to deal with day-to-day discharge related issues and has reviewed its escalation process in advance of winter. POG reports to the System Operational Resilience Group (SORG).

Strategic Discharge Group (SDG)

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

Disabled Facilities Grant (DFG)

Leads at all our district and borough Councils have collaborated on the DFG/housing element of our BCF plans and have jointly developed the narrative on DFG/wider housing support. (Further narrative about DFG plans later in report).

Voluntary, Community and Social Enterprise (VCSE)

Involvement from the VCSE is crucial to development and delivery of the programmes of work that incorporate the BCF. As the ICS has developed the VCSE sector has been exploring how best it can engage and the mechanisms to put in place to enable this to happen and there are three primary VCSE structures that are taking different aspects of engagement forward at system/cross county level. There is a VCSE Alliance as required by the ICS Guidance. In Derbyshire, the Alliance has been meeting since December. Secondly the Derby and Derbyshire Infrastructure Alliance (formerly 3D). DDIA is also a non-constituted body that is a consortium of local VCSE infrastructure bodies (such as CVSSs). The DDIA brief is wider than the ICS, promoting the VCSE agenda in areas such as economic development as well as health and social care. The aim of DDIA is to promote and support a strong, diverse vibrant voluntary and community sector working towards a stronger, fairer society. Finally, VCSE Strategic and Enabling Groups taking stock of VCSE engagement, reviewing the agreement, and tackling blockages/opening opportunities and also bringing together statutory staff in ICS partner agencies who are working on aspects relating to VCSE engagement at system level such as funding, system development, data etc with VCSE counterparts to better link together work.

The place-based priorities relate closely to the wider system priorities whilst the BCF Plan acts as an enabler for these priorities. The IPE and Place Alliance Boards all have representation from the VCSE Alliance providing continuous co-production on the place-based priorities and champion integrated working.

Overall BCF plan and approach to integration

The overall approach to integration and the part played by the BCF plan is detailed in the Executive Summary above.

Joint commissioning meetings have been established as we further progress our ICS arrangements in 2022 where an 8-step plan to further enhance our approach has been developed. (See below)

1. Influencing across our system (different groups and teams / functions) to think about the opportunities of joint commissioning and identifying what they might be / what the 'big' priority areas are.
2. Support development of the JSNA (NHS and LA as joint partners in this) to be more central to our decision-making

3. Setting out our level of intent to jointly work together on addressing key priorities / commissioning differently to drive more integrated care e.g. different contracting or pooling arrangements
4. Supporting the identification of scenarios where joint commissioning may be beneficial e.g. a set of criteria / framework approach
5. Exploring our readiness to maximise the White Paper opportunities and the capacity and capability requirements across functions such as contracting and commissioning; identifying any gaps in expertise or time available to develop more integrated approaches
6. Establishing what good joint commissioning looks like (from process and outcome perspectives) to support broader system development work
7. Contributing to the shaping/developing of the ICS's Integrated Care Strategy
8. Helping to troubleshoot and unblock any specific issues, with a view to signposting or advising next steps

The BCF is used in both Derby and Derbyshire to fund integrated health and social care posts to increase capacity for Autism/Learning Disability Commissioning particularly in relation to admission avoidance, speedier discharge and joint working on accommodation and community support provision. Progress so far includes creation and of a lead provider to run a Community of Practice for a range of VCS organisations who have an interest in contributing to improving the pathway in relation to community support for autistic people. The intention is to use this mechanism to transact work packages without the need to go through formal procurement processes. This will enable us to grow a range of community support more rapidly for pre and post diagnosis in the community

Evidence shows that life expectancy for women with LD is 18 years less than the national average and for males it is 14 years less, with respiratory diseases being the leading cause of death, many of which are preventable and treatable. Studies estimate the Life expectancy for people with Autism at 30 years less than the national average, highlighting that 70% of children with autism and 80% of adults have at least one mental health condition resulting in autistic people at greater risk of dying from suicide than the general population. We know that the uptake of cancer screening is lower across cohorts of people with LD &/or Autism and there is a greater prevalence of co-morbidity with one or more long term condition. The joint commissioning roles are working across system partners to identify the services to be targeted to support this vulnerable group to address the social determinant, increase access to healthcare and ensure adapted interventions are provided in a timely manner to improve healthy life expectancy.

