



**Updated July 2014**

## **Better Care Fund planning template – Part 1**

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

Both parts of the plans are to be submitted by 12 noon on 19<sup>th</sup> September 2014. Please send as attachments to [bettercarefund@dh.gsi.gov.uk](mailto:bettercarefund@dh.gsi.gov.uk) as well as to the relevant NHS England Area Team and Local government representative.

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

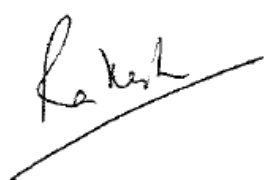


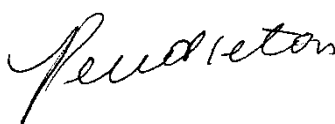
### **1) PLAN DETAILS**


#### **a) Summary of Plan**

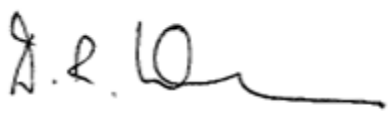
Local Authority	<b>Derbyshire County Council</b>
Clinical Commissioning Groups	<b>Erewash CCG</b>
	<b>Hardwick CCG</b>
	<b>North Derbyshire CCG</b>
	<b>Southern Derbyshire CCG</b>
	<b>Tameside and Glossop CCG</b>
Boundary Differences	<p>The Glossopdale locality has a population of approximately 33,200, is situated within the boundary of Derbyshire County and has NHS care commissioned by Tameside &amp; Glossop CCG</p> <p>Southern Derbyshire CCG includes Derby City Council area with a population of around 250,000</p>
Date agreed at Health and Well-Being Board:	<b>04/09/2104</b>
Date submitted:	<b>19/09/2014</b>
Minimum required value of BCF pooled budget: 2014/15	<b>£3.023M</b>


2015/16	<b>£57.363M</b>
Total agreed value of pooled budget: 2014/15	<b>£16.625M</b>
2015/16	<b>£61.489M</b>

**b) Authorisation and signoff**

<b>Signed on behalf of the Clinical Commissioning Group</b>	Erewash CCG
<b>By</b>	Rakesh Marwarha 
<b>Position</b>	Chief Officer
<b>Date</b>	19 September 2014
<b>Signed on behalf of the Clinical Commissioning Group</b>	Hardwick CCG
<b>By</b>	Andy Gregory 
<b>Position</b>	Chief Officer
<b>Date</b>	19 September 2014
<b>Signed on behalf of the Clinical Commissioning Group</b>	South Derbyshire CCG
<b>By</b>	Andy Layzell 
<b>Position</b>	Chief Officer
<b>Date</b>	19 September 2014
<b>Signed on behalf of the Clinical Commissioning Group</b>	North Derbyshire CCG
<b>By</b>	Jackie Pendleton 
<b>Position</b>	Chief Officer
<b>Date</b>	19 September 2014
<b>Signed on behalf of the Clinical</b>	Tameside and Glossop CCG

<b>Commissioning Group</b>	
<b>By</b>	Steve Allinson 
<b>Position</b>	Chief Officer
<b>Date</b>	19 September 2014


<b>Signed on behalf of the Council</b>	Derbyshire
	David Lowe 
<b>By</b>	
<b>Position</b>	Deputy Chief Executive
<b>Date</b>	19 September 2014

<b>Signed on behalf of the Health and Wellbeing Board</b>	Derbyshire
	Anne Western 
<b>By Chair of Health and Wellbeing Board</b>	
<b>Date</b>	19 September 2014

**c) Related documentation**

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

Document or information title	Synopsis and links
<b>Joint Health and Well Being strategy</b>	<a href="http://www.derbyshire.gov.uk/council/have_your_say/consultation_search/Consultation_search_index/derbyshire_health_and_wellbeing_strategy_2012_-_2015_consultation.asp#results">http://www.derbyshire.gov.uk/council/have_your_say/consultation_search/Consultation_search_index/derbyshire_health_and_wellbeing_strategy_2012_-_2015_consultation.asp#results</a>  The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2012 to 2015.

<b>Council Plan 2014 - 2017</b>	<a href="http://www.derbyshire.gov.uk/images/2014-01-28%20Council%20Plan_tcm44-240053.pdf">http://www.derbyshire.gov.uk/images/2014-01-28%20Council%20Plan_tcm44-240053.pdf</a>  The Council Plan sets out the way the County Council will work and the services it will deliver over the next four years.
<b>Joint Strategic Needs Assessment (JSNA)</b>	<a href="http://observatory.derbyshire.gov.uk/IAS/jsna/">http://observatory.derbyshire.gov.uk/IAS/jsna/</a>  This is a joint Local Authority and CCG assessment of the health needs of the Derbyshire population in order to improve the physical and mental health and well-being of individuals and communities.
<b>Primary Care Strategy – Nottingham and Derbyshire (NHS England)</b>	This strategy is too large to attach. However, it supports and underpins the work of the BCF. If required, this can be provided.
<b>Twenty First Century Healthcare Guiding Principles</b>	 21st C Principles.pdf
<b>CCG Unit of Planning 5 Year Strategies (x3)</b>	Links will be shown here when documents are finalised.
<b>CCG Operating Plans (5)</b>	
<b>NHS Tameside &amp; Glossop CCG CTP High Level Implementation Plan</b>	Tameside & Glossop Care Together Programme: Vision for Integration This is attached to our submission.

## 2) VISION FOR HEALTH AND CARE SERVICES

**a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20**

By 2015, Derbyshire's population will have risen to around 789,500 people, a rise of 19,800 people. This increase is in no small part due to the rising number of older people. The older age groups within the population will rise to a peak over the next few years up until 2035. Traditionally, the 70-74 year and the 75-79 years are the age groups that are the largest client group amongst social care service users. Accordingly, 2018 to 2026 will be the years of peak demand for adult social care service use. More detailed population information is shown in Section 3 – a case for change.

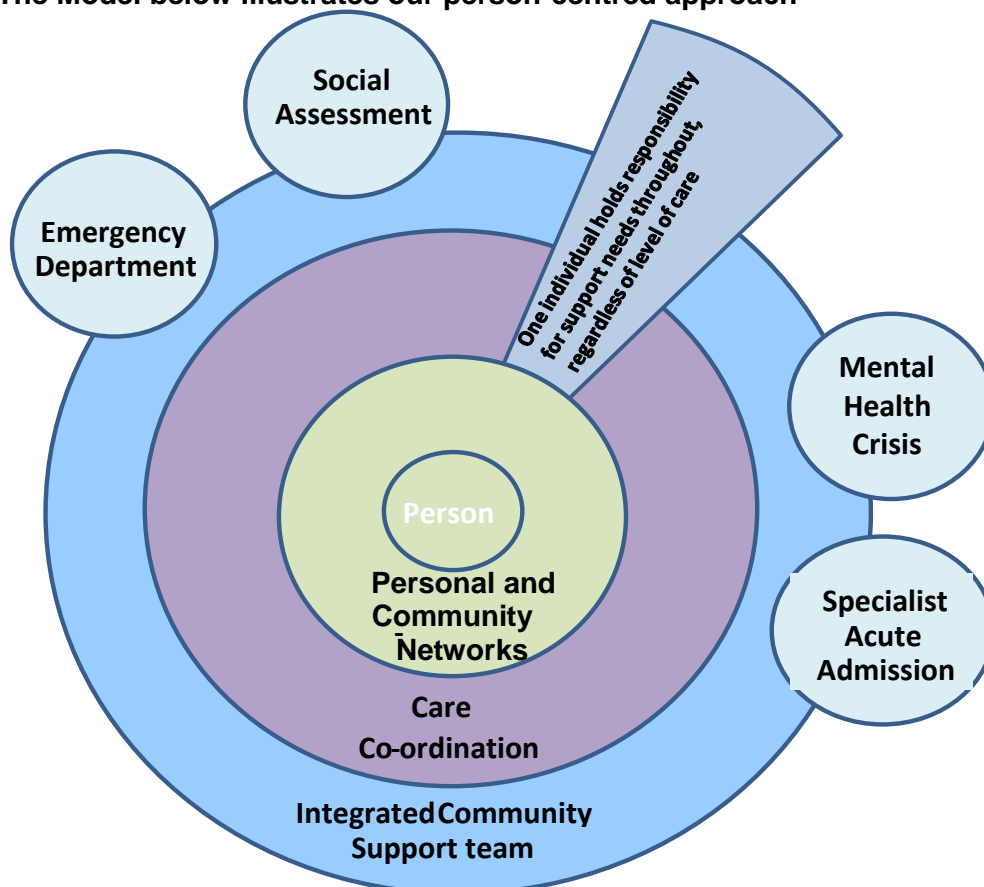
The detailed population changes and analysis within the JSNA have influenced our vision for 2019/20 which focusses on achieving a seamless health and social care system involving:

- Maximising the health and wellbeing of the population
- Making best use of our funding
- Ensuring organisational boundaries do not get in the way of a seamless service for local people.

**We want to move away from current isolated patterns of provision of care and by 2019 we want to place the local person at the centre of our actions, so we have adopted the definition of integration produced by National Voices:**

*"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me".*

**The Model below illustrates our person-centred approach**



**Our Vision** was developed through 8 workshops engaging local NHS commissioners and providers: GP representatives, Derbyshire County Council, Public Health, Healthwatch Derbyshire and the local voluntary and community sector. While its focus has been on integration, the overall Vision applies across the whole health and social care system.

The first stage of moving towards integrated health and social care services was a Derbyshire wide public consultation in 2012. This consultation established six guiding principles upon which any future service changes and developments would be based, regardless of whether the change takes place in a single organisation or is a collaborative endeavour across many organisations. The publically consulted and agreed *21<sup>st</sup> Century Derbyshire Principles* were agreed (see documents listed on page 3), with the addition of one principle:

- All services will be person-centred
- Care will be provided flexibly
- Assumptions will be challenged
- People will be treated with dignity and respect
- We will plan and deliver services in partnership
- Healthy lifestyles will be promoted

The additional principle is:

- **We will build on current joint workforce planning.** To achieve desired changes across the health and social care system in Derbyshire will require significant changes in the roles and functions of staff. We are planning to build on current joint workforce development and significantly enhance it so that we can provide the integrated services required in consultation with the appropriate Trades Unions. We will analyse and manage information about the resources, capacity, skills and knowledge available, as well as required in the future, to meet the needs of people to access personalised support. This will cover both new staff, for example the bespoke training programme recently established for the new Care Co-ordinators; and existing staff to develop the skills and knowledge required to effectively deliver integrated services.

**The Health and Social Care community in Derbyshire has signed up to the following *Enablers*** on which integration work will be based:

- Shared risk and rewards
- A joint identification of people within the scope of any integration activity
- Information sharing, tracking of expenditure and joint evaluation
- Maintaining people in their own home and non-institutional care at an individual and strategic level
- The particular care/support needs of each person
- Co-production with individuals, carers and the community
- Integrated individual assessment of a persons', physical, social and mental needs
- Adopting the national and local dignity challenge
- Co-ordinated Care & Support
- Identified lead professional
- Determined by the team around the person
- Maximise the use of local social capital

We also agree that individuals have responsibilities as well as rights.

All of the above are fully supported by Clinical Commissioning Group 5 year Strategic Plans and the Nottinghamshire/Derbyshire Primary Care Strategy.

As set out above, as a member of the Health and Wellbeing Board, Healthwatch was involved in the workshops arranged to develop the Vision. We have used previous engagement and consultation around the strategic direction of the health and social care system to develop this Plan – as set out in more detail in Sections 2. B) and 2. C) which includes:

- **The NHS Call to Action** led to widespread CCG engagement events which provided further focus and structure to future plans. Engagement plans were developed for each CCG setting out planned activities and timescales for seeking and capturing feedback from the local debates to support development of the five year strategy.
- **Feedback and learning from previous Patient and Public Involvement Stakeholder** events has been taken into consideration and incorporated into the development of plans. This is in addition to feedback received from CCG clinical members, other stakeholders and partners/providers.
- As described above, the CCGs in Derbyshire were fortunate in having undertaken a **preliminary consultation** (*21st Century Healthcare*) with the public on the challenges facing the NHS and, as part of this work, developed a set of principles that underpin changes to services (see above).
- The consultation to develop the **Derbyshire Council Plan** priorities including 'Healthier Communities with Reduced Health Inequalities' and 'A Derbyshire that Cares' has informed this Plan – with a particular focus on developing people's capacity to improve their own health and wellbeing and supporting to live independent active lives for as long as possible.
- The formal consultation that took place to develop the county-wide '**Older People's Accommodation, Care and Support Strategy**' also involved a wide range of individuals, family carers and provider organisation – key messages about the ways older people want to be supported to remain independent have been included in this Plan, for example to provide integrated care as close to the person's home or where practical, within their home.
- **Our approach to developing joint commissioning strategies** is to co-produce them with people who use services and their families. We have taken this approach in developing both the recently refreshed strategies for dementia and mental health. The consultation to refresh of the joint Carers' Strategy is currently taking place, and it is planned to have this completed in time to drive the BCF support for carers.

As set out in detail Section 3 - Case for Change there are a number of key drivers for us to re-shape existing services.

The Derbyshire Health and Wellbeing Strategy identified 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

The strategy identified the following high level priorities:

- Promote independence of people living with long term conditions (including End of Life care) and their carers by focusing on community based support, self-care and care close to home.
- Improve health and wellbeing of older people by strengthening integrated working between health and social care providers and housing related support services

In addition, using the PI Benchmarking data, also set out in more detail in Section 3, we know that Delayed Transfers of Care pose a challenge for Derbyshire; that for older people receiving community mental health services the most common primary reason for admission is urinary tract infections and higher numbers of people are admitted on a Friday night at a greater average cost than on other days.

In addition, to the data set out in section 3) Case for Change, **targeted research** has been undertaken on a number of pilot projects funded through the S.256 funding to establish their impact and cost-effectiveness, which has helped to shape the way we are proposing to deliver person-centred care: both service models and funding. For example during 2013, individuals and family carers were interviewed about a geographically specific pilot providing specialist dementia home care services.

This evidence has led to the prioritisation of the Schemes to be targeted and funded through the BCF, as set out in Annex 1.

The BCF-funded schemes form the core of the integration approach and the associated system changes as set out by the Units of Planning in Derbyshire – North Derbyshire, South Derbyshire and Tameside & Glossop in their 5-Year Plans.

Our approach is multi-faceted and includes: our workforce development plan; strengthening the partnership between the community social work teams based across the eight districts/ boroughs of Derbyshire, early intervention, re-ablement and building strong asset based communities. We are clear that delivering these ambitious aims will require significant service and culture change.

The development of the local integrated care vision and local and national experience has highlighted the importance of a joined-up workforce equipped to work in multi-disciplinary teams. To achieve this requires a range of initiatives and our ambition includes using the BCF Programme and funding to:

- Introduce generic care works able to provide social and health care support;
- Provide support for people with dementia based on a social model across health and social care services;
- Support local service leaders to understand and deliver integrated care across organisations.

We will continue to work with Public Health to enhance prevention, developing a refreshed Prevention Strategy linked to the 21st Century Health Programme. We will also use the learning from the impact and outcomes of investments already made in the development of community social work - including Chesterfield, Bolsover, Erewash and South Derbyshire.

Our priorities for the delivery of the Vision using the BCF are set out in more detail in Annex 1; in summary these are:

- **Scheme 1 Self-help, Prevention and Community Resilience/ Pro-active Intervention and Support** - this will increase the availability of the preventative/self-help level of care and support as illustrated in the diagram 'Generic Model – Levels of Care' – the “care wedge”(Segment No. 1); see Section C  
We recognise the value of social capital/strong asset based communities and want to facilitate its development and promote the approach to improving wellbeing. The Health and Wellbeing Board has established a Social Capital Task & Finish Group to facilitate our strategic approach to the development of social capital and community resilience, with a particular focus on maximising individual independence and reducing dependency.
- **Scheme 2 Integrated Community-based Support/Integrated Episodes of Care** - these schemes cover segment 2 of the “care wedge”, focusing on care delivered in the home or close to home and based on blocks of population of approximately 20,000. It includes projects such as rapid response, intermediate care, priority areas to improve parity of esteem in mental health;
- **Scheme 3 Reducing Admissions to Hospital and Care Homes; and Delayed Discharges/Specific components of Care** - these schemes cover segment 3 of the “care wedge”, including Single Points of Access (SPA), evening/ weekend clinics and community equipment;
- **Scheme 4 Enablers** – a number of key enablers were identified to support the delivery of the BCF integration programme and underpin the overall programme. These include: enhancements to provide 7 day working, integrated workforce development, information sharing initiatives;
- **Scheme 5 Care Act Implementation** – this relates to the new duties arising from the Care Act as identified in the BCF 'Ready Reckoner' and National conditions 7 iv) above and Carer Support, also including: Safeguarding, Veterans, Advocacy, impact of DWP policies.



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

Whilst the different Units of Planning may approach things in a manner that is appropriate to their population, the outcomes will contribute towards the vision for the HWB Board. The Derbyshire Health and Wellbeing Strategy (HBS) has 5 key objectives:

1. Improve health and wellbeing in early years
2. Promote healthy lifestyles
3. Improve emotional and mental health
4. Promote the independence of people living with long term conditions and their carers
5. Improve health and wellbeing of older people

Examples of projects addressing the inequalities gap include :

- The review of Falls & Bone Health
- Dementia
- Stroke
- End of Life (EoL)
- Obesity

Feedback from engagement events or public and patient groups has been used to help shape commissioning intentions and the development of services e.g. dementia, stroke etc.

To illustrate the changes that patients will see the cameos over page tell the story from a patient's perspective.

**Services now .....**



Samantha, 15 years old, has tried to commit suicide

Samantha is being bullied at school and she 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 again and succeed.



Jo, 53 years old, has terminal cancer and is a full time carer

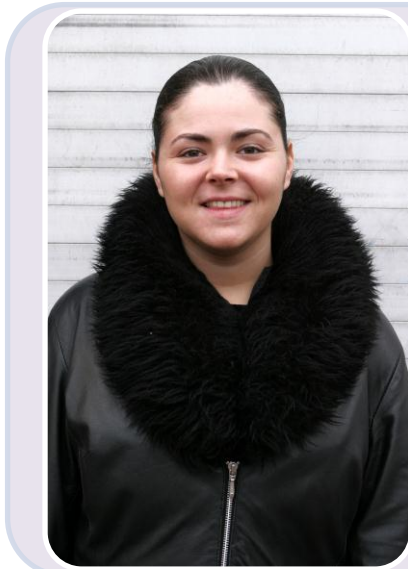
Jo has renal cancer which has spread to her bones. She has broken both her legs from a minor fall and has been admitted to hospital. Jo is a full time carer to her son who has a mental health condition. Despite the support from her case worker, she is unable to be discharged to her home as her son is an alcoholic and it is not deemed safe.



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

Bob is on the Palliative Care register with a Right Care Plan. He is being well cared for, but there is a considerable 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.

## Services in 2019/20.....



Samantha, 15 years old, has thought about committing suicide

Samantha is being bullied at school. 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, has terminal cancer and is a full time carer

Jo has cancer and has been admitted to hospital with associated bone fractures. She is a full time carer to her son who has a mental health condition. 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

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 vitals. Bob feels assured and more in control.

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

The development of integrated care across Derbyshire will deliver a number of generic outcomes within financial resources. These are linked to the HWB Board objectives as described above. However, models will differ according to the needs of each CCG or localities within them. The key advantages to people will be:

All services will be person-centred – delivered in an integrated manner - We will work in partnership with the people needing care and their families and carers to provide care as close to the person's home or where practical, within their home. Where appropriate, we will support them to access the right care in a specialist setting e.g. acute hospital or care home.

Approaches to care will be provided flexibly – taking into account all the circumstances around a person - Care co-ordination will seek to create person-centred solutions. These will be developed alongside the person using their strengths and aspirations supported by multi-agency teams as appropriate. Every older person aged 85+ will have an individualised "winter plan".

People experiencing mental ill health will have both their physical and mental health needs met in a co-ordinated way - This will include veterans. There is parity of esteem and focus in our work programmes between physical health and emotional & mental health.

Individuals will benefit from community facing services - We will have the courage to make changes for the better that will improve the person's experience. We will embrace innovation and find new approaches to care based on the best evidence available. We will commit to monitoring and publishing patient and service user experience data to be accountable to those who use our services.

We will plan and deliver services in partnership - We will actively seek and listen to the views of people and their carers together with those who work within health, social care and the community so that we can plan and deliver improvements. This will be equally important for those with a learning disability or people with mental health issues.

Healthy lifestyles will be promoted - We will support people to help them to make an informed choice about lifestyle and services and identify and provide extra support for those who need and want to make positive lifestyle changes.

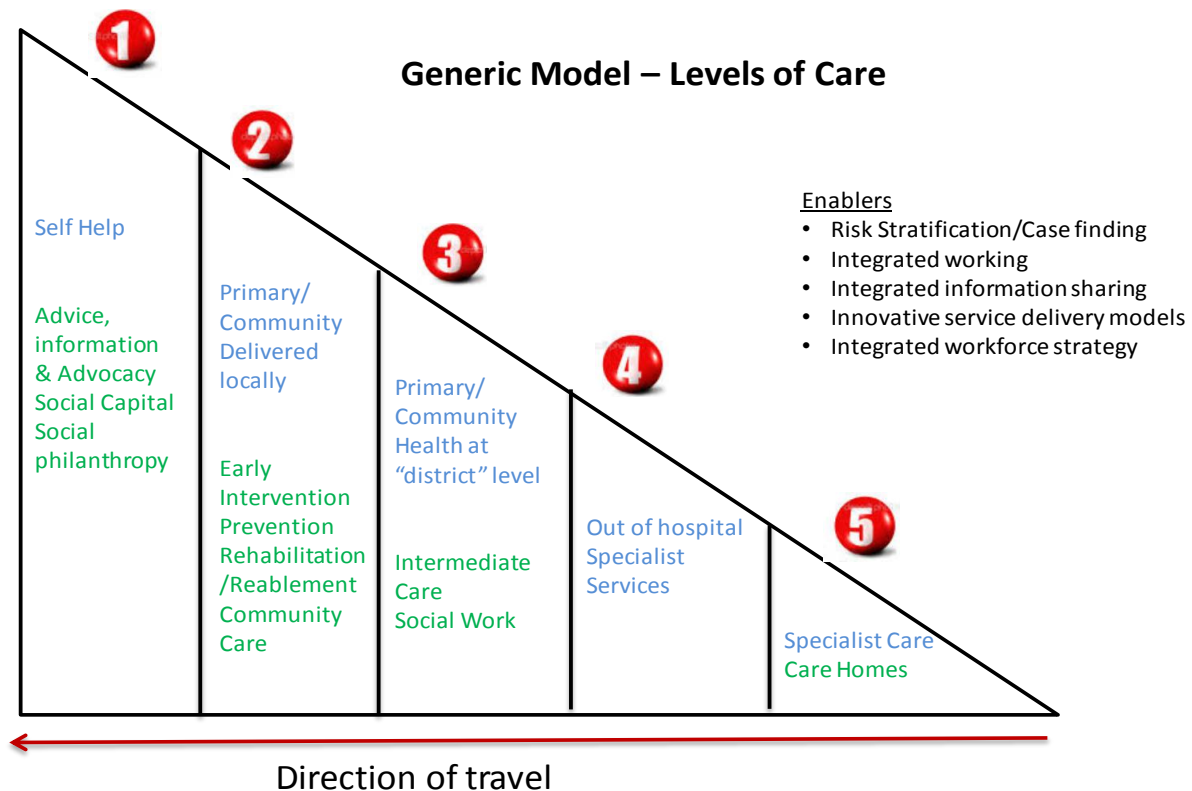
Core Community services will be available 7 days a week - We will seek to ensure that discharges from acute care are facilitated in the most timely way and where possible direct to their home. Accessibility to services will be available for extended hours.