The additional capacity has also enabled some focused work on developing and bringing online new accommodation and support by working with developers and bringing new providers with the ability to deliver enhanced care and support for our BRS cohort. Recent completed projects in Derbyshire are The Glebe which includes 11 supported living and 6 enhanced units of accommodation. In Derby City similar accommodation is now available at Wilkins Drive, providing 6 units of enhanced accommodation and a further 5 Moorwood for BRS clients. Towards the end of this financial year, a further 6 enhanced and 12 supported living units will be opened in Swadlincote in the south of the county.

Relevant commissioners from the ICB and both Councils' Social Care and Public Health Commissioning Teams are increasingly working together and exploring the possibilities of expanding the scope of jointly commissioned services. For example, Derbyshire County Council are leading on a project to explore whether all community sexual health provision could be brought under a Section 75 Partnership Agreement across the three commissioners. Further discussions are planned to consider whether Section 75 Partnership Agreements could be established for our Derbyshire Building the Right Support clients.

ASC Reform paper – People at the Heart of Care sets out a requirement to integrate health, care, and housing in the coming years. A Housing Transformation Fund will be made available in Autumn 2022 and the Derbyshire system will seek to bid for funding to further develop and embed our health, care and housing strategy across the system and identify opportunities to increase the number of adults (of all ages) living in models of “housing with care and support”. In the longer term - we are explicitly intending to shape and stimulate the market for supported housing, through how we target future investment, and develop the partnerships and long-term strategies to drive change.

Implementing the BCF Policy Objectives (national condition four)

Plans for improving discharge and ensuring that people get the right care in the right place

Pre-Covid, the Urgent Care Board, Accident & Emergency Board, and a dedicated Discharge to Assess Board all had oversight of the range of activities in place to maintain hospital flow and avoid unnecessary admissions. During wave 1 of the pandemic, the Discharge to Assess Board was reconfigured to become a Discharge Cell (now called the Strategic Discharge Group) in line with the requirement of the National Hospital Discharge guidance in March 2020. In addition, a dedicated Pathways Operational Group was established under this to focus on more immediate operational pressures and escalations surrounding discharge. We have recognised that despite its name the Strategic Discharge Group agenda was continually driven by acute operational pressures. A revision has been recently undertaken to ensure protected capacity to drive the necessary shift to 'up-stream' work and a Discharge Flow Lead post created to identify the system actions needed for a step change in improvement.

Discharge Improvement and Flow Plan

We have used the components of the High impact change model (HICM) to assess our system to establish improvements. This was accelerated during Covid and there have been regular improvement activities such as focused discussions with NHSE/I and Multi Agency Discharge Events (MADE sessions). We have recently completed our 100 Day Discharge Challenge and the Strategic Discharge Group continues to look for opportunities for continuous improvement. Our ICS dedicated Discharge Flow Lead supports this work and oversees our system wide **Discharge Improvement Plan**. Below is the overview plan developed by the Discharge Flow Lead detailing discharge priorities:

Overview – Discharge priorities

Area	Short-term - now	Medium Term	Long term
Data	<ul style="list-style-type: none"> Partner agreement to report on outcome metrics for all pathways Prioritise signing off IG clearance 	<ul style="list-style-type: none"> Improve KPI monitoring with resource for PDSA to focus on issues Review of discharge budgets 	<ul style="list-style-type: none"> One system shared IT solution to support discharge flow (operational and outcome reporting)
Assessment	<ul style="list-style-type: none"> Review and process mapping of P1 flow undertaken Feedback from this currently being undertaken with partners 	<ul style="list-style-type: none"> Strength based approach roll out to the priority wards working with system partners Ensure 'trusted assessor' documentation is enabling discharge 	<ul style="list-style-type: none"> Strength based approach across all wards and community in partnership Trusted assessor document is robust for discharge
Process	<ul style="list-style-type: none"> MADE / Red day events to manage internal delays 100 day discharge challenge 	<ul style="list-style-type: none"> City testing single discharge model with DCHS and Council Pilot of the hybrid model in agreement with JUCD HRDs Understand benefits of using assistive technology to support discharge 	<ul style="list-style-type: none"> Single discharge model across JUCD with no variation, maximising capacity, use of hybrid workers <ul style="list-style-type: none"> Delivered via provider collaborative, or commissioned from market, or mixed model
Capacity	<ul style="list-style-type: none"> Start work on reducing LOS P1 county 	<ul style="list-style-type: none"> Reduce LOS in P1 county through targeted work and PDSA approach Review and align all current P1 offers : are we meeting SOP and outcomes? 	<ul style="list-style-type: none"> Ensure pathway capacity is fit for purpose? <ul style="list-style-type: none"> le all pathways are able to support patients with the level of complexity being discharged, and have Covid/IPC resilience
Other	<ul style="list-style-type: none"> P1 deep dive still being written up Need system resources identified to deliver system transformation 	<ul style="list-style-type: none"> Agree system cost of discharge spend and options for single financial model and envelope : needs financial support 	<ul style="list-style-type: none"> System focus on staffing to deliver home care : T&C for staff delivering reablement and PVI

A significant number of BCF schemes are directly contributing to our discharge pathways. In Derby – Pathways 1 and 2 are funded through the BCF and iBCF and act as the major but not only, funding stream and primarily support the University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and Chesterfield Royal Hospital Trust. Staff associated with care package brokerage, social work reviews, therapy and admission avoidance interventions are also funded in part by the BCF in City and County. Without the BCF, many of the discharge support schemes would not operate to the same capacity or effectiveness. The focus has been:

- Ensuring all requirements of the Hospital Discharge Guidance are in place particularly in promoting and operating a home first approach
- Addressing any escalation matters that needed a “system” level response through the Pathway Operational Group – this has included development of a discharge pathway for bariatric patients (several of whom experienced delays) and establishing clear arrangements with out of area hospitals
- Sharing good practice about the discharge pathways and how they have been developing and identifying areas for improvement / ways of reducing delays out of pathways
- Overseeing the data and outputs from each of the discharge pathways and developing an interagency data set and joint approach to demand and capacity forecasting (ref: demand and capacity forecasting template)

Winter Pressures work is also being undertaken by Public Health around the critical impact of fuel prices on low-income homes, as well as access to food banks etc. Cold homes = poor health outcomes. The Derbyshire Health Homes project could support on some of this work as part of the review of that service. This is referenced further on in this narrative.

Feedback from NHSE gives us assurance that we are progressing positively towards the right ambitions as a system. Following a NHSE facilitated 'Discharge to Assess Conversation' on 9 July 21, the feedback was that "It is clear the system is working extremely well and is absolutely focused on a home first ethos. There is great leadership and partnership working in place that has a

consistent focus and drive on improvement and progress. This is further supported by a flexible and integrated workforce that clearly puts patients first."

Capacity and Demand Modelling

The BCF capacity and demand modelling has been co-produced with all JUCD partners. System capacity has been defined as 'those joint pathways, which meet our system definitions of D2A, and are funded through the BCF funding streams to deliver D2A pathways 1 & 2. Mitigations to support flow (described below) are not included in this 'system capacity'. This 'mitigation' capacity will be used in the next stage of the capacity and demand modelling. This is to enable us to understand where the gaps are in our 'core BCF care' and enable a clear view as to where we have mitigations which are supporting discharge, but not meeting all of the outcomes of our D2A commissioned pathways. We are intending to use this one version of the truth as the system gap analysis for Derby and Derbyshire to help shape the winter plan 22/23 and support development of mitigations for our surge plan.

In Derbyshire, when there is a lack of provision of pathway 1 there are several mitigations that are in place to support a patient to be discharged. For all of these, if the patient has therapy needs at point of discharge, these will be referred and triaged to be reviewed at home.

- Additional capacity is currently commissioned to provide a bridging service to support a patient to return home which is having some impact in reducing ongoing needs, however, they are not the same as a 'Pathway 1' provision where reablement and rehab are a part of the core offer
- Packages of care are brokered through private care providers to support discharge home. These packages are also not 'reablement' and are from the same providers as provide long term care.