Children and young people will be helped to reach their full potential - The Children's Commissioning work programmes align to the Better Care fund programme, providing appropriate focus to the specific & unique differences in services for children, young people and their parents. The means we have a wider involvement in partners to develop integrated models of care that span across universal to specialist services. Parents and young people have been central to work streams and informing commissioners of their views on services. The emphasis is to enable families to manage within their communities with the right support and access to services. When acute care is needed, there is identified support to manage the journey from home to hospital and back home. Underpinning all decisions is the consideration and emphasis on helping a child or young person reach their full potential.

In summary, there is greater emphasis on supporting people to self-care and to remain within the community with appropriate care packages and is central to the QIPP programmes identified and transacted within contracts in order to reduce avoidable emergency admissions and A&E attendances etc.

**c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?**

The following diagram 'Generic Model – Levels of Care' (The Derbyshire Care Wedge) shows in more detail how we intend to segment the community-based services to maximise individual independence and reduce dependency together with the 'enablers' that must be in place to support the revised approach.



**Expected Outcomes from BCF related schemes linked to the above model:**

- Avoidable emergency admissions to hospital will be reduced (within the profile of predicted demographic change)
- Long-term admissions to residential and nursing home care will reduce.
- Both primary and secondary health services and social care services will be delivered to people closer to their home or locality
- People with complex conditions most at risk of hospital/institutional care will receive increased support and be given better information to manage their condition(s)
- Parity of esteem will ensure that there will be earlier identification of mental health needs and preventive strategies put in place so that mental health and physical health needs are treated in a joined up way
- Re-ablement and Intermediate care services will be joined up so that people can receive the right degree of rehabilitation, in the right place, at the right time to maintain their independence
- There will be more effective use of Telehealth and Assistive Technology to support people to live independently and safely in their own homes
- Improved joint working will lead to more timely diagnosis of dementia which will increase the availability of treatment and support to individuals
- Taking opportunities to test out new integrated approaches for particular geographical and/ or communities of interest

**Specific BCF related changes to achieve this model and are set out in Annex 1**

- Schemes are related to 5 areas:
  1. Proactive intervention, self-help prevention and community resilience
  2. Integration, integrated community based support
  3. Reducing delayed discharges and admissions to hospitals and care homes, specific components of care
  4. Delivering the Care Act
  5. System enablers

Specific details of individual projects are given in Annex 1 – these are all BCF related and will assist in achieving our vision.

The above changes are fully referenced within the CCG 5 year Strategies and the Primary Care Strategy.

### 3) CASE FOR CHANGE

**Please set out a clear, analytically driven understanding of how care can be improved by integration in your area**, explaining the risk stratification exercises you have undertaken as part of this.

This section sets out a clear understanding of the issues that the BCF will be used to address in Derbyshire, supported by data (including graphs). It demonstrates how integration will be used to address the challenges we face over the next 5 years. The contents are as follows:

- Background context
- Health and Social Care issues
- Modelling evidence suggesting excess bed requirements
- Risk stratification
- Why we think Integrated care is the answer to address the current issues and how we are meeting the challenges, including the Financial case for change - set out by Unit of Planning

#### **Background 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.

It is useful to consider each of the districts in a little more depth to get a clearer picture of the spread of people and needs. 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.

The two districts that make up the area to the west are High Peak and Derbyshire Dales.

**Derbyshire Dales** has a population of 71,266, and as such has the smallest population of Derbyshire's districts despite covering the largest area – by a considerable margin. It is also a part of Derbyshire characterised by an older population: 24% of its population are aged over 65, the highest of all our districts. The low population density and older population makes the generation of reliable services that can easily reach the people a matter of particular importance. Derbyshire Dales has one of the higher proportions of people providing unpaid care, although the actual number is the lowest in the county. It ranks highest in England and Wales for the proportion of people providing 1-19 hours a week of care and 8<sup>th</sup> for total care provision.

**High Peak** has a population of 91,111 people, the third lowest population of Derbyshire's districts. It occupies the second largest area meaning that like Derbyshire Dales it has a comparatively low population density. This makes the provision of services which meet the demands of rurality of importance here too. The proportion of people over 65 in High Peak is somewhat lower, at 19%. The proximity of parts of High Peak to Stockport and Manchester and the fact that Glossopdale is covered by Tameside and Glossop CCG adds further complexity to the profile of this district as the connection to Derbyshire for some people can be rather less than for those in other parts of the County.

Derbyshire's other districts can be put into a second group: the eastern districts. These areas have a stronger industrial background and have more urban centres – mostly small, with the clear exception of Chesterfield. The eastern districts reflect the different challenges that background and urbanity raise as well as including the rurality and ageing populations found in the eastern districts.

**Chesterfield** has a population of 104,030 people (the third highest number in Derbyshire) and being a comparatively small area, has by far the highest population density in the county. According to IMD scores, Chesterfield is the second most deprived part of Derbyshire. 20% of Chesterfield's population are aged 65 and over, which is about average for the county. It should be noted that higher levels of deprivation are correlated with certain lifestyle issues that impact on health and wellbeing, notably poor diet, smoking, a higher level of alcohol consumption and a lack of exercise. Chesterfield also has a relatively high proportion of people providing unpaid care.

**Bolsover** has a population of 76,729 people, 19% of whom are aged over 65. Although population density is lower than Chesterfield, it is one of the highest in the county. Bolsover is also the most deprived of Derbyshire's districts and so is likely to be affected by the lifestyle issues mentioned above. The main industry in the Bolsover area for a long time was coal mining. This has had a direct effect on the prevalence of certain health conditions in the area, particularly respiratory diseases. Bolsover has a relatively high proportion of its population as carers, ranking 6<sup>th</sup> in England and Wales overall, 7<sup>th</sup> for those providing 20-49 hours a week of care and 17<sup>th</sup> for those providing 50 or more hours a week of care.

**North East Derbyshire** has a population of 99,281. It has the second highest proportion of its inhabitants aged over 65: 23%. Like Bolsover this is an area with a strong background in mining and so the same concerns apply. It differs from Bolsover in its higher proportion of older inhabitants, and this should be noted. North East Derbyshire is the district with the highest proportion of people providing unpaid care: 13% or about 13,000 people. In fact, this is also the district with the highest proportion of carers in England.

**Amber Valley** has the highest population in Derbyshire: 123,498. 20% of its inhabitants are over 65. Parts of Amber Valley border Derby City which may be important from the point of view of health provision, and also preferred locations of other services. The district combines small towns with rural areas and it covers a fairly large area making rurality a potential issue for some of its inhabitants. Amber Valley has the highest number of people providing unpaid care in Derbyshire.

**Erewash** has a population of 113,170 and covers a fairly small area bordering Derby City to the west and extending very near to Nottingham to the east. The two main towns: Ilkeston and Long Eaton are both on the east of the district. Like in Amber Valley this geography may lead to some variability in where people might wish to go for service provision. It has the third highest level of deprivation in the county and so there may be concerns around lifestyle issues. Erewash has the second highest number of carers in Derbyshire.

**South Derbyshire** has a population of 97,075 and has the lowest proportion of people who are aged over 65: 17%. It is the area of Derbyshire where the greatest population increase in coming years is expected. It borders both Derby City and Burton upon Trent bringing up some of the

same issues mentioned for Erewash and Amber Valley. The district covers a large area and there may be some of the rural concerns mentioned with regard to High Peak and Derbyshire Dales, particularly to the west. South Derbyshire is the district with the lowest proportion of people providing unpaid care.

There is variation in Derbyshire's population and in the challenges faced by each of its districts, but it is clear that health inequalities, rurality, respiratory disease and ageing are among the most important of those.

Reducing inequalities in avoidable mortalities is one of our top priorities along with improving early years health, and reducing illness due to lifestyle issues (alcohol consumption, obesity, lack of exercise). We know from the 2011 Census that 10% of the population have their day-to-day activities limited "a lot" due to a long-term health condition, and another 10% experience limitations to a lesser extent, but together this rate of 20.4% is higher than the England average of 17.6%. Department of Work and Pensions data tells us that over 46,000 people in Derbyshire are in receipt of Disability Living Allowance so it is imperative that we increase and maximise the number of people whose conditions are managed in the community. As a population, we are now living longer than ever before and through a new integrated approach, our aim is to enable Derbyshire folk to live longer as well as healthier than ever before.

The Derbyshire Health and Wellbeing Board covers 5 CCG areas and with two distinct Units of Planning covering North Derbyshire and South Derbyshire. The Derbyshire Health and Wellbeing strategy 2012 – 2015 was developed with contributions from a range of partners including the NHS; the County Council; District and Borough councils; Public Health; LINK (Healthwatch) and the Voluntary and community sector. 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

The strategy identifies the following high level priorities:

- Promote independence of people living with long term conditions (including End of Life care) and their carers by focusing on community based support, self-care and care close to home.
- Improve health and well-being of older people by strengthening integrated working between health and social care providers and housing related support services

### Health and Social Care issues

Adult Care has undertaken an analysis of trends in comparison with comparator authorities as can be seen in the table below which helps us to understand areas where outcomes for people need to improve.

Indicator	2011/12		2013/14	
	Derbyshire	Comparators	Derbyshire	Comparators
65+ in community-based services (/100,000)	7,373	4,885	4,432	3,768
65+ in residential care (/100,000)	1,345	1,359	1,391	1,277
65+ in nursing care (/100,000)	520	483	551	458
65+ rate of admission to care homes (/100,000)	787	716	738	690
% of 65+ offered re-ablement	1.4	2.9	1.0	3.3
% of 65+ still at home 91 days after re-ablement	84.0	83.1	79.7	81.2
Delayed discharges attributable to social care	4.2	2.9	4.8	2.6



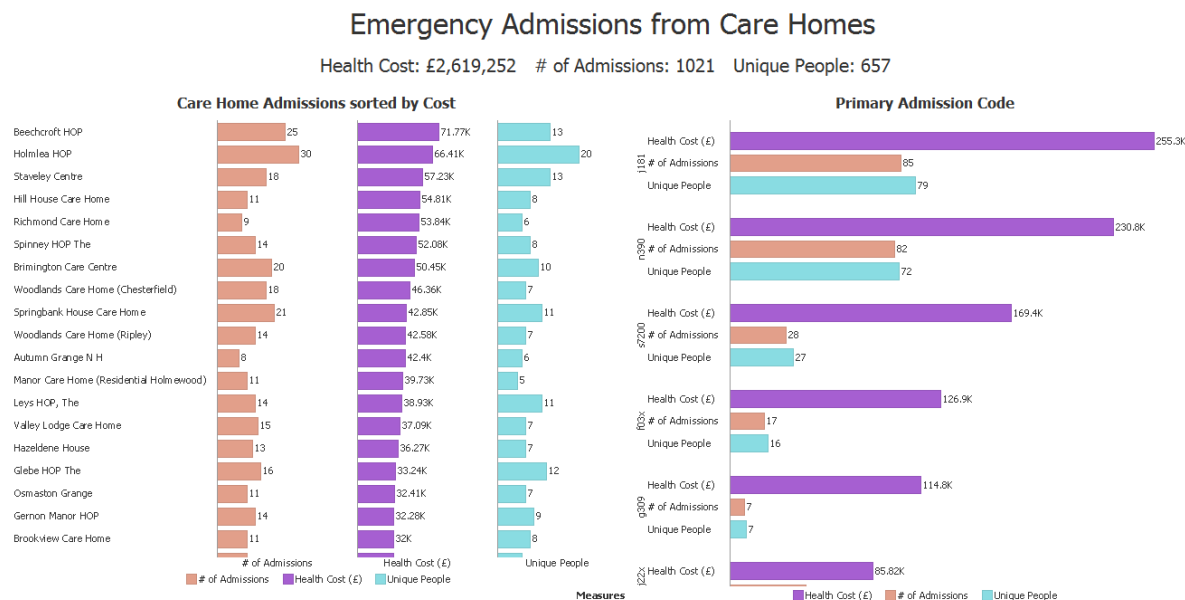
Delayed discharges (all)	11.4	9.5	13.2	10.0
% of people self-directing their support	34.7	39.0	47.6	55.9
% of people receiving direct payments	15.0	12.3	10.8	17.8

The following points can be made relating to the above Table:

- For older adults, the rate of clients in community services is higher than our comparators. This reflects on-going work to ensure that older adults retain independence within their own homes.
- However, Derbyshire still has a greater number of older adults per 100,000 population in nursing and residential care than the comparator average. This demonstrates a need for further community-based work, both within social care and health, to ensure that a greater number of older adults retain their independence.
- Re-ablement services following discharge from hospital are around the comparator average. However, when compared with all patients discharged from hospital only 1% are offered re-ablement services. This indicates a potential need for enhanced re-ablement/intermediate care.
- Delayed Transfers of Care pose a challenge for Derbyshire. All delays and those attributable to Derbyshire County Council are higher than the comparator average. Work is needed to ensure that services are available to patients waiting to be discharged from hospital. This information also illustrates a need for services designed to prevent admission to hospital in the first place.

The analysis of different populations in Derbyshire, combined with integrated data, will allow health care organisations to assess whether integration work is producing the expected results. For example using PI Benchmark data, it will be possible to monitor the number and cost of emergency admissions to hospital via nursing/residential care homes.

Example screen shot:



Source: PI Benchmark

From our work with PI benchmark we have identified the following trends which are being addressed through the BCF projects. This sample is taken over a period of 3 years from 1<sup>st</sup> July 2011 to 30<sup>th</sup> June 2014, apart from the nursing/residential care clients which cover an 18 month period up until the 30<sup>th</sup> June 2014.

The information is a subset of health and social care information. The sample contains

information relating to around 750,000 patients.

While the information does not include all patients, the sample is large enough to be representative of the total population of patients and social care clients.

Pathways for older adults receiving community mental health services have greater average costs than other patients aged 65 and over. The most common primary admission code is n39.0, urinary tract infections, and the most common long-term condition at the time of emergency admission to hospital is hypertension. The average cost of community mental health pathways leading to emergency admissions is greater than other pathways and may indicate a need for additional dementia support services to improve outcomes for clients and to reduce the costs of this type of pathway.

Over a period of 3 years, the total cost of emergency admissions due to falls, in the sample, was £33M, that is, £11M per year. The Falls Recovery Service is designed to reduce the number of emergency admissions to hospital.

The cost of dementia to the Health economy over a period of 3 years was at least £25M for emergency admission to hospital, that is, just over £8.3M per year. A number of dementia support schemes are designed to help patients, carers and care home staff. One aim of these schemes is the reduction of emergency admissions to hospital.

The total cost to the Health economy of emergency admissions to hospital from care homes over a period of 18 months exceeds £2M. Increased dementia support in care homes and the Falls Recovery Service should help reduce the number of emergency admissions from care homes to hospital.

General medicine accounts for the majority of excess bed days. The greatest use of resources 3 months post discharge is within the Health economy, whereas community services see limited use in this period. A number of schemes, such as self-help and community resilience, integrated community based support, and increased re-ablement are designed to improve the availability of community-based services.

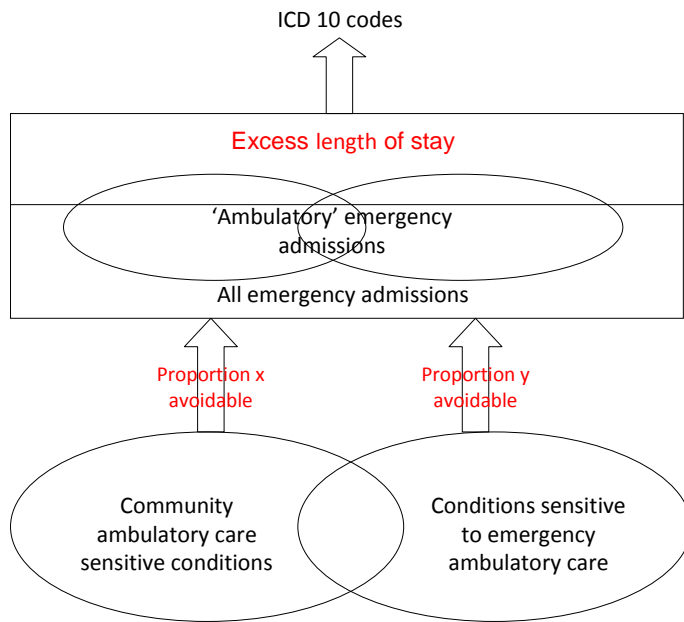
Readmissions within 14 days of discharge from hospital and readmissions within 30 days show a similar picture. This highlights a need for 7 day working to deal with the higher numbers of patients admitted on a Friday at a greater average cost than on other days. Additional re-ablement services should help reduce the overall number of re-admissions, particularly for people readmitted with the same ICD.

### **Modelling evidence suggesting excess bed requirements**

In 2013, Derbyshire Chief Executives (Health and Social Care) commissioned Public Health to look at the population needs for acute beds across Derbyshire (a summary is given below). In addition, risk stratification has taken place both at individual CCG levels and at wider Unit of Planning levels.

The model looked at emergency admissions in adults and children of all ages from the four Derbyshire CCGs to Derby Royal Hospital (DRH) or Chesterfield Royal Hospital (CRH) and used data from 1<sup>st</sup> January to 31<sup>st</sup> December 2013. Recognising that excess emergency bed use is driven by three factors: too many patients going to hospital from the community, too many patients being admitted through A&E or patients staying in hospital longer than is clinically indicated. It is on those areas that the model focuses and is presented in diagrammatic form (see below). By combining published evidence with local data and national comparators, the model

provides a more accurate picture of need than previous aspirational estimates.



The assumptions and manipulations used in the model are based on the best available evidence and made in good faith; this is borne in mind when interpreting the significance of the outputs

The primary aim of the model was to predict the number of emergency hospital beds needed in Derbyshire. Results for both CRH and DRH are presented to enable decision makers to view Derbyshire as a whole health community. The findings suggest that the number of emergency admissions could change from around 31,000 per year to between 21,000 and 25,000 at CRH and from around 43,500 per year to between 31,000 and 36,000 at DRH as shown in Table 1.

**Table 1: Reduced Emergency Admissions**

	From	To	
		Minimum	Maximum
<b>Chesterfield</b>	30 777 (100%)	21 060 (68%)	25 201 (82%)
<b>Derby</b>	43 499 (100%)	31 022 (71%)	36 362 (84%)

Combining the reduced emergency admissions with the shorter LoS of 3.7 days at CRH (current average LoS for EAs at Wrightington, Wigan and Leigh NHS Foundation Trust) and 3.8 days at DRH (current average LoS for EAs at University Hospital of North Staffordshire NHS Trust) equates to a reduction in emergency beds from 423 to between 213 and 255 at CRH and from 674 to between 323 and 379 at DRH as shown in Table 2.

**Table 2: Reduced Emergency Beds**

	From	To	
		Minimum	Maximum
<b>Chesterfield</b>	423 (100%)	213 (50%)	255 (60%)
<b>Derby</b>	674 (100%)	323 (48%)	379 (56%)

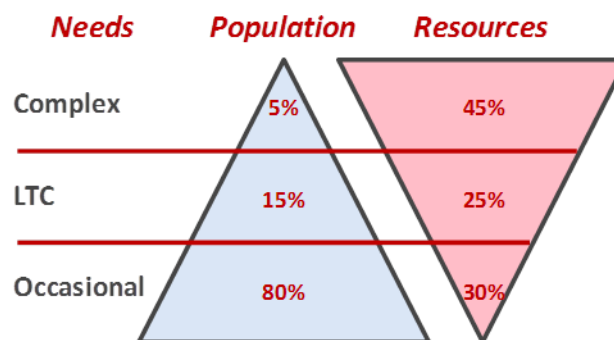
**Table 3: Seasonal Variation**

	Average beds		Calculated winter average beds			Calculated non-winter average beds		
	Min.	Max.	Min.	Max.	%	Min.	Max.	%
<b>Chesterfield</b>	213	255	240	288	100	199	239	83
<b>Derby</b>	323	379	364	427	100	315	354	83

The above is a “snapshot” of the work undertaken; the modelling suggested that between 168 and 210 emergency acute beds at Chesterfield and between 295 and 351 at Derby may be excess to requirements ***in an optimally resourced and functioning health and social care system***. The aim is to work towards the state where all community capacity is in place and the right contractual and cultural changes ensure that the system works optimally.

### **Risk Stratification**

Our overarching approach to risk stratification begins with the assumption that, within a population or given locality, 5% of the population will consume 45% of the health resource. These are patients with complex chronic conditions (elderly, adults and children). A further 15% of the population have at least one long-term condition, and this group consume a further 25% of the health care resource. In total, this means a total of 20% of the population consume 70% of the total care budget.



However, although these people use well over half of the care resources, they often do not receive the optimum care for their needs.

Typically, patients have poor experience of care that:

- Does not support their independence and control
- Is fragmented and difficult to navigate.

And, poor outcomes:

- A poor quality of life for both the patients and their carers.
- Too many people living with preventable ill health and dying prematurely.
- Avoidable emergency and residential care admissions/ readmissions.

So, there is a need to adapt the care system to better meet the changing needs of individuals, families and communities today - to put in place proactive, on-going and integrated care.

Underneath this, as CCG's are statutory bodies, they have approached risk stratification in different ways as appropriate to their own population. Whilst there are similarities, there is not a “one size fits all” model across Derbyshire.

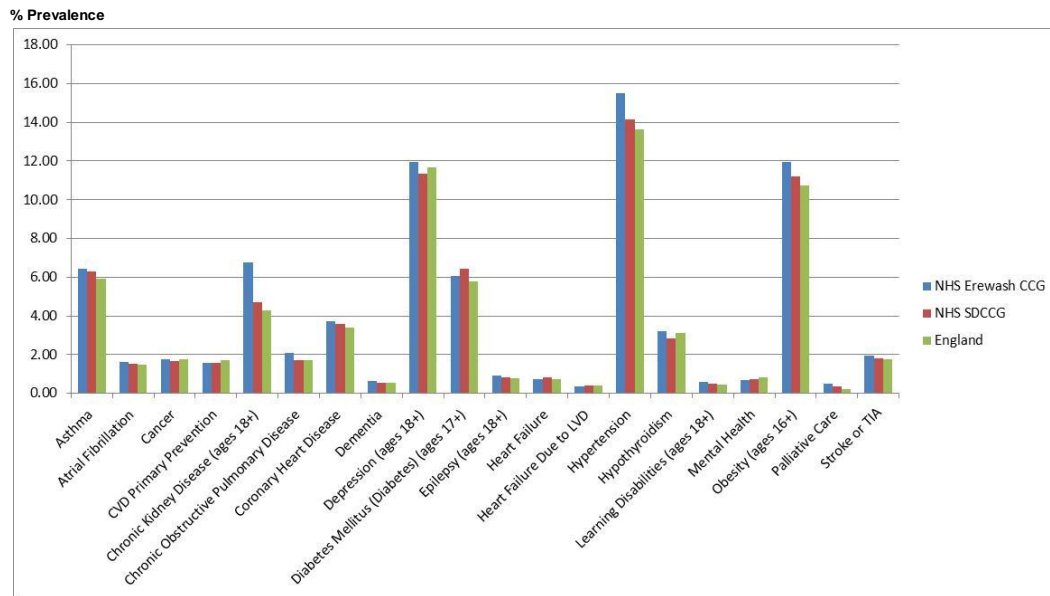
## **South Unit of Planning**

The South Unit of Planning consists of 2 Clinical Commissioning Groups – Erewash and Southern Derbyshire.