For pathways D2A pathways 1 & 2 patients can also be discharged into temporary care home placements, where there is no capacity in the BCF funded bedded care. This is in exceptional circumstances.

Supporting unpaid carers

Derbyshire County's BCF funds dedicated support services for unpaid carers across Derbyshire through the provision of a Carer Information, Advice, Assessment and Support Service (Derbyshire Carers Association) and dedicated online, digital support delivering on key information, advice, and virtual connection with other carers both locally and nationally (Mobilise).

Derbyshire also provide a Carer Emergency Card service to ensure carers have a contingency in place in the event of an emergency or crisis, of which over 850 new carers annually plan for. Engagement with carers and practitioners has recently taken place to understand if carers still value this service and identify how it can be further developed. As a result, the application route has been digitalised and the process streamlined. The cards issued will change in line with the feedback received and a marketing campaign will be launched to promote and increase the reach of the service.

The Carer BCF funding in Derbyshire is £2.1m, which sustains over 20,000 annual support responses across a range of carer issues, along with the delivery of 1,500 detailed carer assessments and 1,400 carer personal budgets (CPB), paid directly to carers to provide a break from caring and/or to sustain their caring roles. CPB are used creatively to deliver personal outcomes, and many range from funding wellbeing services or goods through to essential

equipment to ease the burden of caring. This is in addition to the provision of short-term care for the dependent adult, assessed and delivered by adult social care.

Digital carer support has reached a further 8,000 carers across 2022, through targeted advertising, with 800 carers going on to engage with weekly emails and benefit checks, and a further 185 carers accessing deeper support actions through e-courses, online 'cuppas' with other carers and 1:1 support. Take up of digital resources and support in Derbyshire has been very successful by national standards and will continue to be an area of focus and development.

All commissioned carer services support the outcomes of the Derbyshire system wide carers strategy delivering on the legislative health and social care duties to carers. Planning is underway to ensure the ICB has a clear statement about carers, carer involvement and objectives to support carers.

Carer projects supported	% BCF Budget	Meeting the KLOES
Carer Information, Advice, Assessment and Support Service delivered by Derbyshire Carers Association (DCA) Digital online carer support provided by Mobilise	43.88	<p>Delivery of personalised and condition specific information advice and guidance, including carer assessment, support planning and annual review. These methods help to inform, sustain and balance the caring role, enabling carers to continue.</p> <p>Direct provision of support to carers delivered through a range of support options and community-based initiatives</p> <p>Training and breaks for carers, improving skills, developing knowledge and building resilience</p> <p>Awareness raising with partners across health and social care to help them support carers more effectively.</p> <p>Digital information, group and 1:1 online support.</p>
Carer Personal Budgets (CPB)	35.71	Delivery of a personalised budget which supports a break from caring as defined by the carer.
Adult Care Liaison Worker based in the carers service	1.43	Role ensures whole family approach through record sharing and coordination, that interconnects services, improves carer experience and affords consistency in the determination of support options and value of CPB.
Contribution to Young Carer's Support Service	2.30	The Young Carer's service supports over 200 young carers annually.
DCC Carer Emergency Plan/Card Service	13.2	Support to create a personalised emergency plan, outlining contingency details and nominated contacts, which will support the adult requiring care and support in the absence of the carer
DCC Carer Communication	0.77	Dedicated carers in Derbyshire website delivering accessible, accurate and reliable information which engages carers, informs

Strategy		their role and reduces isolation.
DCC Carer respite provision	2.63	The delivery of community-based, replacement care which provides a defined break from caring and leads to improved health and wellbeing

Derby City's BCF assists with a wide focus on prioritising support for Carers as their needs are often cross cutting in terms of health and social care. In addition to the Care Act required preventative and social work support for Carers, a dedicated service is commissioned (delivered by Citizens Advice Mid Mercia) to involve Carers in identifying their needs, assist them to remain in their caring role and to ensure their individual outcomes are achieved and their health and wellbeing is maintained. The Council is currently reviewing at the provisions in place in the wider care provider market to support respite and day opportunities offer for Carers that are available to people to support carers and met outcomes for customers. This is particularly focused on those people caring for people with a Learning Disability or someone living with dementia.

The BCF funded service with Citizen's Advice proactively reaches out to Carers using a **Carers Conversation** and key to this is working in partnership with the Council and other partners to identify Carers more efficiently and effectively. The aim of the service is preventative, ensuring Carers do not reach crisis point, by keeping them well so they can retain their caring role for as long as possible. Citizens Advice deliver five key services in Derby:

- 1.Information, advice and guidance for Carers
- 2.Carers training
- 3.Wellbeing activities for Carers
- 4.Support and peer support for Carers
- 5.Carers clinics in conjunction with GP services

The table below is a highlight of the service outcomes and outputs from 2021/22 and the areas for improvement that will be taken forward during 2022/23:

Target	
At least 750 carers per annum provided with info and advice	1467 carers were helped through the Helpline in year 1
At least 1250 carers on the service providers mailing list to receive a newsletter/publicity material	474 new carers have signed up to the newsletter. In addition to this there is a partners' mailing list of over 1000
Management information is produced on carers outcomes and changes to services based on the feedback from carers	The service is monitored weekly, monthly, quarterly and annually by the Service Manager. Changes are made to service provision based on trends and emerging carer needs.
At least 300 different carers receiving training per annum – carers can attend more than 1 session up to 3 per annum.	236 different carers were provided with training (79% of target) in 2021

Minimum of 300 different carers within 12 months period. One break per annum for a carer as a minimum offer	173 (58% against target) different carers provided with at least one break.

Disabled Facilities Grant (DFG) and wider services

A Derbyshire Disabled Facilities (DFG) Working Group reports directly to the BCF Programme Board. Each of the District and Borough Councils are represented at this Group to engage with Derbyshire County Council and ICB on DFG activity. This has helped deal with challenges throughout the pandemic, including pressures on supply chains and other factors that have made delivery of adaptations more complex. Derbyshire County Council has passed all DFG funding to the Districts/Boroughs and progress is regularly reported to the BCF Programme Board. A recent corporate audit of the DFG process identified a series of recommendations that have been developed into a work plan overseen by the DFG working group. [This includes in summary:](#)

Recommendation	By When
The collaborative development of appropriate KPI's to monitor the delivery of DFGs in Derbyshire to include: a breakdown of waiting times in relation to Foundations latest adaptations guidelines, quality of interaction with front line teams; ease of access etc. The finer detail of this to be developed over the winter with system partners.	Spring 2023
Single Adaptations Policy audit review.	Autumn 2022
Information Sharing Agreement	Spring 2023
Review of additional resources to the occupational therapist's team	Ongoing
Review of the Terms of Reference for the DFG Planning working group	Autumn 2022
Review of the Disability Design Teams structure as well as their policies and procedures against the DFG system need.	Spring 2023
Development of a Service Level Agreement between the DDT and the District and Boroughs that outlines each authorities' specific requirements	Spring 2023
Review of the Derbyshire Healthy Homes Project including the scope of the service and funding following the end of the Home Improvement Agency contract	Spring 2023
Implementation of a purchasing framework to support the delivery of minor and major adaptations	Autumn 2023 (TBA)

Derby City Council is an upper tier authority and the DFG allocation is made fully available for DFG adaptations and lower-level stay-put interventions through the internal Healthy Housing and Handyperson Services, which the Derby BCF part-funds.

Several District and Borough Councils have updated their housing renewal policies to support a more flexible approach to eligibility and the use of the funding. Amongst the changes have been

lifting of the means test for simpler adaptations which has meant that some of those just over thresholds that were not proceeding with much needed adaptations are now eligible. Derby City Council has adopted a policy for not means testing lower cost/non-complex adaptations where the works are urgently required such as to assist with hospital discharges and palliative care. Derby City Council also has a £20k discretionary top-up facility which unblocks the most complex adaptations (often children's cases with high needs). Relocation assistance is increasingly being utilised for better client outcomes where existing properties either cannot be adapted or where it offers far better long-term solutions.