The following diagram summarises the overall key issues for the South:

### South Unit of Planning

### Our Population – Disease Profile (QOF 11/12)\*



\*Data from Commissioning for Value Tool

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- Comparable disease prevalence across the two CCGs with % LTCs in line with national average
- Approximately 1 in 5 people smoke
- Obesity rates are slightly worse than national average across both CCGs – in children and adults
- Variation in care across GP and localities
- Although performance against NOF is generally in line with national average, there remains significant opportunity for improvement, for example:
- Over 25% of population with LTCs do not feel they have support to manage their conditions
- Experience of primary care is mixed, with room for improvement

### **South Derbyshire Unit of Planning Financial Challenge to 2018/19**

In 2013/14, the South Derbyshire Unit of Planning spent a total of £732m. Based on the forecast pressures (activity growth and cost inflation) presented in both Erewash and Southern Derbyshire CCG's financial plans, if nothing is done differently, there will be a net financial gap of £95.8m by 2018/19.

This assumes that there is a 4% national tariff deflator for each of the 5 years.

### **How we are meeting the Challenge**

Both SDCCG and Erewash CCG have worked closely with Optum (part of United Health) and have already implemented integrated care models with the aim of:

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

Over the next 5 years this will mean:-

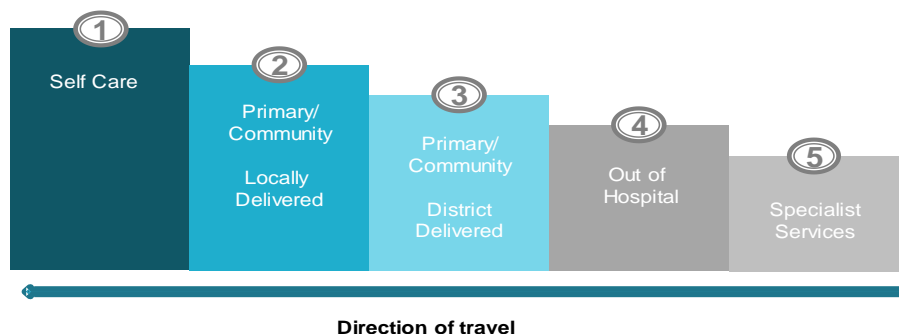
- Better information and more choices for people before they access statutory services
- More people feeling able to stay healthy in their own homes, with the support of formal or informal carers
- A greater proportion of service users accessing Personal Health &/or Social care budgets
- The development of community services based around GP practice populations
- Better availability and usage of Intermediate Care/Re-ablement services
- Improvements in 'Rapid Access Services' to avoid unnecessary hospital admissions
- More people able to access 'a good death' at home, or in a community setting if preferred.
- Less people being admitted to Acute Services where this can be avoided
- A smaller proportion of people being discharged from an acute hospital directly to long term care

The following information explains how the model has begun to be implemented and some of the initial outcomes.



## South Derbyshire Unit of Planning Integrated Care – One Approach, Delivered Locally

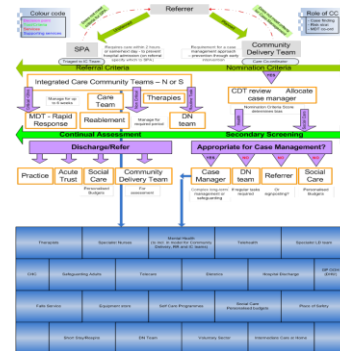
- We have been working with Optum to develop models of integrated care, providing coordinated care for adults identified as high risk of hospital admission or admission to a care homes.
- Applying similar principles, we have tailored delivery models, aligning incentives in order to shift care away from hospitals into the community and ensure our patients and service users get the right care, at the right time and place.
- Over the past two years, we have worked closely together to share successes and learn from common challenges – whilst preserving autonomy.



## South Derbyshire Unit of Planning Progress – Erewash CCG

Erewhash started its journey to integrated delivery in 2012, since this time they have made significant in-roads into delivering more joined up care for patients and a simpler system for all. Achievements include:

- 1 Built the enabling infrastructure to ensure joined up system:**
  - Designed and commissioned Single Point of Access
  - Fully implemented risk stratification
  - Completed review of all high impact areas – used data to drive decisions
- 2 Managed new ways of working**
  - Performance structures to manage system in place including outcomes measurement
  - 6/12 Reviews of SPA performance and areas for improvement/development
  - MDT meetings on high risk patients/families
- 3 Measured results and Outcomes**
  - Correlation between SPA referrals and ED admissions for people with LTCS

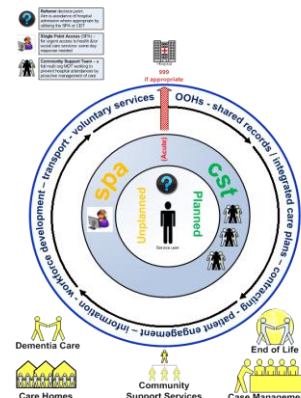


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South Derbyshire Unit of Planning  
Progress – Southern Derbyshire CCG

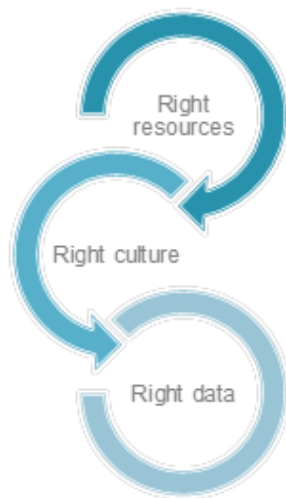
Southern Derbyshire was keen to push its integrated care programme further, faster. Having all of the governance infrastructure in place, they engaged Optum to ensure they had the right resource, trained to the right level working across their joined up system

- 1 Built the enabling infrastructure to ensure joined up system**
  - Recruited >26 wte Care Co-ordinators
  - Recruited Community Matrons, more than doubling the Community Matron resource
  - Development of a Community Support Team Tool Kit
- 2 Managed new ways of working**
  - Established comprehensive multi-agency inductions for Care-Co-ordinators as well as ongoing training.
  - Supported the set up of MDT meetings
  - Supported the set up of Care-Co-ordinator Forums
- 3 Measured results and outcomes**
  - Optum has brought considerable pace to the establishment of the integrated care programme. With the critical infrastructure the CCG is well placed to achieve measurable outcomes and go further, faster



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## South Derbyshire Unit of Planning Top 10 Lessons



1. Imported external experts to drive the programme at pace
2. Leveraged external learning from other health communities
3. Recruited clinical and enabling workforce to ensure appropriate scale
4. Trained all new care navigators/co-ordinators prior to their start
5. Invested in workshops and forums to create open discussions about solutions
6. Got sign up on the models from all stakeholders
7. Leveraged all existing infrastructure even if it didn't sit in the 'right' organisation
8. Based all decisions on facts and data that is available
9. Implement outcomes measurement upfront to embed the processes
10. Constant evaluation of what we believe to be true – challenge anecdotes with facts/data

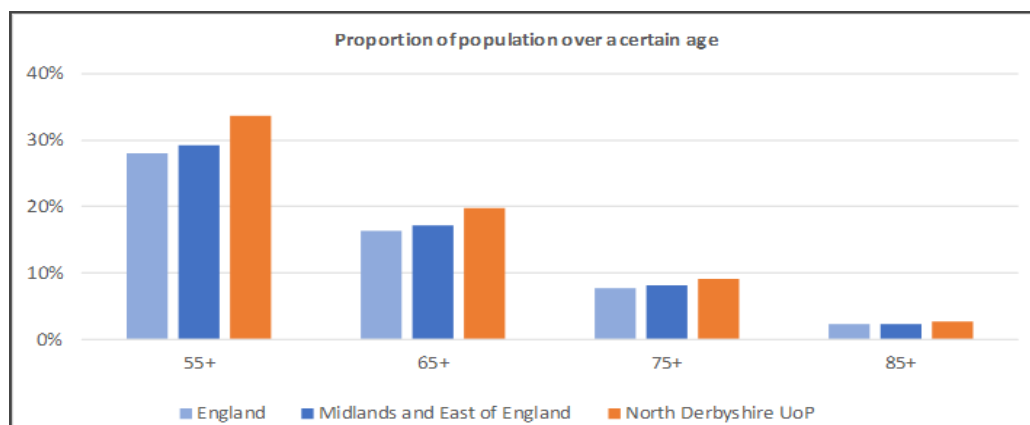
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### North Derbyshire Unit of Planning - challenges:

The North Unit of Planning consists of 2 Clinical Commissioning Groups – North Derbyshire and Hardwick. Key facts about the populations are:

The prevalence of long term conditions across the North Derbyshire Unit of Planning (UoP) is comparatively higher than national and regional averages; the population is comparatively older; there is significant variation in life expectancy and negative variations in some of the determinants of health.

The current proportion of the North Derbyshire Unit of Planning population aged over 75 is 9% (34,000 people); higher than national and regional averages.. This proportion is expected to increase significantly in the coming years.



Average life expectancy across the UoP is slightly lower (0.4 years) than the England average. However, there are significant health inequalities across the UoP with a variation in life expectancy between the most deprived quintile and the least deprived quintile of c.9 years.

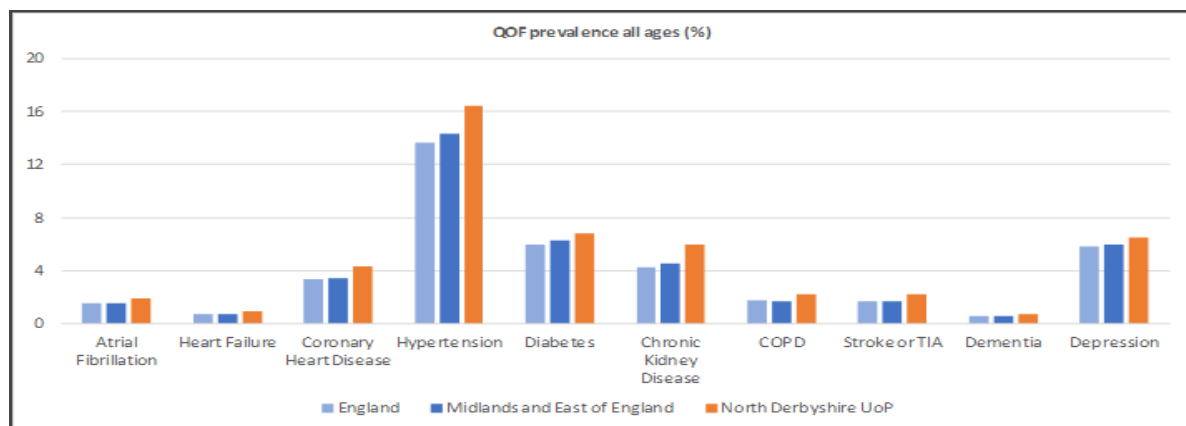


Approximately 70% of the gap is due to circulatory diseases (30%), cancer (20%) and respiratory diseases (20%).

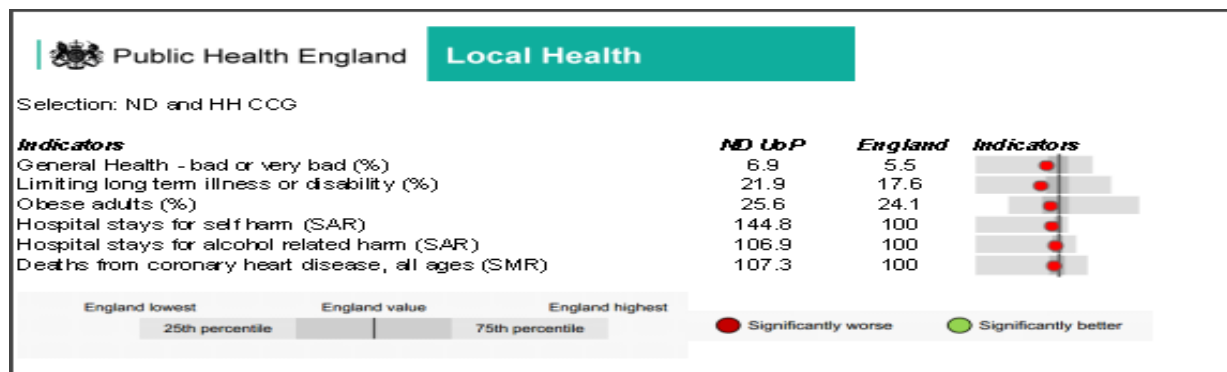
**Life expectancy gap - comparing most and least deprived areas (2010)**

	Male			Female		
	Lower quintile	Upper quintile	diff	Lower quintile	Upper quintile	diff
Bolsover	74.0	80.1	6.1	78.5	82.6	4.1
Chesterfield	73.5	80.4	7.0	80.2	84.7	4.5
North East Derbyshire	76.4	82.6	6.3	80.1	85.8	5.7
High Peak	75.9	81.6	5.7	79.2	83.5	4.3
Derbyshire Dales	78.1	81.9	3.9	82.1	87.5	5.3
<b>Min max comparison</b>	<b>73.5</b>	<b>82.6</b>	<b>9.1</b>	<b>78.5</b>	<b>87.5</b>	<b>8.9</b>

When compared to the average for England and Midlands and East of England, the North Derbyshire Unit of Planning show a higher prevalence of the most common long term conditions.

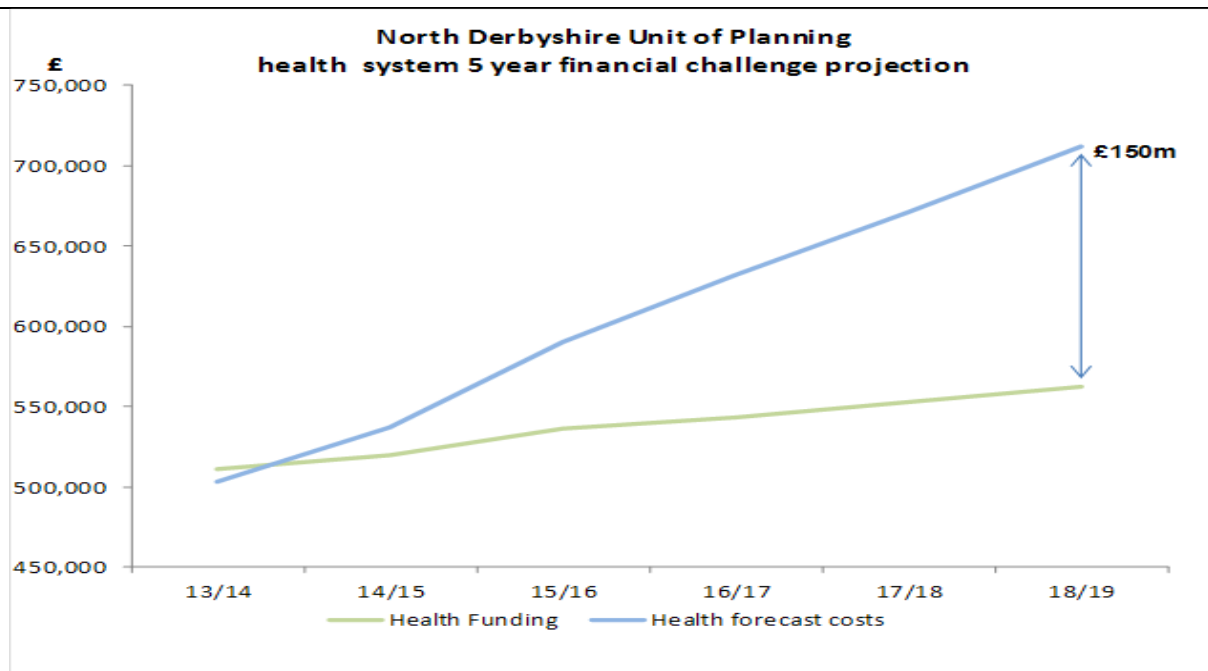


The table below shows selected local health and determinant measures where North Derbyshire UoP are significantly worse than the England average.



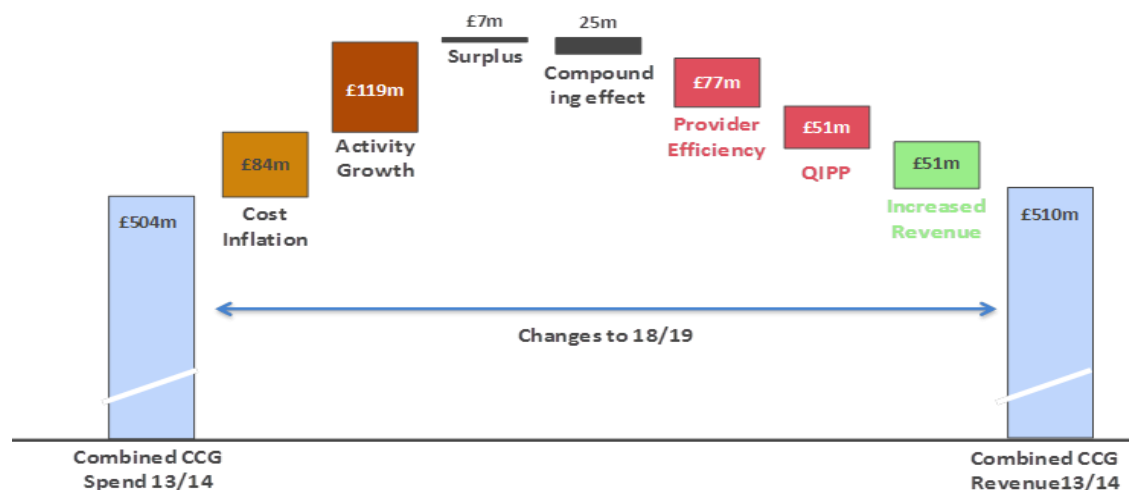
## The Case For Change

In 2013/14, Hardwick CCG and North Derbyshire CCG spent a total of £504m. Based on the forecast pressures (activity growth and cost inflation) presented in the CCG's financial plans, if nothing is done differently, there will be a net financial gap of £150m by 2018/19. However, c.£25m of this is due to the yearly compounding effect of 'not doing anything'. So, if the cost - pressures are met year on year, this would result in a net financial challenge of £125m but Adult Social Care is also forecasting pressures of c.£25m, giving a total health and social care challenge of £150m.



The make-up of the challenge is explained further

- The total pressures facing the health budget are £203m, of which c.40% are due to cost inflation and the remaining 60% activity growth.
- Following adjustments for the existing surplus and the compounding effect, a gap of c.£175m remains.
- Of this, c.£50m will be met by additional revenue to the system,
- This leaves a remaining gap of £125m. (*Plus c.£25m social care.*)
- Nominally, 60% of this gap will need to be delivered by provider efficiencies (4% p.a.) and the remaining 40% by commissioner QIPP.



### How can care be improved by integration?

The North Derbyshire System Plan is founded on the development of Integrated Care to better meet the on-going care needs of the people of North Derbyshire. The vision is of a person centred health and care system that will enable people to self-care, to keep well for longer and to reduce the level of unplanned care they receive. Fundamentally, through Integrated Care, the system will aim to keep people:

- Safe & healthy – free from crisis and exacerbation.
- At home –out of social and health care beds.
- Independent – managing with minimum support.

For people with on-going care needs, Integrated Care will support them to be independent and in control. They will have care plans in place, developed with them and their carers, specific to the outcomes that are important to them. People and teams who are multi-skilled to meet their mental, physical and social care needs will support them. It will ensure that joined up services are provided – patients will not be aware of multiple agencies that may be involved.

The principles agreed in public consultation (see section 2a) will be embedded in Integrated Care.

Consequently, this will improve the quality of life for people and carers.

- Fewer people will suffer preventable ill health and die prematurely.
- There will be less unplanned care - emergency and residential care admissions/ readmissions.
- Transfers and transitions of care will be managed effectively.

*The system has chosen to adopt the National Voices definition of Integrated Care that is effectively described by Kings Fund's 'Sam Story' video animation.*



To deliver on the system aims described above will require individuals and teams to work in a more integrated way - organised around the person and community. The role of facilities will change to provide community 'hubs' from which local health and social care services operate and services will also be integrated into wider networks (beyond Borough/CCG boundaries) that offer effective access to specialist expertise and services.

Services and teams will operate within networks focusing on supporting the person (service user):

- **Personal network:** The System recognises the importance of the person's 'home' network – where most care is provided – and its link with primary care through a care co-ordinator.
- **Locality network:** Provides support to individuals through a resilient multi-functional team that operates 7 days a week. Based within a community locality (of minimum c.25k population and up to 100k). This will evolve from the existing Virtual Ward and Community Support Team services. There will be flexibility in how this is delivered by locality to best meet local community needs.

- **Integrated Care System:** Multiple locality teams will operate within the overall Integrated Care System which will have shared: governance arrangements, aligned incentives, clear accountability for outcomes, system leadership, information systems & an overall approach to workforce development.

Whilst not necessarily the focus of the Better Care Fund, the North Derbyshire plans describe a comprehensive set of aims, besides the development of Integrated Care, by which the system will also improve and align other aspects of the care system, represented in terms of the elements of a high quality, sustainable health and care system. These include:

- Primary care: a consistent 7 day model, differentiated access and support for patients with long term conditions and rapid high quality routine care, delivered in part through the development of greater joint working and primary care 'at scale'
- Emergency and urgent care: allowing patients to navigate the urgent and emergency care system to get the right care in the right place, first time through a cohesive network and true Single Point of Access for health professionals, providing 24/7 access to physical, social and mental health services, and the implementation of Keogh standards for 7-day working and pathway delivery
- Children's services: improving health and wellbeing in early years' through early intervention and prevention. Integrated Care will support vulnerable children, young people and families including: emotional and psychological wellbeing; children with on-going needs; troubled families; looked after children; children and young people with special educational needs
- Elective care: more 'fluid' provision- specialists working with generalists; alternative types of outpatient clinic; single end to end service commissioned for a specific conditions
- Mental Health: new service models developed to engage those with more chaotic lifestyles, those with LTCs and those with dementia whose needs are best met by a range of providers working together; a standardised Primary Care service that feels empowered and capable to directly manage mental health problems
- Specialist care: collaboration on a regional or sub-regional scale to bring together the necessary critical mass to maintain rotas/cover and realise economies of scale with Consultant resource pooled to provide specialist 24/7 regional centres and outreach to local hospitals to provide continuity of care
- Adult Social Care: building strong asset based communities: increasing co-production with people; supporting people to remain independent and in control of their lives through person centred services; providing support in the community when needed

### **Modelling of the impact of integration in North Derbyshire**

The 5 year plan relies on three main levers:

- Managing demand for services
- Delivering care in the right setting (and making savings through reducing bed stays)
- Delivering services more efficiently

Within and alongside the overall plan the Better Care Fund sets out a plan covering all three but focused on the first two levers, through the development of proactive intervention and integrated care. Our modelling suggests that this 'rebalancing' of the plan away from an over-reliance on increased efficiency will deliver financial balance.

### **Tameside and Glossop CCG – context and challenges**

The local health economy (including the CCG's spend on Glossop residents) is forecast to be £74m in deficit by 2018-19 if we 'do nothing'. The Better Care Fund and our wider Care Together programme is a fundamental part of the economy-wide strategy to bridge this financial gap and, at the same time, deliver the right care at the right time in the right place for all Tameside residents.