Several District and Borough Councils have changed their approach to stairlift provision to make it less bureaucratic, enhanced the ability to recycle and install for shorter timeframes as well as removing some of the means testing. Most Derbyshire District and Borough Councils also allocate some of their funding to support the county-wide BCF Healthy Homes Service which supports discharge planning and admission prevention as well as providing first time heating for eligible households, blending BCF allocations with other forms of funding such as Energy Company Obligation.

Derby City Council has been accepting recommendations for adaptations from external Occupational Therapists such as hospital discharge teams and OTs engaged by service users to streamline the assessment process and reduce duplication.

Our approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

We have continued to develop the joining up of housing, health and social care through the Derbyshire Housing and Health Systems Group. Under the leadership of Public Health this forum has enabled increased focus on the relationship between housing and health. There has been continued progress in the Group's work in 2022 through the delivery of focussed operational group work plans with focus on homeless and vulnerable people with the intention of monitoring numbers of interventions. Key actions being progressed include:

- Delivering new professional pathways from UHDB specialities to housing services and other associated functions like debt advice. To create more effective professional relationships that deliver ongoing preventative support targeted to the individual's housing need.
- Completing detailed assessment of the services to tackle hoarding. Hoarding is sizeable challenge that impacts on professionals being able to deliver their interventions safely in a person's home. The DHHSG recognise this as a significant risk for both professional services and individuals and drives toward a system approach that includes dealing with the psychological issues that sit behind hoarding whilst creating a more joined up approach to existing practical services.
- The priority one operational group (a focus on housing and vulnerable populations to improve wellbeing and reduce health inequalities) collaborates on influencing the wider system to support people to remain living independently in their own homes. This work focuses on increasing the reach and access to aids, adaptations and associated low level services that support independent living. Through increasing early accessibility to information and advice as well as practical guidance and support this will reduce the number of people requiring more complex health and social care interventions.
- Collaboration around maintaining independent living services, all of which is important to increase the reach and access to adaptations and associated work. Working with the system at a local level to embed these services as part of a joined-up community response creating low level support capacity for the system.

- Support for a new Derbyshire Homelessness Strategy which will be the system response to reducing homelessness and not just from the housing perspective.
- Promotion of energy efficiency and affordable warmth for more vulnerable residents setting up work to prepare for signposting for winter and the projected high energy bills. The Derbyshire Healthy Homes Project is aiming to distribute around 2000 electric blankets for winter 2022/23.

Equality and health inequalities

JUCD has established a system Equality, Diversity, and Inclusion (EDI) collaborative with all our partners from across the health, care and wider LRF to explore what value we could add to EDI from a system perspective. This intent has been strengthened by the COVID experience and the light shone on systemic and historic inequalities that need addressing. The Director of People and Inclusion at Derbyshire Healthcare is leading the group. Our ambition is to put inclusion at the centre of cultural transformation. The EDI Collaborative have been tasked to produce a system baseline utilising all available data, so we have a clear sense of our current workforce profile compared with our population.

Equality impact assessment is fully embedded into single and multi-agency processes for developing strategy, policy and commissioning plans. For NHS organisations, assessing impacts of proposals on groups with the nine protected characteristics is part of a wider quality impact assessment process. Completed equality impact assessments are presented at a regularly convened system level Quality Panel to provide assurance and challenge.

The health of people in Derby and Derbyshire is varied compared to the England average. There are marked inequalities within the ICS footprint, for example:

Population Outcome Indicators

		County	City	England
Poverty	-Under 16s in relative low income families	14.7% ↑ (20,212)	23.7% ↑ (12,807)	19.1%
Housing	-Households in fuel poverty (low income, low energy efficiency) ¹	13.8% → (49,145)	15.6% → (17,089)	13.4%
Employment	-Young people NEET	3.3% ↓ (530)	7.4% ↑ (430)	5.5%
	-Gap in employment for people with a LTC	13.2% →	11.1% ↓	10.6%
Unhealthy Weight	-Reception: Prevalence overweight/obese ²	21.4% ↓	21.5% →	23.0%
	-Year 6: Prevalence overweight/obese ²	32.8% →	38.9% →	35.2%
	-Percentage of adults overweight/obese	66.8% →	62.5% →	62.8%
Smoking	-Women smoking at time of delivery	11.8% (800) ↓	11.9% (332) →	9.6%
	-Adult smokers ³	11.0%	11.5%	12.1%
Alcohol	-Alcohol related hospital admissions (per 100,000)	586.7 → (4898)	628.6 ↓ (1459)	455.9
Inactivity	-Adults physically inactive	20.5% →	26.4% →	22.9%
Mental Health	-Estimated prevalence of common mental disorders (16+) ⁴	16.0%	17.7%	16.9%

Source: Public Health Outcomes Framework

¹Significance not calculated

²NCMP data collection affected by COVID-19, Interpret with caution

³New data, no trend

⁴Estimates, no trend

Key: Compared
to England

Significantly
Worse

Similar

Significantly
Better

Change from
previous

↑ ↓ Getting
Worse

→ No
Change

↑ ↓ Getting
Better

System wide population health indicators: 'Turning the Curve'

Life expectancy and healthy life expectancy are determined by interactions between multiple factors.

These indicators are recommended to the system as important 'markers' on the way to improving high-level outcomes. They address direct risk factors for the main causes of death, illness and inequalities, including mental health:

- Reduce smoking prevalence
- Increase the proportion of children and adults who are a healthy weight
- Reduce harmful alcohol consumption
- Improve participation in physical activity
- Reduce the number of children living in low-income households
- Improve air quality
- Improve self-reported wellbeing
- Increase access to suitable, affordable and safe housing.

Health Inequalities Indicators

JUCD has identified additional indicators to reduce specific inequalities in the system drawing on local data and NHS recommendations ¹

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

Proposed Principles and Actions

- A shared understanding and ownership of health inequalities
- Clear direction and expectations, with all parts of the system identifying their own role in achieving the objectives
- Clarity on accountability through the system
- Moving towards distribution of capacity and resource according to need
- Focusing equally on the impact of inequality throughout prevention, access, experience, and outcomes of services taking a proportionate universalism approach
- Use intelligence and evidence to understand health inequalities, make decisions and review our progress

¹ <https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/>

- Citizen engagement: strengthening the voice of communities and lived experience in our health planning
- Alignment between the ICS and the City and County Health and Wellbeing Boards

That for each of the Priorities identified below it is intended to monitor the numbers of people positively impacted by each of the initiatives to ensure effectiveness and where appropriate improve activity with provision being coordinated at Place level

Priority Area	Key Actions 2022-23
Expansion of smoking cessation provision	<ul style="list-style-type: none"> • Work with Maternity Transformation Programme to embed learning from Smoking in Pregnancy deep dive exercise
Improved uptake of the NHS Diabetes Prevention Programme	<ul style="list-style-type: none"> • Carry out risk stratification exercise at PCN level to identify areas to target and focus resources • Rollout of waves 3 and 4 of low-calorie diet pilot • Embed health psychology in triage process to direct patients to most appropriate structured education provision
CVD prevention	<ul style="list-style-type: none"> • Expand access to cardiac rehabilitation provision, with a more person-centred approach • Implement and evaluate provision of blood pressure monitors at home • Develop Derby and Derbyshire network of cardiac arrest First Responders and defibrillators
Progress against the NHS Long Term Plan high impact actions to support stroke, cardiac and respiratory care	<ul style="list-style-type: none"> • Embed hypertension case finding and management in primary care • Complete the review of the Hyper-Acute Stroke Unit at Chesterfield Royal Hospital • Establish pilot Long-Term Conditions Hub, to test integrated approach to diagnostics, clinical measurement and treatment for patient with key co-morbidities • Build capacity to deliver pulmonary rehabilitation
Expansion of NHS digital weight management services	<ul style="list-style-type: none"> • Re-establish face to face services, with initial focus on most vulnerable patients (patients with learning disabilities and mental health problems)

Place-based care strives to reduce health inequalities for patients living in specific geographical areas by bringing health and social care organisations together to work collaboratively.