The integrated system will seek to support more people via community based, prevention and early intervention initiatives to reduce demand on more intensive health and social care services. Where formal health and social care services are required, these will be focused on rehabilitation/re-ablement and regaining self-caring skills in the first instance to reduce the potential for a progression on to more specialist or intensive provision. The system aims to reduce the overall demand on intensive secondary care provision or intensive residential and nursing care services.

We aim to focus intervention and expect health gains to be within this population, and through managed work streams and specialist pathways, tracking results and outcomes through effective evaluation frameworks. The importance of local joint working plans being designed around clear, expected and shared health outcome measures features in all of our planning. The focus on improved outcomes from integrated working can then link to a wider evaluation around the efficacy of our organisational integration.

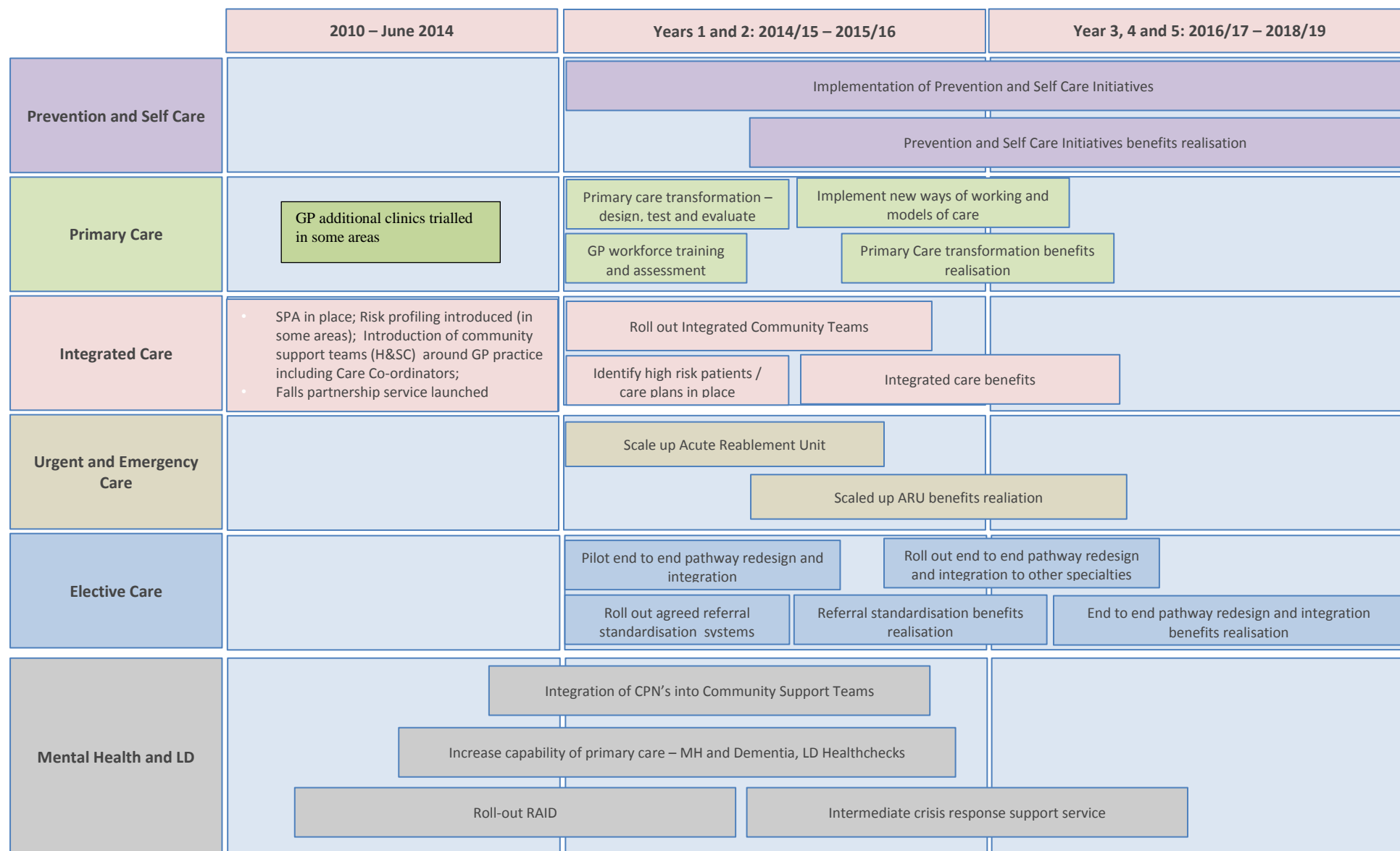
The commissioning organisations are building on the strong local platform for joint working to deliver a fully integrated health and social care service, creating a more sustainable, local health and social care economy for residents, providers and commissioners.

Commissioners are clear on the benefits required from integrating services in order to ensure the accountable provider base has clear responsibilities. Integration must;

- Support people and families to support themselves-this means investing in low level support to reduce the demand on high-end care. It also requires staff to identify at risk groups, intervene early and build resilience through enhancing a person or families own skills to manage their condition/situation.
- Deliver a better patient/user experience through more seamless care delivery – this means fewer referrals and hand offs, better continuity of care across different services and making every contact count.
- Drive quality, accountability for statutory responsibilities and delivery of outcomes and ensure the involvement of individuals in service design.
- Provide a different configuration of services, building on what works well already, to ensure the right care is delivered, in the right place at the right time.
- Create sustainable locally based providers with a flexible, multi skilled workforce.
- Deliver the necessary cost efficiencies without compromising care.

#### 4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies



The figure above sets out an overarching plan for the system transformation county wide, giving a sense of how the work streams fit together.

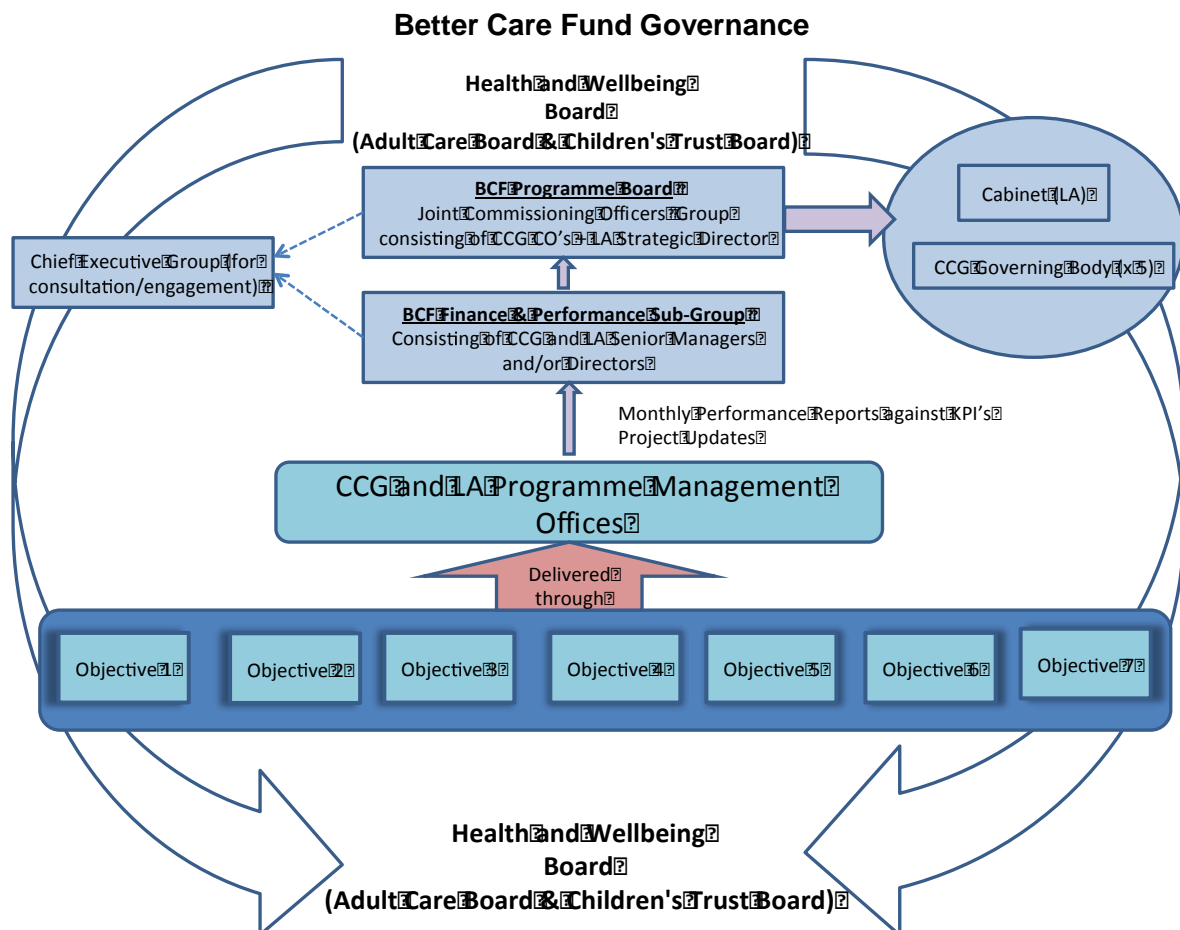
b) Please articulate the overarching governance arrangements for integrated care locally

**Governance will take place through the structures described in the diagram below. The Health and Wellbeing Board (including the Adult Care Board and Children's Trust Board) will "wrap around" the work of all the groups involved in delivery of the BCF. CCG and LA Programme Management Offices will ensure delivery and reduce un-necessary duplication of work.**

Regular monitoring of progress will be reported through the structures described below and include views of individuals and their families. Separate governance structures sit below the HWB Board level within the two Units of planning to ensure delivery of the 5 year CCG plans of which the BCF is an integral part. These are described in more detail in Section C

During 2014/15 dedicated resource was made available to initiate the work required to establish principles and working arrangements for the S75 pooled budget.

The BCF will be monitored through a Programme Management Office approach with the following overall structure:



The Governance and reporting structures are being further refined as part of the development of the S75 agreement and will ensure there are clear reporting and decision-points identified to align, for example, with the three System Resilience arrangements across Derbyshire (Tameside & Glossop – System Resilience Group; South Unit of planning – System Transformation and Resilience Board; North Unit of Planning – 21<sup>st</sup> Century System Plan Delivery Board).

**c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track**

Whilst the overarching governance is through the Health and Wellbeing Board structure (as set out in Section 4b) there are individual governance structures within the two Units of Planning. The separate structures are required to monitor the progress of the 5 year strategic plans (of which the BCF is an integral part) and to ensure that all parties are held to account. The governance structures are described below:

**South Unit of Planning**

The System Transformation and Resilience Board (STAR Board) has two main functions:

- To drive the development of the Five Year Strategic Plan across the South Derbyshire Unit of Planning; agree the programmes of work that are necessary to deliver the Plan and hold all partners to account for delivery. This will include the BCF.
- To act as the System Resilience Group for the South Derbyshire Unit of Planning. This will ensure that there is systematic planning of service delivery across both urgent and planned care. The detailed work to support this function will be undertaken by the Urgent Care and Planned Care Delivery Groups.

Accountability for both these functions continues to lie with individual organisations and the STAR Board does not have executive powers. However, the STAR Board has very senior representation from all organisations and will be expected to hold all organisations to account for the delivery of their agreed contributions to achieving both the Plan and system resilience.

The STAR Board will also have clear lines of reporting to the Derby City (N.B. SDCCG covers both City and County) and Derbyshire County Council Health and Wellbeing Boards; Adult Care Boards and Children's Trust Board.

The STAR Board will work across boundaries to improve outcomes for service users, by establishing partnerships and better working relationships between all Health and Social Care organisations in the South Derbyshire area and health community. Specifically, it will determine local service needs, initiate the local changes needed and address the issues that have previously hindered whole system improvements.

As part of its system resilience function, the Board will plan for the capacity required to ensure delivery, and oversee the co-ordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers.

To promote a culture of continuous improvement and innovation, with respect to safety of service's clinical effectiveness and patient experience.

**Responsibilities**

**System Transformation**

- Develop, through agreement with all partners, a Five Year Strategic Plan for South Derbyshire, including BCF
- Develop, through agreement of all partners, programmes of work for implementation of the Plan and how these will be delivered by the Board's sub-group structure
- Hold all organisations to account for delivery
- Monitor progress against the Plan
- Ensure system cohesion
- Ensure all organisations have involvement in and (as appropriate) approval of the Better Care



Fund

- Ensure the alignment of key infrastructure work including I M & T, Workforce, Estates, Communications, Public engagement
- Lead the required cultural and behavioural change to enable the local system to work as equal partners in a high trust, open and transparent health and social care economy

**System Resilience**

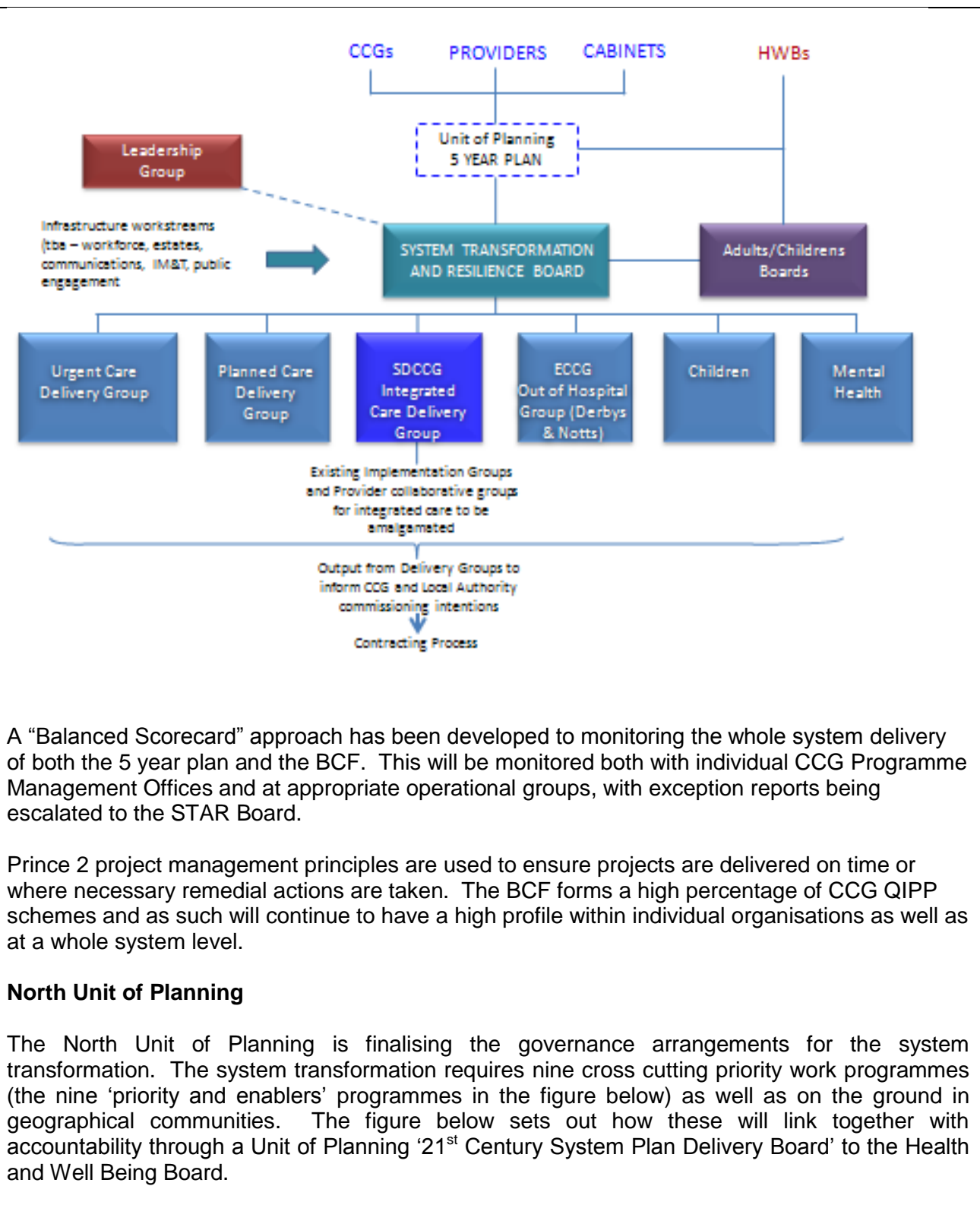
- Fulfil the role of a System Resilience Board based on reporting from the Urgent Care and Planned Care Boards
- Develop and sign off an annual operational resilience and capacity plan by involving all key local organisations
- Ensure rigorous and on-going analytical review of the drivers of system pressures using a clear set of agreed KPIs and a performance dashboard, so that solutions to these pressures may be developed with a collaborative approach
- Ensure appropriate evaluation is in place for new and existing investments.
- Receive a monthly update on the use and impact of non-recurrent resilience funding
- Build consensus across members and stakeholders on the use of non-recurrent funds and marginal tariff and agreement of relevant and specific KPIs for each scheme.

**Accountability**

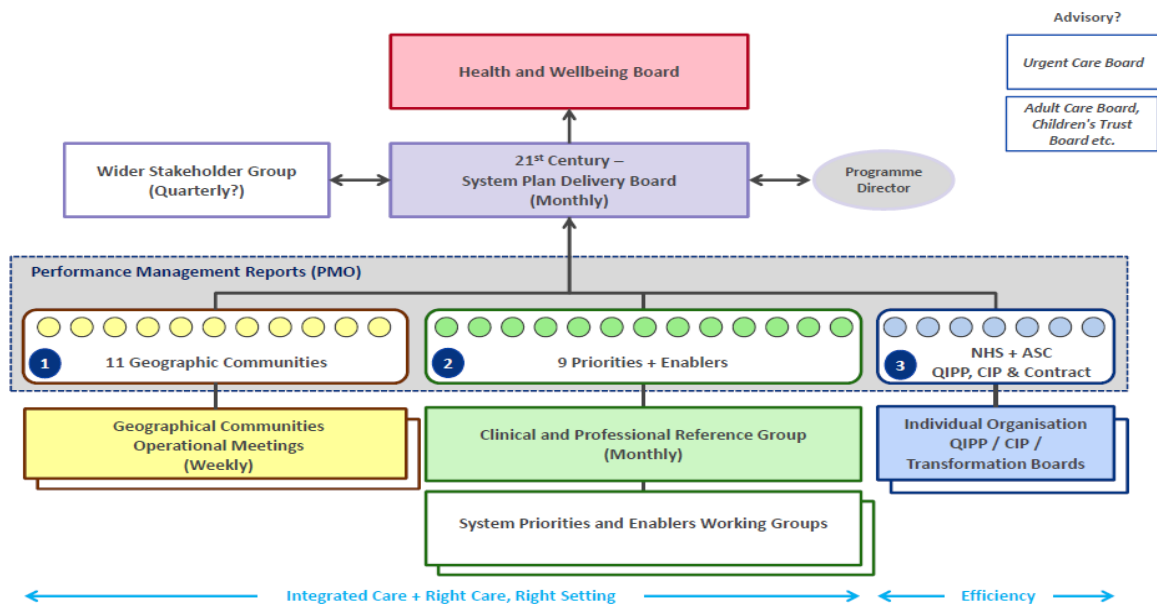
System Resilience Groups are not statutory bodies and hence have no formal binding decision making role. However there will be occasions when members of the STAR Board, who are taking on the system resilience responsibilities, will be asked to make decisions on behalf of their organisation; such situations will be notified in advance wherever possible so that members can ensure the necessary arrangements are in place for delegated authority from statutory bodies.

The STAR Board will make regular reports to the Health and Well-being Boards and their sub-committees.

The STAR Board will be supported by 4 established sub-groups: Urgent Care Delivery Group, Planned Care Delivery Group, Southern Derbyshire's Integrated Care Delivery Group and Erewash's Out of Hospital Board (South Derbyshire part). The links between existing Children's and Mental Health planning/delivery structures still need to be finalised.



### Proposed Programme Governance Structure



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The figure below sets out the proposed terms of reference for the main groups within the structure above. The aim is to establish a matrix approach that empowers geographic communities to deliver change on the ground, supported by expert groups that set out best practice and offer advice and practical help. Individual organisations will be responsible for change via their own transformation boards and the whole programme will be co-ordinated and overseen by a System Plan Delivery Board, and ultimately by the Health and Well Being Board.

### Outline TOR for key reviews

*DRAFT - work in progress*

#### 21<sup>st</sup> Century - System Plan Delivery Board

- Purpose:** Directing the delivery of the System Plan –
  - Holding organisations (each other) to account for delivery of the planned changes and delivery of the outcomes
  - Agreeing changes to the plan; [directing investment?]
  - Empower & support Geographical Communities to deliver IC
- Scope:** 100% view of System Plan changes; focus on integration over and above organisational boundaries
- Members:** Independent chair, lay rep, Chiefs (CCGs, MH, CRH, Community, ASC, EMAS,...), Programme Director, CPRG Chair, ...
- Reports to:** HWB Board

#### Geographical Community - Weekly Ops Review

- Purpose:** Reviews operational care delivery performance
  - Monitors key performance indicators & identifies improvement needs / opportunities
  - Monitors progress of service changes
  - Identifies needs for enablers / cross system initiatives
- Scope:** delivery of IC within a Geographic Community
- Members:** IC Development Lead, Clinical Lead, operational team leaders, commissioner support lead, information, HR, finance, [Director Sponsor]
- Reports to:** 21<sup>st</sup> Century - System Plan Delivery Board
- Accountable to:** [COOs team]

#### Clinical & Professional Reference Group

- Purpose:** Ensures changes are coherent, flexible and consistent
  - Directs system wide priority changes & roadmap
  - Approves system wide practice changes
  - Supports Geographical Communities to deliver IC
- Scope:** system wide changes (clinical priorities and enablers)
- Members:** Lay person, Clinical / Professional Directors of CCGs, MH, CRH, Community, ASC, EMAS, ..., Programme Director, System level design leads, ...
- Reports to:** 21<sup>st</sup> Century - System Plan Delivery Board

#### Organisation Transformation Boards

- Purpose:** Reviews & directs delivery of organisation plans
  - Monitors progress of key changes
  - Monitors deliver of cost efficiency (CIP)
  - Identifies needs for enablers / cross system initiatives
- Scope:** delivery of improvements that do not operate cross system
- Members:** [locally determined]
- Reports to:** Governing Body / Board & 21<sup>st</sup> Century System Plan Delivery Board

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#### **d) List of planned BCF schemes**

**Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.**

The Better Care Fund Schemes are part of an overarching system transformation, which is referenced above. The Health and Wellbeing Board agreed 7 overarching system objectives to deliver integrated services that:

1. Build strong asset based communities
2. Support people to remain independent and in control of their lives
3. Provide support in the community when needed
4. Reduce the need for hospitalisation or admission to long term care
5. Improve outcomes and the quality of services provided
6. Reduce inequalities
7. Develop the necessary infrastructure to achieve objectives

These seven objectives, coupled to the five year strategic plans, have driven the development of the BCF projects. These projects have then been grouped into five broader themes in Annex 1:

1. Proactive intervention, self-help prevention and community resilience
2. Integration, integrated community based support
3. Reducing delayed discharges and admissions to hospitals and care homes, specific components of care
4. Delivering the Care Act
5. System enablers

Detailed Scheme Descriptions are attached for each of the five schemes above in Annex A.

## 5) RISKS AND CONTINGENCY

### a) Risk log

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

#### Introduction:

The risk log below is intentionally high-level as it covers the whole health and social care system in Derbyshire. Each individual project within the BCF has its own project plan and associated risk log which is monitored through either the CCG or Unit of Planning. The BCF Finance and Performance sub-group will receive monthly monitoring reports from individual Units of Planning, CCGs and Adult Care PMOs as appropriate. The reports will include any exceptional risks that have an impact on the totality of the BCF. By exception, risks will be escalated to the BCF Programme Board. The HWB Board will receive quarterly reports of progress, high-level risks and any mitigating actions. It has been agreed, as part of the development of the management of the BCF, to hold a system-wide workshop to ensure that commissioners and providers alike understand the impact of risks on each of the schemes and the overall BCF.

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
BCF does not achieve the planned reductions in Acute activity at the required rate due to delays in implementation impacting on developments, or unanticipated cost pressures slow down implementation	4	5  Overall activity reductions are forecast at £4.868m in 2015/16. A 20% impact would therefore increase the cost base for commissioners by c£974K  Risk falls on CCGs	20 High	Monthly monitoring at the BCF Programme Board and BCF Finance and Performance sub-group  On-going monitoring of emergency care admissions, Reablement Services (beds and community) etc.

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
The existing contractual arrangements with providers are not conducive to the commissioning of new models of care resulting in the failure to realise the service and financial benefits expected for the BCF schemes	3	4 Commissioner failure to realise financial benefits System failure to achieve benefits of schemes / programme Financial impact –as described in the risk of increased non elective admissions £280,000 This impact will fall on CCGs or providers	12 Medium	Health and social care community commitment to the development of accountable care organisations/systems which will encompass the BCF schemes  Monitored through 21 <sup>st</sup> Century Group/STAR Group and Finance & Performance sub-group linking to the BCF Programme Board
Social Care cuts affect delivery of targets and ability to fund preventive services.	4	5 Financial impact (exact impact on health and social care not ascertainable at this point) Risk falls on CCG commissioners and Local Authority. It is not possible to scale this until the full extent of the budget pressure within the LA is known at District level	20 High	Current consultation and engagement seeking how to minimise impact.  On-going leadership from the Finance and Performance Sub-Group and BCF Programme Board to ensure that there are sufficient resources to realise our BCF vision and meet targets - reallocation of BCF resources where necessary/ appropriate

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
Performance-related funding reliant on outcomes that may not be evidenced in the short to medium term, and contingent upon activity from patients registered to other CCGs not within or part of Derbyshire's BCF plans	3	4 Risk falls on CCG commissioners, with a similar impact to the risk above, around non-delivery of savings which will require non-recurrent funding to maintain the programme	12 Medium	Monthly monitoring of outcomes at a senior level through the System Resilience Group/STAR Group and Integrated Care Boards and early identification of slippage.  Monthly monitoring and evaluation of the five schemes to ensure that services/projects within the schemes are fit for purpose and meeting expected outcomes within timescales
Quality of care and financial stability of providers across all sectors is adversely affected due to the changes proposed	3	4 Impact on outcomes in Domains 4&5 of NHS Outcomes Framework, and Domains 3&4 of the Social Care Outcomes Framework Impact on service providers which is at this stage not quantifiable	12 Medium	On-going leadership from the System Resilience Group/STAR Group and Integrated Care Boards  Early engagement of partners with work programmes agreed in partnership at a senior level

<b>There is a risk that:</b>	<b>How likely is the risk to materialise?</b> <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	<b>Potential impact</b> <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	<b>Overall risk factor</b> <i>(likelihood *potential impact)</i>	<b>Mitigating Actions</b>
Agreement for whole scale change from all partners, including changes to ways of working is not forthcoming	3	4 Change does not happen at the required scale and pace which will impact on achievement of performance metrics. This will then require additional non-recurrent support from commissioners Risk will fall on CCGs, providers and LA commissioners	12 Medium	On-going leadership from the 21 century group or STAR Group and Integrated Care Boards Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line
National changes to Urgent and Emergency Care (primary care, A&E and OOH) and changes to the primary care contract impact on the design of schemes	3	4 Potential impact on commissioners in relation to the value for money that is ascertainable from contracts, and additionally, impact on providers implementing the requirements of the contracts (including the potential for financial impact where requirements are not met). This is not quantifiable at this stage	12 Medium	NHS England Area Team representation on the System Resilience Group/STAR Group and Integrated Care Boards
Insufficient recruitment of qualified and skilled preventive staff	4	5 Staffing and skill shortages for new key front-line staff. While not all new schemes require significant	20 High	Monthly monitoring at a senior level through the System Resilience Group/STAR Group and Integrated Care Boards



There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
		additional staffing, the impact will be on additional costs (locum staff) or non-delivery of savings. This will have to be assessed in due course at individual scheme level Risk will fall on providers and CCGs and LA commissioners		Workforce development plan in place, including a succession plan  Review recruitment and retention plans (annual)
'Sign up' and cultural change from all partner organisations is not achieved resulting in failure to deliver the schemes/programme	2	4 User experience and outcomes remain unchanged/worsen Staff satisfaction remains unchanged/worsens Organisation (health and social care, commissioner and provider) failure/system failure.  Financial impact – as described above Risk will fall on CCGs, providers and LA commissioners	8 Medium	Monthly monitoring at a senior level through the 21 century Group/STAR Group and Chief Executives/Strategic Directors Leadership Group (Health and Social Care)
Patient/Service User/Carer resistance to schemes requiring behavioural change will result in failure to achieve reductions in health and social care activity	3	3 Decreased user satisfaction Organisations: Provider activity levels remain unchanged or potentially increase	9 Medium	Implementation of stakeholder engagement strategy. (NB: stakeholders have already been broadly engaged in the development of strategic and local plans and have a

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
		(with potential impact on the delivery of access standards) Commissioners unable to realise financial benefits and potentially have increased cost of additional activity. This impact will fall across the health and social care community with CCGs bearing the cost impact of increased activity in the Acute Sector		strong voice from structural i.e. committee level and local/neighbourhood/client group/GP practice level.
Introduction of Care Act will result in an increase in the cost of care provision from April 2016.	4	4 At this stage this is not fully quantifiable. The likely impact will be on the sustainability of current social care funding and plans which may not be fully funded.  Risk will fall on LA commissioners and CCGs & NHS providers	16 High	Local work on costings will inform decisions about how requirements will be implemented.  New national funding expected.

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
Impact on the Voluntary and Community Sector has not been fully scoped.	3	4 The voluntary sector play a key role and any funding changes would adversely impact on the BCF  Risk will fall on CCGs	12 Medium	To utilise the information from the 2014/15 projects and associated BCF activity to provide more detail.
Information Governance: local arrangements contingent upon national agreement	4	4  Difficulties in sharing patient / service user information between health and social care professionals  No anticipated financial impact Risk will fall on CCGs, LA Commissioners and NHS providers	16 High	Monitoring of situation at BCF Programme Board level and where necessary escalation to the System Resilience Group/STAR Group and Integrated Care Boards Informal local systems in place for MDTs and community staff

## **b) Contingency plan and risk sharing**

*Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners*

The amount included in the Better Care Fund (BCF) Contingency Fund for Derbyshire is £4.87m; see the Payment for Performance tab 5 in Part 2 of the plan. This has been calculated by using an indicative price for non-elective admissions of £1,490.

Derbyshire is a complex health economy, comprising 4 CCGs working and with a 5<sup>th</sup> in Tameside within the Local Authority boundaries, working as three units of planning (Tameside, North and South Derbyshire), and a two-tier local government structure, consisting of a County Council and eight District/Borough Councils. There is a wide range of voluntary sector providers, some with a very local focus, and others who are able to operate effectively across the county. The two major acute Trusts relate primarily to the Derbyshire CCGs although there are some cross-boundary flows and referrals in and out of county for tertiary services. Relationships between CCGs and providers, across CCGs, and with aligned health and social care commissioning with the Local Authority are strong, both collectively and individually. The Health and Wellbeing Board has been actively engaged in supporting and driving the BCF plan for Derbyshire and considers the risk sharing approach to be appropriate for the complex environment described.

Governance structures are in place both at Unit of Planning level and at HWB Board level. The Better Care Fund Programme Board has been established to oversee the delivery of the Derbyshire Better Care Fund as set out in Section 4. The Finance & Performance sub-group that reports into the BCF Programme Board will be responsible for monitoring and reporting the performance of the Better Care fund schemes and key performance indicators.

Some county-wide risk sharing arrangements are already in place, for example, for continuing care, high cost placements and high cost drugs. However, much risk sharing (particularly for non-elective admissions) is most appropriately administered at an individual CCG level and linked to the unit of planning because of the provider geography.

It has, therefore, been agreed that mitigation and contingency are enacted at the level at which the risk has occurred. This enables the risk to be effectively managed, ensures that the most appropriate mitigation is implemented, and embeds accountability at the relevant point within the health and social care system. It has been agreed to hold a system-wide workshop to ensure that commissioners and providers alike understand the impact of risks or each of the schemes and the overall BCF.

Quarterly reconciliation on the P4P element will be signed off by each CCG's appropriate Committee and they will be responsible for overall performance within their P4P allocation. Any variation from plan at local CCG or unit of planning level will be analysed and investigated at this level. The accountable CCG and unit of planning concerned will take corrective action and implement appropriate recovery plans. P4P 'at risk' funding will be paid proportionately in line with the split of contribution to the reduction in non-elective admissions, as per Part 2 of the template based on resident population.

CCGs have historically managed activity variances, and have processes and governance structures in place to identify these early and mitigate the risk. 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.

The financial risk to the BCF Plan is the failure to meet the Payment for Performance target and therefore additional non-recurrent investment available via the BCF is reduced (£4.87m). This will affect all commissioners across Health and Social Care. However the Payment for Performance element will not form part of the Adult Care or Health's recurrent expenditure plans. The financial risk remains with commissioners whilst alternative models of commissioning and contracts are explored.

The total P4P will be subject to the following measures:

- The performance-related funding will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 2015/16, against the trajectory set out in the BCF plan.
- Payments will be made in arrears: May 2015 (based on Q4 2014/15 performance); August 2015 (based on Q1 2015/16 performance); November 2015 (based on Q2 2015/16 performance); February 2016 (based on Q3 2015/16 performance).
- At each 'payment point', CCGs will release money into the BCF pooled fund on the basis of performance to date, against plan. Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned full-year reduction against the baseline).
- A projection of performance against the trajectory will be made and in utilising this Derbyshire Adult Care and CCG's will prioritise an agreed schedule of non-recurrent investments in service developments to support the Better Care Fund implementation (the investments are tabled below).

The performance fund remaining for non/reduced performance will be used by CCGs to fund over performance associated with failure to deliver the non-elective activity reductions in the acute sector.

Projects that will release non-recurrent monies are set out below and are described in Annex 1 – each individual project within the BCF has its own project plan and associated risk log which is monitored through either the CCG or Unit of Planning as set out in Section 5 of this plan.

A BCF balanced scorecard is under development based on the balanced scorecard used by the South Unit of Planning. This will be available monthly to the Finance & Performance Sub-Group.

The projects that will release non-recurrent monies are set out below: -

1. **Re-ablement and Intermediate Care** - The focus of this investment will be to fill existing gaps in services including community health services and then to drive up the baseline of equitable provision. Services will be enhanced through the Single Points of Access (SPAs), so they are accessible 7 days a week. The investment will include additional hands-on care staff, together with community nurses and therapists.
2. **7 Day Working** - The developments in Intermediate Care, Re-ablement and Rapid Response services will enhance the existing community based 7 day services.
3. **Rapid Response Service** - Enhance existing rapid response services in health and social care to ensure that home based social care and community health services are equitably available across the county at times of crisis.
4. **Dementia Services** - The revised Dementia Joint Commissioning Strategy is intended to support the health and social care response to the rapidly increasing number of people with dementia. This would include a number of schemes e.g. carer support, support in acute hospitals etc.

5. **Diagnosis and support services for people with autism** - Following the Autism Act 2009 and the recent central government review of its implementation has led to local gaps in service being identified. Two areas are of particular priority, reducing the 2 year waiting time from referral to diagnosis and to ensure that information and support services are available immediately after diagnosis.
6. **Integrated Workforce Development Delivery** - The development of the integrated care vision and local and national experience in delivering integrated care has highlighted the importance of a joined up workforce equipped to work in multi-disciplinary teams
7. **Community Equipment** - Providing support for more people in their own homes and promoting their independence of more formal care will be supported by the provision of community equipment, including assistive technology.
8. **Adult Mental Health Services** - The draft revised Joint Commissioning Strategy for Adults with Mental Ill Health is intended to deliver the national strategy “No Health Without Mental Health” and deliver additional local priorities. A number of priority areas relate to improved integration.
9. **Information sharing across Health and Social Care** - Work is well advanced to improve information sharing between local health and social care services. This is based on providing reciprocal access to relevant organisations systems, within existing information governance policies. Investment to implement this, including its use of the NHS number as prime identification for patients, includes the provision of the necessary hardware, software and on-going support for users.
10. **Administration and performance monitoring of the pooled Better Care Fund** - The introduction of the Better Care Fund as a pooled £57m budget in 2015/16 will require careful management and oversight. The pool partners include 5 local Clinical Commissioning Groups and the County Council, which will host the pooled budget. S256 funding will be used 2014/15 to prepare for the pooled budget and it is proposed to continue to fund a Pooled Budget manager from 2015/16 onwards.

## 6) ALIGNMENT

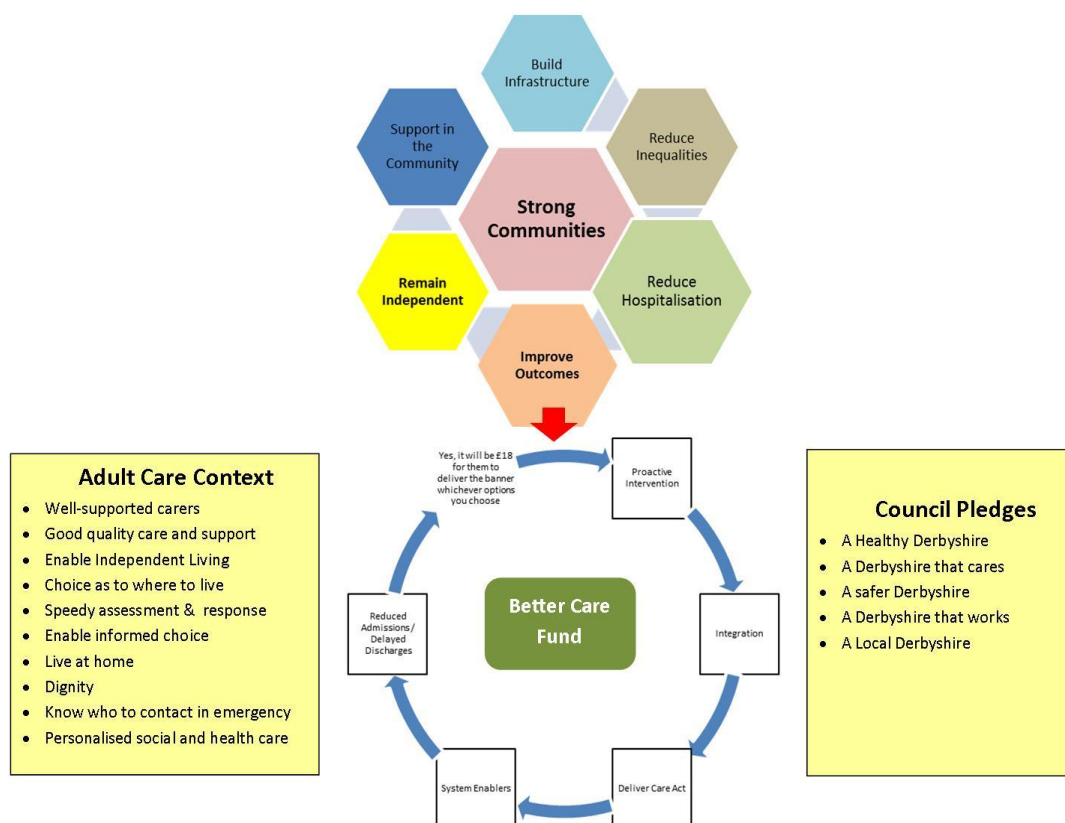
a) Please describe how these plans align with other initiatives related to care and support underway in your area.

Our aims and objectives have been drawn from:

- Joint planning led by the Health & Wellbeing Board.
- Analysis of our gaps in co-ordinated responses.
- Feedback from local people.
- Feedback from local service providers.
- Local joint strategic plans.
- Other priorities set out in the NHS Mandate and “Everyone Counts: Planning for Patients 2014/15 to 2018/19” (Dec 2013)
- The announcement of integration pioneer sites in October, and the integration roadshows.
- Feedback from CCG ‘Call to Action’ and other local engagement events.
- Feedback from Health and Social Care Commissioners.

Sections 2, 3 and 4 outline our plans for further integration.

The diagram below links out the seven Better Care Fund objectives to the five schemes, and how these in turn link to the 5 year ‘Unit of Planning’ planned system objectives for the North and South of Derbyshire, together with links to Derbyshire County Council Adult Care plans.



b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Table below highlights the links between the 5 Derbyshire County BCF Themes and the Unit of Planning Objectives as agreed in 14/15 Planning submission. Whilst the BCF and Operational plans are well aligned, these links will be further tested as part of the development of a system wide 5 year plan, which is due to report in November/December 2014.

Key Themes	Link to BCF objective	Link to 5 year Plans (Ambitions)	Link to DCC Adult Care Plans
6. Proactive intervention, self-help prevention and community resilience	1,2,6	<ul style="list-style-type: none"> <li>Reducing years of life lost from treatable conditions</li> <li>Improving the quality of life for those with 3 or more LTCs through the use of personal budgets</li> <li>Reducing avoidable admissions by improving primary and community care and self-management</li> </ul> <p>All schemes link to both North and South Units of Planning System Objectives</p>	<ul style="list-style-type: none"> <li>Well supported carers</li> <li>Good quality care and support</li> <li>Enable independent living</li> <li>Choice as to where to live</li> <li>Speedy assessment and response</li> <li>Enabled informed choice</li> <li>Live at home</li> <li>Dignity</li> <li>Know who to contact in an emergency</li> <li>Personalised social and health care</li> </ul>
7. Integration, integrated community based support	2,3,4,5		
8. Reducing delayed discharges and admissions to hospitals and care homes, specific components of care	2,3,4,5,6		
9. Delivering the Care Act	1,2,3,6		
10. System enablers	7		



c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas that have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

At the time of writing, the CCGs are in discussion with NHSE regarding the changing national picture for co-commissioning and this will be developed over the following months.

## 7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

### a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Our locally agreed definition is “to offset the impact of the Adult Care budgetary cuts to ensure the provision of assessment, care and support for people identified as high risk and their family carers.”

A particular emphasis will be on Adult Care’s contribution to integrated care services across all client groups:

- Ensuring that we can respond to increasing numbers of people with eligible social care needs, including people with dementia and people with learning disabilities
- Supporting delivery of the Care Act
- Supporting the delivery of personalised services for clients and carers
- Promoting and commissioning effective preventative social care and support services

Adult Care has worked with the five Clinical Commissioning Groups to develop the proposed programme, which takes into account increased funding and enhanced oversight.

The identification of the local social care services to be protected was developed based on:

- The priorities identified in the Joint Strategic Needs Assessment (JSNA) and the Health & Wellbeing Strategy, including population demand and projections identified for Adult Care
- The impact of the County Council’s savings target for Adult Social Care
- Lessons learnt from the projects delivered using the S. 256 transfer of funding from the local NHS to the County Council for Adult Social Care
- The specific Care Act implementation funding identified in the BCF allocation
- Maintaining the eligibility threshold for access to Adult Care services at Substantial

Derbyshire County Council is required to make budget reductions of £157 million by 2018, which is 30% of the Council’s total budget, as identified in its Five Year Financial Plan. The Council recognises the need to protect the most vulnerable people and as a result has allocated some resources to meet the pressures of demographic growth. We know from the

2011 Census that we have got greater numbers of older people and fewer young adults and children than ever before living in Derbyshire; we also know that by 2033 our population structure will be older still with 28% aged over 65, 15% over 75 and 6% over 85. In raw number terms, in 2015 those aged over 65 make up 160,000, growing to 225,000 by 2030.<sup>1</sup> That is an increase of 65,000 people and has major ramifications for the future planning of health and wellbeing services.”

The Council’s Five Year Financial Plan shows a proposed decreased budget totalling £19.8m for Adult Care 2015/16, with £5.4m per annum towards meeting increased demographic pressures. It is proposed that the balance of unfunded additional demographic pressures will be funded from the BCF.

Office for National Statistics (ONS) subnational population projections by persons, males and females, by single year of age. The latest subnational population projections available for England, published 29 May 2014, are full 2012-based and project forward the population from 2012 to 2037.

**ii) Please explain how local schemes and spending plans will support the commitment to protect social care**

The focus of the programme will be on those areas where insufficient social care support would be detrimental to the delivery of the Better Care Fund objectives and metrics, as set out below:

- Maintaining existing adult social care services that have a demonstrable health benefit, with a particular focus on:
  - Reducing avoidable emergency admissions to hospital.
  - Reducing long-term admissions to residential or nursing home care.
  - Delivering social care services to people closer to their own home or locality, (together with both primary and secondary health services).
  - Increasing support and providing better information to people with complex conditions most at risk of hospital/institutional care, to manage their condition(s).
  - Re-modelling and improving the integration of Re-ablement and Intermediate care services, so that people can receive the right degree of rehabilitation, in the right place, at the right time to maintain their independence.
  - More effective use of Assistive Technology to support people to live independently and safely in their own homes.
  - Improving joint working to support more timely diagnosis of dementia which will increase the availability of treatment and support to individuals.
  - Protecting the national eligibility threshold for access to Adult Care services at Substantial.
- Funding innovation that is of joint benefit to adult social care and the local NHS.
- Allocating funding to support the enhanced integration programme between Adult Care and the local NHS.

Funding towards the implementation of the Care Act.

BCF Objective	Social Care Services to be protected	
	2014/15	2015/16
Building strong asset-based communities	-	Voluntary Sector Spend
Support people to remain independent and in control of their lives.	Specialist equipment: to develop a flexible fund for sourcing specialist equipment for individuals where this will promote self-care/independence.	2014/15 activity, plus: Equipment budget and DFGs.
	Telecare: to support the existing Telecare programme through the provision of equipment and response services.	
	Dementia support: to develop community services offering a central point of contact for people with dementia & their carers, supporting them through their diagnosis and throughout their illness.	
	Specialist Dementia Home Care: to provide a specialist home care service linked to local mental health services to support people at home and reduce admissions to hospital. This service currently operates in South Derbyshire and is being piloted in Chesterfield.	
	Autistic Spectrum Disorder support: to respond to the recent Autism Act and the statutory guidance by improving preventative services, particularly for people with Asperger syndrome.	
	Learning Disability Day Opportunities: to assist in the transformation of day opportunities for people with a learning disability. This will include pump priming time limited mentoring and community engagement support for people currently using day services.	

BCF Objective	Social Care Services to be protected	
	2014/15	2015/16
Provide support in the community when needed.	Integration Programmes: to support Adult Care services that are contributing to delivering the current integration plans with each of the CCGs. This includes the social care consequences of the current 'pro-active case management' (Virtual Ward) and equivalent service developments and enhanced out of hours assessment and care and support services.	2014/15 activity, plus: Social care input to 7 day integrated community teams.
	Supporting people with dementia in care homes: to provide enhanced fees to independent sector care homes that meet jointly agreed standards for dementia care and are successful through a vetting process. The standards will be based on a social model of support including minimum use of anti-psychotic medication.	
	Falls Recovery: to train and support community wardens to assist Lifeline customers who have fallen. This is intended to reduce Ambulance service calls to non-injured fallers.	
Reduce the need for hospitalisation or admission to long-term care.	Enhanced re-ablement; and capacity to support the merger with intermediate care/ health rehabilitation: to promote people's independence and maximises their chance to continue to live in their own homes. Develop the use of generic care workers to reduce the number of people providing support to a person.	
	Residential care and home care to support people to remain outside Acute care settings: to continue with the enhanced social care services to minimise both delayed transfers of care from hospital & avoidable hospital admissions.	
Improve outcomes and the quality of services provided.	-	2014/15 activity, plus: Increased capacity linked to community

BCF Objective	Social Care Services to be protected	
	2014/15	2015/16
		teams; home care and specialist support for people with dementia.
Reduce Inequalities.	-	2014/15 activity, plus: Increased capacity to support joint assessments and lead professionals; roll-out of Time to Change.
Develop the necessary infrastructure to achieve agreed BCF objectives.	A number of projects will need to be completed during 2014/15, to provide the data and evidence required to formulate detailed integration plans in preparation for 2015/16. These will include, but are not restricted to:	
	Establish pooled budget/ s.75 arrangements: recruitment to short-term posts, identified in the BCF Plan, including a manager for the s.75 pooled budget.	
	Establish additional performance management systems.	
	Mapping of existing infrastructure/ detailed reviews: <ul style="list-style-type: none"> <li>• Review of re-ablement and intermediate Care.</li> <li>• Review of voluntary sector spend, against agreed integration priorities.</li> <li>• Review of SPAs: including the delivery of Planned Care and Rapid Response.</li> <li>• Dementia Strategy implementation.</li> <li>• Autism Strategy implementation.</li> <li>• Review of equipment/ ICES.</li> </ul>	

BCF Objective	Social Care Services to be protected	
	2014/15	2015/16
	<ul style="list-style-type: none"> <li>• Role of Accountable Lead Professional.</li> </ul>	
Implications of the Care Bill.	<p>Funding towards the costs of implementation including the infrastructure and ICT implications of the Care Bill:</p> <ul style="list-style-type: none"> <li>• Personalisation.</li> <li>• Carers.</li> <li>• Information, advice and support.</li> <li>• Provider quality profiles.</li> <li>• Safeguarding.</li> <li>• Assessment &amp; eligibility.</li> <li>• Veterans' financial assessments.</li> <li>• Law reform.</li> </ul>	

**iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)**

The total amount from the BCF allocated for the protection of Derbyshire Adult Social Care Services is: £18.595m this includes:

1. £15.793m - to support the local schemes and spending plans detailed in section ii) above;
2. £2.802 - this is the current indicative Derbyshire 'Ready Reckoner' Care Act BCF implementation funding for the following areas of activity:

- Carers
- Information, advice and support
- Safeguarding
- Assessment and Eligibility
- Veterans
- Law Reform
- Advocacy
- Impact of DWP policies
- Care Act capital investment

**iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met**

The implementation of the Care Act in Derbyshire is being overseen through a formal project management approach portfolio approach that includes our Integrated Care Programme and the Care Act Implementation Programme. A dedicated Care Act programme coordinator is in post and leads have been identified for the thematic topics for action.

**v) Please specify the level of resource that will be dedicated to carer-specific support**

Carer-specific resource has been identified from two sources within the Derbyshire BCF plan:

- a) The Care Act implementation allocation: £1.038m to:
  - I. Put carers on a par with users for assessment
  - II. Introduce a new duty to provide support for carers
- b) The NHS Funding for Carers element of the BCF: £1.962m

Current work is taking place to refresh the Derbyshire Carer's strategy; our intention is to use this as a framework to commission support for carers that, along with the implementation of the Care Act duties in relation to carers, will improve outcomes and achieve our local vision for integrated health and social care services – as set out in Section 2 above.

**vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?**

There have been no significant changes to Derbyshire county council's budget since the original April BCF plan was submitted.

**b) 7 day services to support discharge**

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Investment has been made in acute and community services to deliver 7 day working and includes:

- Further development of Single Point of Access to 7 day working.
- Plans for integrated care teams include a move to 7 day working, where not already in place.
- Full compliance with Keogh in all contracts.
- The extension of primary care services across 7 day working and the further integration of community and primary care services in support of patients with LTC's and frail older people.

Social work capacity at Chesterfield Royal Hospital has been enhanced and Adult Care Out of Hours Team expanded, to strengthen admission avoidance and discharge planning and to support the development of 7 day working for all health and social care services; capacity in pharmacy and Allied Health Professionals at Chesterfield Royal Hospital has been increased to support 7 day working.

The Chesterfield Royal Hospital NHSIQ 'NHS Services, Seven Days a Week Transformational Improvement Programme' early adopter pilot will inform further expansion of 7 day working; the evaluation of "Peak Flow" week 10<sup>th</sup>-17<sup>th</sup> September (following ECIST review) will be used to assist service redesign and investment to achieve optimum 7 day working within available resources and future priorities (transport availability has already been identified as critical to ensuring the flow of patients and work is underway to scope this). Similar work is in hand for Royal Derby Hospital. The current organisation and effectiveness of the Single Points of Access for Derbyshire are being reviewed.

Full plans are available both within CCG 5 year Strategic Plans and the Area Team Primary Care Strategy.

**c) Data sharing**

**i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services**

The NHS number is currently captured in over 60% of Adult Care records. Adult Care is committed to this principle and plans to have it fully in place by the end of 2015. Proposals are being developed for discussion with NHS colleagues to re-invigorate the batch-matching of records in line with practice up to now to ensure that this data is held on record, recognising that not all referrals emanate from the NHS and therefore an element of retrospective matching will always be required.

Adult Care is currently re-procuring its case management system (electronic social care



record). This is at an advanced stage and the single supplier (CoreLogic) remaining in the process is actively exploring the usage of ITK enabled Spine-Mini Services. This will enable Adult Care to access PDS data held on the NHS Spine, to match and retrieve NHS Numbers without the need for maintaining Spine compliance or the use of NHS Smartcards.

Refer to Information Standard ISB 0149 [http://www.isb.nhs.uk/documents/isb-0149/amd-136-2010/index\\_html](http://www.isb.nhs.uk/documents/isb-0149/amd-136-2010/index_html)

Self-assessed performance against IG Toolkit standard 11 – 421 or 11-422 (reference varies between organisational views) and evidenced in the published report

<https://www.igt.hscic.gov.uk/Home.aspx?tk=418705489316493&cb=3d05ac2c-920a-454d-8b9b-8f954754b591&Inv=7&clnav=YES>

Identify which method for tracing is in use HSCIC

**ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))**

Adult Social Care is currently undertaking a procurement process for its case management system (electronic social care record). As part of this we are looking for maximum flexibility from suppliers around integration and inter – operability.

The single supplier (Corelogic) now remaining in the process is already engaged with NHS Connecting for Health (NHS CFH) and the Department of Health in the Health and Social Care Integration programme, working on two major strands: PDS Integration and CAF Messaging. As part of the CAF messaging programme, the supplier is developing ITK messages with NHS London and it is anticipated that the processes and lessons learnt there will aid implementation in Derbyshire.

Corelogic has also been fully engaged in the Social Care PDS Early Adopters (SCPEA) programme from the outset, and has completed Development and System Testing of all PDS functionality, including meeting all the Information Governance requirements. Once again, it is anticipated that this work will be of benefit in Derbyshire in terms of implementing improved data sharing.

Another element of the overall procurement process is the provision of home care scheduling software. The current supplier (Advanced Health and Care), which is part of the consortium bidding for the new contract, has an existing product that allows data to be exported and imported through an API.

Where data was provided by a CCG or CSU, the Information Governance Assurance Statement they issued to NHS England as part of the conditions to process data under the NHS Act section 251 Regulations will provide assurance that the appropriate IG controls were in place and the data processing was conducted under a lawful basis.

Caldicott 2 recommended risk stratification should only be conducted using technology that allows data to be extracted from its source, pseudonymised, stratified automatically and returned in a non-identifiable format without it being seen by a human throughout the process.

**Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.**

There is a full commitment from Adult Care to making sure appropriate IG controls are in place. We are actively exploring this with NHS colleagues.

The IG processes within Derbyshire are now ISO 27001 compliant following a recent audit and award of certification. Adult Care is an active member of the corporate IG group and was recently commended within the ISO 27001 accreditation process for its close attention to IG. Adult Care has a Caldicott Guardian at a senior management level and three further staff part of whose roles focus on IG, recognising the centrality of IG to its work. This work is both proactive and reactive and is well embedded within the work of the department.

Particular attention is being paid now to the possibility of mutual access to records recognising that improved and efficient delivery of services to clients/patients is at least in part dependent on better access to each agency's data on health and social care. A recent meeting with CCGs and GEM agreed a process for exploring this further through a set of workshops with Adult Care and Health staff covered by two practices within Hardwick CCG. This work will run alongside a full review of the IG controls that will need to be in place. This work will serve as a pilot for wider implementation.

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

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

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

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

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

Overall accountability across the organisation lies with the Chief Operating Officers who have overall responsibility for establishing and maintaining an effective information governance assurance framework for meeting all statutory requirements and adhering to

guidance issued in respect of procedural documents.

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

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

[http://www.derbyshirepartnership.gov.uk/images/Derbyshire%20Partnership%20Forum%20SP%20-%20v%203%204\\_tcm39-112507.pdf](http://www.derbyshirepartnership.gov.uk/images/Derbyshire%20Partnership%20Forum%20SP%20-%20v%203%204_tcm39-112507.pdf)

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

#### **d) Joint assessment and accountable lead professional for high risk populations**

##### **i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them**

Under the enhanced service 'Avoiding unplanned admissions; proactive case finding and patient review for vulnerable people' GP practices are tasked with identifying patients as high risk, and sets a target of 2% as the number of patients likely to be at high risk.

The enhanced service asks GP practices to use a risk stratification tool. However we continue to await clarification for the Information Governance surrounding the use of risk management tools. In the meantime, local systems are being utilised. Currently individual teams are using a range of criteria and approaches to assess risk, including co-morbidity, number of Long Term Conditions, hospitalisation, falls and recent bereavement. The comprehensive development of formal liaison/link Social Worker arrangements by district community social work with all GP practices in Derbyshire during 2013/14 has strengthened care co-ordination and priority case management. Further pilot development work to accelerate the development of integrated care teams based on several local communities and working with specific GP practices are part of the PDSA cycle underpinning the implementation of the system plans for the UOPs. Current existing processes will be systematised with the introduction of standardised risk stratification tools (to be rolled out in 2014/15) and formalised approaches to allocating a lead professional and agreeing accountability.

As well as this we have extrapolated data for one CCG area (2012/13) to provide an initial level of need on which to base planning assumptions for the whole of Derbyshire, which will continue to be refined during 2014/15:

- Self-Care/ Support Management: 113,729 (15 % of Derbyshire population).
- High Risk: 29,056 (4 % of Derbyshire population).

High Complexity/ Case Management: 3,432 (0.4 % of Derbyshire population).

**ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population**

As already described, the complexity of the landscape in Derbyshire across health and social care means that there is not a single approach to implementing integrated care. However, there is a similar model of care across the health and social care that all deliver a joint assessment and improved accountability for patient care and support.

These models have been developed from the investment in the “Unique care” pilots funded in 2009 and carried forward by the CCGs and the County Council; for example: the Virtual Ward and Community Support Teams

The MDT meeting provides an opportunity for the integrated teams to review the assessment and develop a care plan. This will also include an assessment of risk. Patients with a high or escalating risk of admission are reviewed, and an MDT case management plan is implemented. Patients identified by this process are admitted onto the caseload or virtual ward, with their needs fully assessed and reviewed as part of MDT meetings until they are stepped down to the most appropriate level of care within the wider integrated health and social care team.

Accountability is assured within this MDT process, and the model puts the patient at the centre of care decisions and requires GP practices to play an active part in the MDT. All patients are allocated a named care co-ordinator at MDT meetings, who is accountable for ensuring that the care plan and agreed interventions are delivered by the various team members. This person could be any of the MDT members, depending on the patient's primary needs.

While the GP remains medically accountable for all patients identified in a primary or community care setting, the GP may not be the named care co-ordinator, as it is not always practicable to oversee multiple and complex interventions from a wide range of people. With the 2014/15 General Medical Services contract changes, this is due to change to meet the requirement that all patients within a certain risk level are assigned a named accountable GP, who ensures they are receiving co-ordinated care.

It is likely that lead accountability for oversight and ownership of the patient's care plan will nearly always sit with the GP, but it could be another care professional according to the patient's particular health and social care needs. Medical accountability will remain with the GP, but care co-ordination and delivery responsibility will be allocated to the individual professional who can most effectively manage the integration of required interventions through the MDT.

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

**iii) Please state what proportion of individuals at high risk already have a joint care plan in place**

As discussed in section (i) above by the end of September 2015, 2% of patients will have a care plan in place. These will have been developed and led by General Practice, however in Derbyshire because of joint working already in place many of these will already in fact be joint care plans. In addition there are a number of other patients (for example those with

complex mental health needs) who already have joint care plans. Work is on-going to quantify this number.

## 8) ENGAGEMENT

### a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Healthwatch has been involved in the workshops arranged to develop the Vision as a member of the Health and Wellbeing Board. We have drawn on previous engagement and consultation around the strategic direction of the health and social care system to develop this Plan which includes:

- **The NHS Call to Action** led to widespread CCG engagement events which provided further focus and structure to future plans. Engagement plans were developed for each CCG setting out planned activities and timescales for seeking and capturing feedback from the local debates to support development of the five year strategy.
- **Feedback and learning from previous Patient and Public Involvement Stakeholder** events has been taken into consideration and incorporated into the development of plans. This is in addition to feedback received from CCG clinical members, other stakeholders and partners/providers.
- As described above, the CCGs in Derbyshire were fortunate in having undertaken a **preliminary consultation** (*21st Century Healthcare*) with the public on the challenges facing the NHS and, as part of this work, developed a set of principles that underpin changes to services (see above).
- The consultation to develop the **Derbyshire Council Plan** priorities including 'Healthier Communities with Reduced Health Inequalities' and 'A Derbyshire that Cares' has informed this Plan – with a particular focus on developing people's capacity to improve their own health and wellbeing and supporting to live independent active lives for as long as possible.
- The formal consultation that took place to develop the county-wide '**Older People's Accommodation, Care and Support Strategy**' also involved a wide range of individuals, family carers and provider organisation – key messages about the ways older people want to be supported to remain independent have been included in this Plan, for example to provide integrated care as close to the person's home or where practical, within their home.
- Our approach to developing joint commissioning strategies is to co-produce them with people who use services and their families. We have taken this approach in developing both the recent dementia and mental health draft strategies.

**Targeted research** undertaken during 2013, interviewing individuals and family carers about a project to deliver specialist dementia home care services has helped to shape the way we are proposing to provide the different 'Levels of Care' – see pages 12/13 above.

## **b) Service provider engagement**

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

### **i) NHS Foundation Trusts and NHS Trusts**

Our Vision was developed through 8 workshops engaging local NHS commissioners and providers involving: GP representatives, Derbyshire County Council, including at various times, Public Health, Healthwatch Derbyshire and the local voluntary and community sector. While its focus has been on integration, the overall Vision applies across the whole health and social care system.

The first stage of moving towards integrated health and social care services was a Derbyshire wide public consultation in 2012. This consultation established six principles upon which any future service changes and developments would be based, regardless of whether the change takes place in a single organisation or is a collaborative endeavour across many organisations. Publically consulted and agreed *21<sup>st</sup> Century Derbyshire Principles* were agreed as:

- **All services will be person-centred**  
We will work in partnership with the people needing care and their families and carers to provide care as close to the persons home as possible, and when appropriate support them to access the right care away from home.
- **Care will be provided flexibly**  
We will listen to and understand the person's complete needs and meet them by using all services and resources available. We will ensure that we will co-ordinate care across health, social care and voluntary services to ensure people receive the right care from the right service at the right time.
- **Assumptions will be challenged**  
We will have the courage to make changes for the better that will improve the patient experience and obtain the best value for money. We will embrace innovation and find new approaches to care based on sound evidence. We will commit to monitoring and publishing patient experience data to be accountable to those who use our services.
- **People will be treated with dignity and respect**  
We respect and value the people who use and work in the health and social care system in Derbyshire and we will invest resources to support the health and well-being of our communities.
- **We will plan and deliver services in partnership**  
We will actively seek and listen to the views of people who use and work in the health and social care system in Derbyshire so that we can plan and deliver services in partnership and be accountable to them.
- **Healthy lifestyles will be promoted**  
We will support people to help them to make an informed choice about lifestyle and services and identify and provide extra support for those who need and want to make positive lifestyle changes.

### **ii) primary care providers**

General Practice, working through Clinical Commissioning Groups, has driven the development of the system plans of which the Better Care Fund plan forms a part, so has been closely involved.

Other primary care providers have been less involved, though there has been some discussion regarding the overall vision with both the pharmacy, optometric and dental local committees. Further work will need to be done with all primary care providers as the plans develop and are implemented.

### **iii) Social care and providers from the voluntary and community sector**

Social care providers have been involved in discussions about health and social care integration and as part of this, the Better Care Fund, over an extended period. Social care providers deliver a range of services that support the integration agenda, including home and bed based re-ablement; Intermediate Care; Extracare Housing and Rapid Response services. They are involved in planning and delivering new ways of integrated working together with CCGs and NHS providers.

The Health and Well Being Board has led the debate with providers about the Better Care Fund. Individual schemes and projects have been discussed with social care and providers from the voluntary and community sector in more detail particularly where the providers have or will have a role in delivering the service

An extensive consultation has been undertaken this year with the voluntary and community sector with a view to prioritising funding for the sector to meet the outcomes from the Better Care Fund metrics.

### **c) Implications for acute providers**

**Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:**

- **What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?**
- **Are local providers' plans for 2015/16 consistent with the BCF plan set out here?**

#### **a) Implications for the acute sector**

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

#### Overview:

Acute Provider Trusts have been involved in discussions with CCG's, the Local Authority and other organisations e.g. Community providers throughout the six month planning period. As part of these discussions a piece of work has been commissioned from Public Health to identify the number of acute hospital beds required to meet the needs of the current population. This will be based on analysis including hospital discharge information and demographic projections to extrapolate future need. This work will be completed in Q1 of 2014/15. However, in 2014/15 contracts, CCGs have transacted their QIPP plans to reduce avoidable emergency admissions (this information will be added to the plan once finalised).

QIPP savings have been transacted within all 2014/15 contracts with the acute sector. 2015/16 QIPP plans have also been shared with acute providers at Point of Delivery level.

QIPP will be monitored in year.

Agreed levels of non-recurrent “Call to Action” money, Marginal Rate Emergency Threshold (MRET)/Transformational Money have been included to assist with the reduction in the cost base of providers. Changes to Community Services to support these changes have been also been funded via MRET or readmissions money.

*There is a general consensus that the number of **avoidable** non-elective admissions could reduce in the region of 25-30% (in people aged over 65s) “Ceteris Paribus”; within the profile of predicted demographic change. This needs to be validated using the public health output and additional work being carried out by Finnamore Ltd (Consultancy).*

The continued development and delivery of an integrated estates model across the local NHS and County Council is intended to ensure that the release of fixed costs as a result of integrated services is optimised.

### **Headlines**

Key areas which continue to be explored are:

- Greater joint working with a shift of staff to the community as part of the Community Team. This will be included in workforce development and re-training.
- Increasing the number of community services engaged in supporting people’s physical and mental health.
- Reduction in non-elective admissions (within the profile of predicted demographic change).
- Further development of liaison services between acute and mental health services e.g. Rapid Assessment Interface and Discharge Psychiatric Liaison Service (RAID).
- Better case management and self-care – this will necessitate a longer term culture change.
- Decreased length of stay – people discharged in a timely way.
- Impact on acute providers including the impact on infrastructure costs.
- Continued involvement of clinicians and front line teams in the identification of how to deliver transformational change.
- Optimal use of the local NHS and Council buildings and land.

We have ensured that CCG plans, including the 5 Year Strategies and QIPP reflect the above.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.



## Annexe 1 Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Each individual project within the BCF has its own project plan which will further identify where there maybe a need to commission new services, change service delivery. The BCF Finance and Performance sub-group will receive monthly monitoring reports from individual Units of Planning, CCGs and Adult Care PMOs as appropriate.

<b>Scheme ref no.</b>
1
<b>Scheme name</b>
Self-help, Prevention and Community Resilience/Proactive Intervention and Support
<b>What is the strategic objective of this scheme?</b>
<p>This scheme relates to segment one of the “care wedge”. Its strategic objectives are to:</p> <ul style="list-style-type: none"> <li>• Help people help themselves as much as possible</li> <li>• Delay/ negate the necessity of approaching statutory services for support.</li> <li>• Prevent readmissions to hospital</li> <li>• Facilitate people finding solutions within their own community</li> <li>• Build up community resilience and social capital</li> <li>• Prevent admissions to residential care</li> <li>• Promote client independence and remain living at home with dignity</li> <li>• Facilitate hospital discharge</li> </ul>
<b>Overview of the scheme</b>
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> <li>- What is the model of care and support?</li> <li>- Which patient cohorts are being targeted?</li> </ul>
<p>This scheme comprises a suite of services, which support the people in the top 20% of the population and develop the strategic objectives detailed above. In detail they are:</p> <p>a. <b>Telecare:</b> An existing S256 scheme, which provides access across the County to approximately 100,000, predominately older people using the community alarms service. The focus to-date has been on the use of telecare to assist people leaving hospital, prevent avoidable admissions and to underpin care and support for vulnerable people including people with learning disabilities. This equipment is often linked to Community Alarms monitoring centres that can trigger an appropriate response for an individual. It is an area in which there is a wide range of equipment available, ranging from pendant alarms used by many older people, through to falls sensors and technology that can remind people to take their medication. Access to this service is by contacting Call Derbyshire. The use of Telecare is more closely linked to levels of demand and there is not a fixed budget for each locality. Its potential use should be, and is, considered in ‘virtual ward’ or equivalent discussions. Telecare will be expanded to include telehealth where appropriate e.g. FLO <b>Value £1.136m</b></p> <p>b. <b>Supported self-care schemes</b> –a range of schemes to help manage people to manage their long-term conditions and stay healthy such as telephone based health coaching, FLO telehealth. Self-care is centred on the person and their support networks, which are both formal and informal. Maintaining people in level 1 of the “Derbyshire Care</p>

Wedge” (see pages 12/13 above) to have a “good life” is the primary aim. This level includes the use of assets, social capital, self-monitoring, prevention and education.

**Value: £214K**

- c. **Supporting people with Dementia in Care Homes** - is an existing S256 scheme and provides information and practical support for people with a diagnosis of dementia and their family carers. It is intended to support people from immediately post diagnosis through their continuing illness. The service includes Dementia Support Workers who work with individuals and their families and point them in the direction of support services such as the provision of practical information through to Dementia Cafés and groups. The service is available across the County and is currently provided by the Alzheimer’s Society. Another objective of the Derbyshire Dementia Support Service is to provide information and advice services to people living with dementia or people worried about their memory, and their carers. It supports people pre-diagnosis and throughout their journey with dementia. The service is delivered by Dementia Support Workers based in each locality of Derbyshire. They provide 1:1 support, information and advice, and facilitate peer support groups, carer support groups and carer information training programmes across the County (excludes Derby City).

**Value: £1.034m**

- d. **Dementia Support** – In 2014, there are 160,000 people aged 65 and over living in Derbyshire. Just over 10,600 of these people will be affected by dementia. This will rise to 10,900 in 2015 and 11,250 the following year. By 2018, the number will be 12,000. The revised Dementia Joint Commissioning Strategy is intended to support the health and social care response to the rapidly increasing number of people with dementia. Initiatives will include:

- Improved early diagnosis, including responding to diagnosis in primary care, and consequent provision of dementia support services.
- Enhanced home care for carers to support their continued provision of care to the person with dementia. This will build on the experience of schemes in Swadlincote and Chesterfield.
- Implement the enhanced intermediate care services in two further Community Care Centres in Heanor and Darley Dale.
- Improved support for patients with dementia in acute hospital.

**Value: £1m**

- e. **Falls Recovery Service** – An existing S256 scheme. There are 160,000 people aged 65 and over living in Derbyshire in 2014, growing to 164,000 people by 2015. During 2014, almost 42,000 people in the 65+ age group will fall; 28,500 people will be in danger of repeated falls due to an on-going mobility problem (e.g. going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed). It is from this group that 3,200 people will experience a fall that will result in a hospital admission. For a vulnerable older person, a fall is a very frightening experience even when no injury is sustained. It leaves some people feeling very insecure and anxious about a re-occurrence. For many of the 3,200 people who are admitted to hospital though the admission is unnecessary because they do not required medical attention, just time to recover and a helping hand to calm them.

The Falls Recovery Service is a 24 hour service that monitors falls through a Lifeline. Emergency Response Officers assist uninjured fallers to get back up from the floor using safe moving techniques and equipment. Following any incident the person’s GP and family members are notified accordingly so that falls prevention services can be accessed for further help. It has been recognised that minimising the number of older

people who fall and preventing inappropriate acute hospital admissions is a joint priority across Derbyshire. This service has been jointly developed over the last two years and focuses on reducing avoidable calls to the East Midlands Ambulance Service (EMAS) and providing prompt support for older people who have fallen. It is tenure neutral, available to people in their own homes as well as in sheltered housing via lifeline alarms. It has involved training the lifeline/community alarm staff and providing them with equipment so that they can lift an older person who has fallen but is uninjured. This avoids a call to EMAS and potential conveyance to hospital. By using staff already available locally it also lifts the older person with a minimum of delay.

**Value: £345K**

- f. **Autism Spectrum Disorder** – National Prevalence rates indicate that there are just over 4650 people aged 18-64 predicted to have an autistic spectrum disorder resident in Derbyshire in 2013.

In June 2013 we conducted a survey of people affected by autism. The Survey respondents represent just 1% of the wider population of people with autism. Results can only be illustrative of likely range of views of people with autism and their carers. An existing S256 scheme. The Autism Act 2009 placed statutory duties on the local NHS and Adult Social Care organisations to improve the diagnosis and support provided for Adults with Autistic Spectrum Disorder (ASD). While there has been an emphasis on diagnosis and training for staff, it is also important to improve support for people with ASD and their family carers.

A proportion of the funding will be allocated to Derby & District Branch of the National Autistic Society to provide support to clients and family carers. CCGs are also reviewing services to improve access to speedier diagnosis and integrated support would provide significant benefit to people with autism and their carers. The balance of the funding will purchase additional diagnosis services. Work is on-going to develop the Autism Strategy and to review system capacity for diagnosis and support for children, young people and adults.

**Value: £774K**

- g. **Day Opportunities** – An existing S256 scheme. This is part of the national and local strategies for improving support for people with a learning disability. It involves providing wider and more flexible opportunities for people during the day. There are many people with a learning disability who want, and are able, to make more use of mainstream public activities and who also want to work. To support these aims, there is a Community Connector Service that was piloted across the County. This involves some Adult Care Day Service staff being seconded to the new service, providing intensive time-limited support to people with a learning disability who want to try out this new approach. Community Connector services have been developed successfully in other parts of the county. The aim is to continue this project, as there is a correlation between social interaction and remaining healthier.

**Value: £414K**

- h. **Voluntary sector Single Point of Access (vSPA)** – the vSPA is to provide one referral route into health and social care voluntary services to support patients to receive services at home or as close to home as possible (*please refer to Single Point of Access as described in Scheme 2*)

- i. **Welcome home Scheme** - this is a telephone call service aimed at reducing the risk of readmission by ensuring the patient has all needs met following discharge and is aware of how to self-care/manage as appropriate. The aim is to ensure timely discharge data

from Secondary Care Providers is available to Care Coordinators. The Care coordinators identify appropriate patients to ensure they have all immediate needs met on discharge e.g. medication, food and drink is available, they are warm enough, care package has started/recommenced, mobility is sufficient to access furniture/rooms/amenities, equipment has been provided/fitted, etc. They also check the patient has all information/knowledge they need to make a full recovery and/or are able to make decisions/ contingencies to prevent an unnecessary readmission to hospital which may include what services are available to them and how to access them and co-writing care plans. Any needs identified are referred to the appropriate organisation or professional with the agreed expectation of a speedy resolution. Additional therapy and community matron hours are available to rapidly address any highlighted needs. It is expected the Care Coordinator could also work within and support the SPA dependent upon future developments.

**Value: £160K**

- j. **Sitting Service** – this is a short, intensive day and night sitting service that provides support to a person who is deemed to be at risk of hospital admission if remaining at home unsupported. A sitting service has been operational in Erewash since January 2014, provided by DCHS, originally funded by ECCG through winter pressure monies and MRET. Initial evaluation has proven that the service has prevented admission or assisted more timely discharge. The aim is to provide a support worker during the day and/or overnight in an emergency situation, where without the service, the patient would be admitted to an in-patient facility. The ‘sitting’ support worker provides emergency assistance/supervision with personal care, mobility, nutrition, medication, etc. This is alongside established integrated community services assessing and meeting the needs of the patient. Sitting service is provided for up to 3 days/nights. If on-going night care is required, the current level of demand on the service and patient need is reviewed and the service is either extended or alternative care provision is sought e.g. care home or re-ablement bed as appropriate, prior to considering admission to in-patient setting. Access is via SPA and professional referral.

**Value: £240K**

- k. **Falls Partnership Service** - The FPS provides a 50/50 primary/secondary response to people (> 50yrs) who have fallen at home or their usual place of residence. The FPS is fully integrated into the 999-ambulance pathway and can be used as an alternative to an ambulance crew attending the patient following appropriate triage by ambulance control. The aim of the service is to avert inappropriate hospital admission for patients who fall and which would likely result in an acute admission. It is able to deliver an immediate response to the multi-faceted issues of patients who fall bringing together services that have previously worked independently.

**Value: £544K**

- l. **Carers** – the current level of investment will be maintained. However, the Derbyshire-wide Carers’ Strategy is being refreshed for 2015 and carers’ needs are being addressed through the work of the Integrated Care Board (South) the Integrated Care Steering Group (North). The intention is to review current provision in line with the new models of care and the requirements of the Care Act 2014.

**Value: £2.02m**

#### **The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- (a) The service is commissioned and provided by Derbyshire County Council.
- (b) This service is commissioned by SDCCG and provided by a range of private, NHS and third sector providers
- (c) These services are commissioned by Derbyshire County Council and provided by the Alzheimer's Society
- (d) This service is commissioned and provided by Derbyshire County Council
- (e) This service is commissioned by Derbyshire County Council and provided by the Autism Society
- (f) The service is commissioned and provided by Derbyshire County Council
- (g) These services are commissioned by DCC in a lead commissioning arrangement with the CCG and provided by a range of organisations including the VCF and independent sector.
- (h) This service is commissioned by jointly by North Derbyshire CCG, Erewash CCG and Hardwick CCG and is provided by North Derbyshire Voluntary Action (NDVA)
- (i) This service is commissioned by Erewash CCG and delivered by Derbyshire Community Health Services
- (j) This service is commissioned by Erewash CCG and delivered by Derbyshire Community Health Services
- (k) This scheme is commissioned by Hardwick CCG & North Derbyshire CCG and will be delivered through a collaboration of providers – EMAS, DCHS, Red Cross & DHU
- (l) This scheme is commissioned jointly by North Derbyshire CCG, Erewash CCG, Southern Derbyshire CCG and Hardwick CCG and is provided by a range of statutory and voluntary sector providers

### **The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Many of the services in this theme are tried and tested with a well-established evidence base for their efficacy. Many of the services have been witnessed within the American healthcare system and evidenced by United Healthcare e.g. Health coaching, welcome home calls, sitting services etc.

Various evidence has been collated for this scheme and those under 2 and 3, for example:

- United Healthcare – evidence from the USA; appointment of Optum to assist with the development of an Integrated Care approach
- King's Fund – various
- North West London approach
- Torbay approach
- Evaluation of FLO
- Local research & monitoring as part of the commissioning cycle.

### **Databases searched**

Cochrane Library, NHS Evidence, Medline, CINAHL, EMBASE, HMIC, PsycINFO, Soc Index, SSRG, Care Services Efficiency Delivery (CSED) Programme Archives

### **Why Telecare and Telehealth?**

Telecare is a service that enables people, especially older and more vulnerable individuals, to live independently in their own home. 90% of people say that that is their wish and telecare allows it to happen. Equally it gives peace of mind to family, friends and carers, knowing that when they are unable to watch over their loved ones, telecare will. Telecare is as much about the philosophy of dignity and independence as it is about technology and services. The service package, and choice of technology, is provided to support the

individual in their home and is tailored to meet their needs. It can be as simple as the basic social alarm service, able to respond 24/7 in a given situation, it can include sensors and triggers such as motion or fall detectors and fire and gas alarms, that trigger a warning to a response centre staffed 24 hours a day, 365 days a year. It can also include location devices that can be used to enable an individual to have security outside of their home.

As well as responding to an immediate need, telecare can work in a preventative mode, with services programmed to monitor an individual's health or well-being. Often known as lifestyle monitoring, this can provide early warning of deterioration, prompting a response from family or professionals.

Telehealth works by monitoring vital signs, such as blood pressure, and transmitting the data to a response centre or clinician's computer, where it is monitored against parameters set by the individual's clinician. Evidence that vital signs are outside of 'normal' parameters triggers a response. To be successful telehealth needs to be part of the care pathway for managing long-term conditions.

Telecare and telehealth can be used on their own or in combination in order to best meet the needs of the individual and get the best fit with local services, including those provided by family and friends. The services need to balance technology with other forms of care and support and be reviewed in the same way as all other packages of health and social care.

### **The Whole System Demonstrator (WSD) Programme**

The Whole System Demonstrator (WSD) programme is the largest randomised control trial of telehealth and telecare in the world. The trial involved 6191 patients, 238 GP practices across three sites, Newham, Kent and Cornwall and was set up to look at cost effectiveness, clinical effectiveness, organisational issues, effect on carers and workforce issues. It focused on three conditions, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and coronary heart disease.

The headline findings for the telehealth element of the trial were published in January 2012. These findings show that, if delivered properly, telehealth can substantially reduce mortality, reduce the need for admissions to hospital, lower the number of bed days spent in hospital and reduce the time spent in A&E:

- 15% reduction in A&E visits
- 20% reduction in emergency admissions
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs
- 45% reduction in mortality rates

At least three million people with Long Term Conditions and/or social care needs could benefit from using telehealth and telecare. To achieve this level of change the Department of Health is working with industry, the NHS, social care and professional partners in a collaboration with a difference

### **Dementia Support**

As part of the refresh of the Derbyshire Dementia Strategy 2014-19, engagement with people with dementia and carers identified support and information services as one of the top priority areas for improvement. (See also Derbyshire Dementia Strategy refresh 2014-19). We are conducting an Evaluation of the Dementia Support Service following its operation over the first few months that is providing very valuable feedback as to how to optimally design services to better address need.

**Falls Recovery Service**

Early local trials in the north of the County show that of 73 patients referred to the scheme, 42 (66%) did not require hospitalisation. Furthermore, the savings made from avoiding admission in the first 7 weeks, equated to 24% of the Service's annual running costs from which we can project an overall net saving from the avoidance of hospital admission.

**Autism Spectrum Disorder - Diagnosis & Support**

People with Autism are a very hard to reach group. We carried out a Survey in partnership with Derby City to find out what people with Autism need most help with. The Survey was relatively small scale but nevertheless a good starting point. 36 out of 44 respondents had a formal diagnosis (82%). 17 respondents receive a health or social care service (39%) All Derbyshire Districts were represented amongst respondents but the numbers are too small to draw out any firm conclusions about geographical differences. Most respondents (32%, 14 people) were in the 16-24 age group. 3 respondents were aged 55-64 and one respondent was aged over 65. 30% did not indicate their age group. 52% were male & 48% female. 82% of respondents were white & the remaining 18% chose not to disclose their ethnic background. 61% live in their parent's home. 5% were in residential care and 18% lived in a rented house/flat. 7 people (16%) live in their own house or flat. Families were identified as the most providers of help by 48%. 14 respondents described how easily help was available as poor (32%) and a further 10 (23%) as "below average". 5 respondents thought it was "good". 41% described the quality of help as poor.

There were a number of areas of that were prioritised as important to people with autism:

- 57% help with communication
- 66% help to meet friends
- 50% Help to get a buddy or volunteer
- 50% Help to find groups and join in activities
- 32% help to contribute to community
- 36% help with counselling
- 52% help to manage behaviour
- 14% help with physical health
- 20 (45%) help with anxiety
- 46% help with employment
- 27% help with training
- 41% help with personal care
- 11% help to get better housing
- 11% help to make home easier to live in.
- 46% help to cook and shop
- 41% help to manage money

This help is required by people on a daily basis (39%) to a few times a week (66%) Perhaps given the nature of autism, and the relative youth of the predominant group of respondents, it is not surprising that areas of expressed need for help centre around opportunities for social communication and meaningful activity rather than health and personal care matters.

We also know that people with Autism are unable to receive any form of public support until they have received a formal diagnosis yet diagnostic practice is patchy and inconsistent.

**3****Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan  
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

<p>All of the above schemes will have additional, non-financial benefits or non-measurable benefits. Outcomes include:</p> <ul style="list-style-type: none"> <li>• Reduction in emergency hospital admissions</li> <li>• Reduction in admissions to residential care</li> <li>• Increased falls prevention</li> <li>• Reduction in hip fractures</li> <li>• Increased self-esteem</li> <li>• Greater opportunity for patient choice regarding location of care</li> <li>• Patients feeling well supported with high satisfaction levels</li> <li>• Comprehensive well, co-ordinated and managed care</li> <li>• Higher medication compliance</li> <li>• Higher care plan compliance</li> </ul>
<p><b>Feedback loop</b></p> <p>What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>
<p>The schemes form part of the South Unit of Planning and North Unit of Planning Transformation Programme and are monitored through the Programme's governance. The projects that make up this programme are managed via the individual CCG PMOs</p>
<p><b>What are the key success factors for implementation of this scheme?</b></p>
<ul style="list-style-type: none"> <li>• Information Sharing System level agreement on the framework, approaches and protocols for sharing patient information across all parts of the system</li> <li>• Estates System wide coordination of opportunities and challenges relating to health and social care estate</li> <li>• Workforce System level agreement on the approaches and mechanisms for enabling multi-agency working and team development both within the short term and medium to longer term</li> <li>• Culture/Organisational Development: Identify cultural / OD enablers that will help to foster stronger working relationships at all levels of organisations to deliver patient care</li> <li>• Communications System wide plan for wider engagement and communications of the system plan and its implementation</li> <li>• Finance and contracting - Financial planning to ensure delivery of the system plan - cross system and provider aligned. Alignment of contracting arrangements to enable the system changes.</li> <li>• Clinical Governance Clinical and professional governance standards and processes to support integrated care</li> </ul>



<b>Scheme ref no.</b>
2
<b>Scheme name</b>
Integrated Community-based Support/Integrated Episodes of Care
<b>What is the strategic objective of this scheme?</b>
<p>This scheme covers segment two of the “care wedge”, focusing on care delivered in the home or close to home and based on blocks of population of approximately 20,000. Its strategic aims are:</p> <ul style="list-style-type: none"> <li>• To provide person-centred care that promotes independence and recovery through an integrated approach reduce hand-offs and duplication</li> <li>• Improve the experience of the individual when accessing care</li> <li>• Focus on the top percentage of people with complex needs who frequently attend hospital</li> <li>• Helps people avoid going into hospital unnecessarily by creating services that offer an alternative to hospital stay, supports people to remain in their community and works 7/7 and 24/7 where appropriate</li> <li>• Helps people be as independent as possible after a stay in hospital</li> <li>• Prevents people from having to move into a residential home until they really need to</li> <li>• Ensuring that shared care &amp; contingency plans are in place for ‘top [5%]’ with a particular focus on people with dementia</li> <li>• Providing care coordination and case management via an Integrated multi-disciplinary community teams</li> </ul>
<b>Overview of the scheme</b>
<p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> <li>- What is the model of care and support?</li> <li>- Which patient cohorts are being targeted?</li> </ul>
<b>COUNTY-WIDE SCHEMES</b>
<p><b>A Rapid Response/Re-ablement</b></p> <p>Enhance existing rapid response services in health and social care to ensure that home based social care and community health services are equitably available across the county at times of crisis. These services should be available to start providing support rapidly (within 30 minutes) to support people to remain at home.</p> <p>The services would remain in place for up to 48 hours in the week and 72 hours at weekends to allow time for more detailed assessments and, as appropriate, wrap-around support packages to be put in place.</p> <p>Access to the services would be through existing systems, including Call Derbyshire, SPAs and Derbyshire Health United (DHU).</p> <p><b>B Re-ablement and Intermediate Care (Including “Enhanced Re-ablement”)</b></p> <p>There is a track record of delivering home and accommodation based re-ablement and intermediate care services. These have a proven effectiveness but there needs to be a step change in their scale and equitable provision across Derbyshire. This will enable us to:</p> <ul style="list-style-type: none"> <li>• Promote clients independence and ability to remain living as independently as possible</li> <li>• Support prompt discharge from acute hospitals including hospitals based outside the boundary of Derbyshire</li> <li>• Reduce inappropriate re-admissions and/or admissions to long term care.</li> </ul>

The focus of this investment will be to fill existing gaps in services including community health services and then to drive up the baseline of equitable provision. Services will be enhanced through the Single Points of Access (SPAs), so they are accessible 7 days a week. The investment will include additional hands-on care staff, together with community nursing and therapy staff.

**Value: £7.834m (for schemes a and b above) – existing S256 is £5.894m**

### **C Dementia Support**

The revised Dementia Joint Commissioning Strategy is intended to support the health and social care response to the rapidly increasing number of people with dementia. (Please cross-reference with Dementia in Scheme 1)

### **D Parity of Esteem - Adult Mental Health Services**

The draft revised Joint Commissioning Strategy for Adults with Mental Ill Health is intended to both deliver the national strategy “No Health Without Mental Health” and deliver additional local priorities. A number of priority areas relate to improved integration. These include: -

- Developing community crisis response mechanisms to prevent escalation and avoidable hospital admissions.
- Develop parity of esteem across the whole system pathway.
- Increase AMHP capacity to support preventative and enablement interventions.
- Introduce an en-ablement service by changing the focus of current Community Support Workers using extra training and support.

**Value: £1m**

### **E. Delayed Transfers of Care (Existing S256)**

- Adult Care works hard to minimise the number of people whose discharge from acute or community hospitals is delayed. The services here include:
- Social Workers and OTs whose role is to assess people’s needs and make arrangements to ensure the availability of the necessary social care services require post discharge.

Re-ablement / discharge to assess beds in County Council care homes for older people. These beds are used on a short-term basis to ensure both prompt hospital discharge and to support people’s recovery and to maximise their independence. This operates flexibly, but initially designated beds include:

<b>North East</b>	Staveley	3 beds
	(The Grange, Eckington	1 bed
	Holmlea, Tibshelf	1 bed
<b>South East</b>	Hazelwood, Ilkeston	1 bed
	Ladycross House, Sandiacre	1 bed
	Ada Belfield, Amber Valley	1 bed
<b>West</b>	The Leys, Ashbourne (1	1 bed
	Underhall, Darley Dale	1 bed
	Ecclesfold, Chapel-en-le-Frith	2 beds

**Value: £2.644m**

## **South Unit of Planning**

**F. Community Support Teams/Community Delivery Teams** have been created which are based on clusters of GP practices and based on populations of approximately 20,000. The teams are made up of social workers, primary and community health services staff. Care co-ordinators who act as the lead professional for people with complex care needs and case co-ordinators/community matrons who provide practical support and chasing up of key information relating to a persons case support them. The teams are designed around the evidence base provided by Torbay and the USA via Optum.

The work of the CST/CDTs is supported by key community-based services such as enablement and recovery services, home support, day services, aids and adaptations. Where appropriate, these are accessed via a personal budget and taken as a direct payment. One of our ambitions is to increase the number of direct payments used by older people and to increase the number of personal health budgets as we believe this approach will improve the quality of care and achieve efficiencies.

Specific elements of this scheme include:

- **Integrated Teams** – including care co-ordinators, case co-ordinators/community matrons, community nursing, community OT, community physiotherapy, social workers and CPN alignment to the team. Care Co-ordinators actively manage high-risk patients by using either the RISC tool (Optum) or other case finding methods. This helps to identify those most at risk of admission so that discussions can take place at weekly/fortnightly MDT meetings.
- **Care Home Support** – this co-ordinates care in an integrated way for frail/elderly patients who may currently fall outside the existing pathways to healthcare access, shifting the focus to community provision. The aim is to provide a proactive and holistic approach to care. The Care home support services fits integrally with the Integrated Care model in that it supports transfer of care from an in-patient setting (community and acute) into a Multi-Disciplinary Team delivering care in or around the patient's place or residence.
- **Respiratory/Pulmonary Rehabilitation** - The Community Pulmonary Rehabilitation service in Erewash CCG provides an equitable, patient centred service, providing the best possible outcomes for patients improving their quality of life and reduces their symptoms (thus reducing hospital readmissions). The multi-disciplinary service offers eligible patients access to a programme of exercise and education in Long Eaton and Ilkeston through a flexible model incorporating both cohort and rolling programmes. The Integrated Care Teams will ensure every adult with complex care needs gets the right treatment and support in the right place and at the right time by
- Continuing the development of the practice-based Community Support Team (already in place) to include risk stratification and mental health support.
- Delivering an Integrated Care Team delivering mental and physical healthcare, social care and voluntary services
- Including a discharge to assess and manage (D2AM ) model to work with the CST and ICT
- Developing the existing Single Point of Access to service the wider NDCCG / HCCG Integrated Care model linking to voluntary sector / Derbyshire County Council and Derbyshire Community Health Services and working towards 7 day working.

**Value: £5.779m**

**G. Memory Assessment Services** – the development of current MAS to enable people to be diagnosed earlier and to assess services that will allow them to remain at home longer with appropriate support.

**Value: £500K**

### **North Unit of Planning**

Integrated Multidisciplinary Community Teams and services

This initiative straddles both proactive intervention and support and integrated episodes of care schemes.

**H. Integrated Care Team/Community Support Team** is a team providing services for a population between 20,000 – 75,000 across geographical communities in the Unit of Planning. It comprises Occupational Therapists, Physiotherapists, Nurses (including ANPs), CPNs, Pharmacy, Social Worker (case worker and personal carer), GP, Geriatrician, Sitting Service/overnight homecare, Dietician and Speech Therapists, ophthalmologist, dentists, chiropodist, hearing aid services and voluntary sector. The Integrated Care team is linked to the hospital acute reablement unit (or equivalent) with staff rotating through this in/out of community so there is constant up-skilling and awareness of services and skills that exist elsewhere. The team will provide appropriate reablement and Intermediate Care according to the needs of the population. The Single Point of Access functionality will be integral to the delivery of the ICT. Additionally, the Community Support and Integrated Care teams will have access to specialist nurses (e.g. COPD, Heart Failure, 'admiral' nurses) and secondary care specialist opinions.

The target patient cohort has not been rigidly defined, as we would not expect that a definition would be rigidly enforced. Where a need is identified and it is appropriate to include a person under the scope of the integrated care work, then the health and social care professionals' decision should prevail.

The Integrated Care/Community Support Teams will proactively support the needs of the 'top 20%' of the population – approximately 80, 000 people across Unit of Planning. The Northern Derbyshire Unit of Planning is investing time and resources to ensure risk stratification and patient identification.

This scheme will be phased in across the Unit of Planning during 2014 /15 and fully implemented from 2015.

Shared care and contingency plans in place for 'top [5%] used by all care provider (including family and friends) – with particular immediate focus on people with dementia.

Community Support/Integrated Care Teams will be supported as necessary by other services and facilities, for example:

- Provision of 'step down' beds to manage the transition from acute to community during periods of high activity
- Provision of a specialist community IV therapy service to allow patients requiring IV to be treated at home.

**Value: £2.662m**

**I. Chesterfield Royal Hospital Acute Reablement Unit** - the ARU provides an integrated approach to providing high quality person centred medical care for acutely unwell frail older people and aims to restore the person to their previous level of function whenever possible, to reduce avoidable hospital acquired harm by reducing length of stay without compromising patient safety or care and to enable a seamless transition from hospital to primary care on discharge.

**Value: £804K**

**J. Chesterfield Royal Hospital Discharge Ward (Basil Ward)** – Basil Ward is a discharge ward at CRH used when people have complex needs and discharge is likely to be extended.

**Value: £1.246m**

**K. RAID** – The service offers a comprehensive range of mental health specialties within one multi- disciplinary team, so that all patients of 17 and above can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity and complexity. The service operates 24 hours a day, 7 days week (24/7). It emphasises rapid response, with a target time of one hour within which to assess referred patients who present to ED and 24 hours for seeing referred patients on the wards. The service aims to meet the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia

**Value: £894K**

### **Tameside and Glossop**

#### **a. CHHECT**

The Community, Home and Hospital Enhanced Care Team is a new service building on the success of a twelve-month pilot scheme the Integrated Response and Intervention Service (IRIS). The aim of CHHECT is to provide an integrated Health and Social Care Community service that delivers a 24 hour / 7 days per week 'wrap around' Intermediate Care step up provision. The service aims to optimise the level of care and support provided within people's own homes within the community therefore reducing avoidable interventions within an acute setting (including emergency attendances and admissions) and reducing unnecessary admissions to residential care.

**Value: £74K**

#### **b. GP Over 75s**

The government has determined that there will be a specific focus on those patients aged 75 and over and those with complex needs. The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. The intention is to extend such arrangements to people with long-term conditions. We will provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people.

**Value: £158K**

### **The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- (a) This service is commissioned by jointly by North Derbyshire CCG, Erewash CCG, Southern Derbyshire CCG and Hardwick CCG and is provided by DCHS
- (b) This service is commissioned by North Derbyshire CCG, Erewash CCG, Southern Derbyshire CCG, Hardwick CCG, DCC and is provided by DCHS , DCC & a range of voluntary sector providers
- (c) This service is commissioned by jointly by North Derbyshire CCG, Erewash CCG, Southern Derbyshire CCG and Hardwick CCG and is provided by DCC
- (d) This service is commissioned by North Derbyshire CCG, Erewash CCG, Southern Derbyshire CCG, Hardwick CCG & DCC and is provided by DHCFT & DCC
- (e) The Area Team, CCGs and DCC jointly commission these services & is provided by DHCS, DCC, GPs, DHCFT & voluntary sector
- (f) The CCGs commission this service & it is provided by DHCFT
- (g) The Area Team, CCGs and DCC jointly commission these services & is provided by DHCS, DCC, GPs, DHCFT & voluntary sector
- (h) The Area Team, CCGs and DCC jointly commission these services & is provided by DHCS, DCC, GPs, DHCFT & voluntary sector
- (i) This service is commissioned jointly by North Derbyshire CCG, Hardwick CCG and DCC

- and is provided by DCHS & DCC, voluntary sector
- (j) This service is commissioned by jointly by North Derbyshire CCG & Hardwick CCG and is provided by CRH
  - (k) This service is commissioned by jointly by North Derbyshire CCG & Hardwick CCG and is provided by DHCFT
  - (l) This service is commissioned by jointly by North Derbyshire CCG & Hardwick CCG and is provided by DCHS

### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Various evidence has been collated for this scheme and those under 2 and 3, for example:

- United Healthcare – evidence from the USA; appointment of Optum to assist with the development of an Integrated Care approach
- King's Fund – various
- North West London approach
- Torbay approach

The evidence base is inconclusive around integrating care. There is no model described so far in the literature, which demonstrates a robust evidence base upon which to base our outcomes. However, there is some evidence from some parts of the country, which indicate possible outcomes for our ICP. The Nuffield Trust conducted an evaluation of several models of integrating care. Their conclusion was: "The service models evaluated to date generally appear not to be associated with reductions in emergency hospital admissions (Purdy, 2010; Purdy and others, 2012)"

This has also been the conclusion of others with respect to community models of care for frail older people (for example D'Souza and Guptha, 2013).  
[http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation\\_summary\\_final.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf)

The limited evidence available does suggest that there may be a positive impact on the following indicators:

Patients have an improved experience of care
Carers perceive that the patients experience is improved
Staff have increased job satisfaction in the delivery of care
Crises are managed at home / in the community
Patients are discharged from hospital as soon as they are medically fit

Our approach is to set a baseline and measure these indicators throughout the programme. By monitoring those indicators and the system impacts, we expect to evolve the model of delivering integrated care and change the model accordingly.

In order to enable robust evaluation of the integrated care programme, further work has been conducted in order to define a specific age group of patients, which could utilise the services within the programme.

Reviewing the last 3 years of emergency admissions, 86% of emergency admissions are for adults aged >18 years and 73% of adults admitted as an emergency, are aged 48 and above. The cohort for the evaluation of the integrated care programme has been defined on the average age of adult admissions (>48 years), which is 73 years old. It must be noted however that this age bracket is intended for measurement of indicators within the programme – the care and services which are proposed as part of the programme will not be specified based on the individuals age but rather on the basis of need.

### **A Rapid Response**

CSED in partnership with Bristol PCT and Bristol City Council originally published evidence demonstrating the efficacy of a rapid-response multi-disciplinary health and social care service.

Cost savings were calculated by comparing the cost of treatment in hospital against the cost of providing community-based service. In 2008/09 the service achieved savings for the PCT of £3.6 million. CSED also calculated the services achieves net savings for the social care system of £442,000

The above figures equate to a savings rate of £832,600 per 100,000 of the population

### **B Reablement and Intermediate Care**

- CSED has collated and developed evidence to show that homecare re-ablement has significant benefits both for people receiving a service and for councils.

A prospective longitudinal study commissioned by CSED and published in December 2010 found tangible evidence of improvements in outcomes, dependency levels and perceived quality of life.

- Impact of homecare re-ablement on social care outcomes – ‘significant short-term impact on outcomes was evident when we looked at social care outcomes for the whole cohort, both at an overall level and the individual domains’ – at follow up ‘statistically significantly better social care outcomes ... than people in the comparison group’
- Impact of homecare re-ablement on dependency levels – ‘changes occurring over time in the whole cohort suggest short-term improvements in activities of daily living after receiving a re-ablement service such as the ability to: get out of doors and walk down the road; wash face and hands; have a bath, shower or wash all over; get dressed and undressed; having control of the bladder’
- Impact of homecare re-ablement on perceived quality of life
  - ‘changes occurring over time in the whole cohort suggest a significant improvement in perceived quality of life after receiving re-ablement services’
  - at follow up ‘statistically significant better perceived quality of life ... compared to the comparison group’
- Impact of homecare re-ablement on perceived health-related quality of life – ‘re-ablement service had a significant impact on health-related quality of life among the whole sample, highlighting the positive impact this service has had on the lives of service users’.
- Care Services Efficiency Delivery (CSED): Homecare Re-ablement Toolkit \_ business case\_better service outcomes\_updated March 2011 2
  - Post re-ablement phase, service users were reporting fewer problems with mobility, self-care, usual activities, pain/discomfort, anxiety/depression and improvements in their general health.
  - at follow up, other than mobility, for which there was little change from baseline for 80% of people in both groups, in the re-ablement group, ‘there was a statistically significant improvement in health-related quality of life over the 12 months .... whilst there was no change in the comparison group’.
- Impact of homecare re-ablement on perceived health – changes occurring over time in the whole cohort suggest a significant short-term improvement in perceived health after receiving re-ablement services. At an individual level around a third of service users reported that their health had improved after receiving re-ablement services – at follow-up it would seem that this declined over time to a level similar to that within the comparison group whose level appears to have remained reasonably static over the period. For more information on evidence collated by CSED, see the final report of the Prospective Longitudinal Study.

High levels of customer satisfaction CSED has also collated and published a number of examples of council satisfaction surveys amongst people and their carers which show that the service is highly regarded. For more information, see Assessment Tools and Satisfaction Survey and Establishing an Effective Performance Management System for Homecare Re-ablement and System and Form Design. Increased independence and reduced demand for on-going homecare Homecare re-ablement complements the work of other 'restorative' services and actively promotes greater independence for people to help them remain at home. Evidence shows that where a homecare re-ablement service is mainstreamed and effectively implemented, it can reduce the demand for on-going homecare packages for many people, reducing the pressures on social care budgets. Work by the DeMontfort University from their evaluation of a service in Leicestershire County Council shows that:

- without a phase of homecare re-ablement, 5% no longer required a homecare package whilst 71% continued with an unchanged package.

Care Services Efficiency Delivery (CSED): Homecare Re-ablement Toolkit \_ business case\_better service outcomes\_updated March 2011

### **Specialist Dementia Home Care Service**

We have conducted our own local research in Derbyshire which has told us:

- People with dementia very often have a range of additional physical conditions and this was the case for the clients in this evaluation.
- Caring for a person who has dementia is on the whole more stressful than caring for people who have physical impairment alone. This is evidenced by the fact that carers in the SHCS group have reliably higher scores on the GHQ-12. Caring for a person with a physical impairment is stressful too, but not as stressful as caring for a person with dementia. The SHCS reduces carer stress significantly; 94% of carers interviewed have lower stress levels after the service has been implemented. Comparison Group clients also have lower stress levels at the end of service but the reduction is less marked. Stress level reductions were highly statistically significant.
- Better social care related quality of life outcomes were achieved for the SHCS Group after service provision, as measured by ASCOT. This again was also the case in the Comparison Group.
- The average number of hours and visits required by carers and clients in the specialist home care service does not reduce over the course of the service like it does for carers and clients of the Re-ablement service.

Out of 133 clients who used the service during the course of this evaluation, just 8 clients (6%) were admitted to an assessment bed. The majority of SHCS clients (46%) continued to be maintained by "mainstream" social care services. 38 clients (29%) did not require a further service.

20 clients were admitted to hospital but this was due to a medical condition and not for the reason of their dementia condition. The reasons for their admission ranged from falls (n=6), cancer in 5 cases, infection in 2 cases, with the remaining cases being for constipation, anaemia, infection, jaundice, stroke, accidental overdose and raised calcium.

Cases were evaluated for the main service "result": the largest single service achievement was the prevention of admission to long-term care (i.e. residential) for 44 of the 133 clients (33%). The next highest category is the enablement of the carer to continue caring for longer when they might otherwise have felt unable to continue: (n=29 / 22%). The remaining categories are broadly similar: Facilitating hospital discharge, 13%, increased independence,



13%, and Prevented hospital admission 12%.

#### Carer Feedback

Carers of clients of both types of service express high levels of satisfaction and relief from the receipt of the service. With specific regard to SHCS, the main themes emerging from carer and client feedback are the flexibility of the service is, how quickly it can be implemented in a time of potential crisis, and how approachable, knowledgeable and friendly the carers are.

Analysis of client activity logs showed that whilst Re-ablement is almost entirely focused on helping the client to re-establish independence for personal care tasks, SHCS is more focused on the client as an individual, and encompasses the provision of emotional support to the carer and the client, going as far as engaging them in reminiscence activity and hobbies.

#### Financial Considerations: / Cost Benefit Analysis

Figures for patients who are registered with North Derbyshire CCG and Hardwick CCG show the average unit cost of an admission to hospital for a person with dementia is £3,889 in total and the average length of stay of 19.7 days. This is a more expensive admission cost and a longer average length of stay than for non-dementia patients. If we make even a fairly conservative estimate and assume that 40 people were prevented from being admitted to hospital for an assessment, given that the operating costs for the service for the year are around £130,000, then there is an annual saving of £25,500. A significant proportion (30%) of the carer interviews reported that, had it not been for the timely and flexible intervention of the SHCS, the carer would have had little alternative but to cease caring with the likely outcome of an assessment bed hospital admission.

#### **2013-14 performance:**

- 82 new service recipients
- 74% discharged clients remained at home, 16% admitted to hospital, 2% to residential or nursing care, 2% to respite care;
- 35 recipients were prevented from admission to hospital, 7 were facilitated hospital discharge by service, 9 were prevented from going in to long term care.

#### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

#### **Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

All of the above schemes will have additional, non-financial benefits or non-measurable benefits. Outcomes include:

- Increased number of people who receive Wrap around MDT delivery of support and maintenance within the community setting from Nurses and Physiotherapists
- Rapid access to services

In order to enable robust evaluation of the integrated care programme, further work has been conducted in order to define a specific age group of patients which could utilise the services within the programme.

Reviewing the last 3 years of emergency admissions, 86% of emergency admissions are for adults aged >18 years and 73% of adults admitted as an emergency, are aged 48 and above. The cohort for the evaluation of the integrated care programme has been defined on

the average age of adult admissions (>48 years) which is 73 years old. It must be noted however that this age bracket is intended for measurement of indicators within the programme – the care and services which are proposed as part of the programme will not be specified based on the individuals age but rather on the basis of need.

The targets for 2014/15, indicated in the table below, are hypothesised based on the limited evidence available. These targets are specific to the scope of the programme until March 2015.

#### **Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The schemes form part of the South Unit of Planning and North Unit of Planning Transformation Programme and are monitored through the Programme's governance. The projects that make up this programme are managed via the individual CCG PMOs

#### **What are the key success factors for implementation of this scheme?**

- Information Sharing System level agreement on the framework, approaches and protocols for sharing patient information across all parts of the system
- Estates System wide coordination of opportunities and challenges relating to health and social care estate
- Workforce System level agreement on the approaches and mechanisms for enabling multi-agency working and team development both within the short term and medium to longer term
- Culture/OD Identify cultural / OD enablers that will help to foster stronger working relationships at all levels of organisations to deliver patient care
- Communications System wide plan for wider engagement and communications of the system plan and its implementation
- Finance and contracting financial planning to ensure delivery of the system plan - cross system and provider aligned. Alignment of contracting arrangements to enable the system changes.
- Clinical Governance Clinical and professional governance standards and processes to support integrated care

#### **Scheme ref no.**

3

#### **Scheme name**

**Reducing Admissions to Hospital and Care Homes and Delayed Discharges / Specific Components of Care**

#### **What is the strategic objective of this scheme?**

This scheme covers segment three of the "Care Wedge". The strategic objectives of this scheme is to:

- Reduce avoidable admissions to hospital
- Reduce avoidable admissions to care homes
- Reduce the number of delayed discharges

#### **Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme has a number of components which may be summarised as follows:

- a. Single point of contact/assess (SPA) and rapid response service** – aimed at those at risk of admission - supported by assessment staff and a range of community-based services, including GPs. The Voluntary Sector are also involved in assisting with access to their services (V-SPA). This is a 7 day service aimed at reducing the risk of readmission/admission to an in-patient setting or attendance at A&E by providing one point of contact that can co-ordinate care packages.

**Value: £976K**

- b. Additional Evening/Weekend Clinics – GP and APN** - Locality based access to primary care services building incrementally until patients have access to services 8 to 8 each day 5 days per week. Incremental increases to weekend arrangements to meet identified need (not necessarily full 8 to 8 unless patient demand identified.) This will benefit all patients improving the patients' primary care experience. Services will be initially tested in a single location with plans to have access for all Erewash patients from October 2014. This delivers access as close to "home" as possible.

**Value: £468K**

- c. Early support stroke discharge** - The most common transfer, and the most stressful to patients, is that from hospital inpatient care back to their home. Early Supportive Discharge (ESD) or stroke community services are based in patient's homes where support is provided during this transition and specialist rehabilitation is delivered within the first few days of discharge. 'Early supported Discharge teams are effective both in terms of clinical benefit and resource use and yet only 22% of trusts have one. One of the most common complaints of patients is that they feel abandoned when they leave hospital. The failure to provide specialist community stroke teams may be contributing to this perception' (National Sentinel Stroke Audit for 2006).

**Value: £543K**

- d. End of Life Care (palliative care consultant, hospice at home, night sitting)** – a range of services have been commissioned to support the delivery of high-quality end of life care and to enable people to die in their preferred place of care (*included in scheme 1 and 2 above*)

**e. Community Equipment / Specialist Equipment**

Derbyshire's population of older people will continue to significantly increase over the next 15 years. Currently there are 160,000 people aged 65 and over growing to 164,000 by 2015. Of those, 52,100 people aged 65 and over are unable to manage at least one self-care task without help (e.g. bathe, shower dress/undress, feed themselves, take medicine). Relatedly, 63,400 people of this age group are unable to manage at least one domestic task on their own (e.g. shopping, wash and dry their clothes, clean windows, deal with personal affairs). Some of the people in these groups can be "re-abled" with a short-term intensive service to help them gain independence and prevent a sudden decline into dependency. Specialist equipment provision is part of this scheme.

Providing support for more people in their homes and promoting their independence of more formal care will be supported by the provision of community equipment, including assistive technology. The current pooled budget is overspending by £2.0m, with a major contributing factor being the increased needs of people being discharged from hospital or living in the community. The introduction of 7 day working is also likely to increase demand for speedy equipment provision.

It is proposed to incorporate the existing pooled Community Equipment budget into the Better Care Fund and to invest in additional provision, including covering the current overspend. The current review of equipment provision will inform the organisational

<p>arrangements, including the re-procurement of the service.  <b>Value: £3.491m</b></p> <p><b>f. Primary Care Support to Care Homes:</b>  The North Unit of Planning CCGs have commissioned primary care to align practices to care homes and provide additional clinical input into care homes to ensure effective care plans are in place and implemented.  <b>Value: £750K</b></p> <p><b>g. Reducing premature mortality</b>  The North Unit of Planning CCGs have focused additional investment on areas of high need and significant causes of premature mortality. The early focus has been to invest in reducing deaths from heart failure and COPD/ respiratory, and has included additional heart failure nurses and additional pulmonary rehabilitation  <b>Value: £820K</b></p>
<p><b>The delivery chain</b>  Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>a. This service is commissioned by the CCGs and provided by Derbyshire Community Health Services and the Voluntary Sector  b. This service is commissioned by the CCGs and provided by DCHS  c. This service is commissioned by the CCGs and provided by DCHS &amp; Derby Hospital  d. This service is commissioned by jointly by North Derbyshire CCG &amp; Hardwick CCG and is provided by CRH and voluntary sector  e. This service is commissioned by CCGs and DCC and delivered by Medequip</p>
<p><b>The evidence base</b>  Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>Various evidence has been collated for this scheme and those under 2 and 3, for example:</p> <ul style="list-style-type: none"> <li>• United Healthcare – evidence from the USA; appointment of Optum to assist with the development of an Integrated Care approach</li> <li>• King's Fund – various</li> <li>• North West London approach</li> <li>• Torbay approach</li> </ul> <p>Community Equipment Services provides a range of equipment from simple aids for daily living to more complex pieces of equipment enabling people to stay in their home environment. Community Equipment Services provides equipment that plays a vital role in helping disabled people of all ages to develop their full potential and to maintain their health and independence. It facilitates hospital discharge with the provision of equipment e.g. beds, mattress systems, allowing people to be in a place of their choice. There have been a number of studies published over the years which have demonstrated the efficacy of the provision of simple aids and adaptations in reducing dependence on other people for help with personal care tasks (e.g. SPRU, University of York, 2000 Surveying outcomes of equipment and adaptations). In that study, one third of those who had received major adaptations reported that these had prevented deterioration in their quality of life, confirming the importance of maintenance as an outcome of social care.</p>

<b>Investment requirements</b>
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
<b>Impact of scheme</b>
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Many of the impacts will be measured e.g. reduced admissions, reduced A&E attendance, reduced readmissions etc. together with the financial impact. However, change to reflect same as others there will also be benefits such as: <ul style="list-style-type: none"> <li>• Easier and better co-ordinated care</li> <li>• Reduced burden on GPs i.e. one call will assist in arranging care</li> <li>• Patient satisfaction and quality of experience</li> <li>• Less time spent in hospital i.e. care in the right place</li> </ul>
<b>Feedback loop</b>
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The schemes form part of the South Unit of Planning and North Unit of Planning Transformation Programme and are monitored through the Programme's governance. The projects that make up this programme are managed via the individual CCG PMOs.
<b>What are the key success factors for implementation of this scheme?</b>
<ul style="list-style-type: none"> <li>• Information Sharing System level agreement on the framework, approaches and protocols for sharing patient information across all parts of the system</li> <li>• Estates System wide coordination of opportunities and challenges relating to health and social care estate</li> <li>• Workforce System level agreement on the approaches and mechanisms for enabling multi-agency working and team development both within the short term and medium to longer term</li> <li>• Culture/OD Identify cultural / OD enablers that will help to foster stronger working relationships at all levels of organisations to deliver patient care</li> <li>• Communications System wide plan for wider engagement and communications of the system plan and its implementation</li> <li>• Finance and contracting financial planning to ensure delivery of the system plan - cross system and provider aligned. Alignment of contracting arrangements to enable the system changes.</li> <li>• Clinical Governance Clinical and professional governance standards and processes to support integrated care.</li> </ul>

<b>Scheme ref no.</b>
4
<b>Scheme name</b>
<b>Enablers</b>
<b>What is the strategic objective of this scheme?</b>
<ul style="list-style-type: none"> <li>• To support the delivery of the BCF schemes</li> </ul>
<b>Overview of the scheme</b>
Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none"> <li>- What is the model of care and support?</li> <li>- Which patient cohorts are being targeted?</li> </ul>

**a. 7 day working is linked to the delivery of the schemes set out above**

The developments in Intermediate Care, Re-ablement and Rapid Response services will enhance the existing community based 7 day services. The provision of a stable and equitable response will also require additional services including:

- Enhanced community nursing services, particularly to support people living at home with long term conditions and associated needs
- Additional social worker and OT assessment time to respond to new referrals in extended daytime hours and at weekends. The referrals may involve hospital discharge or community based referrals.

**Value: £1.5m**

**b. Integrated workforce development delivery**

The development of the integrated care vision and local and national experience in delivering integrated care has highlighted the importance of a joined up workforce equipped to work in multi-disciplinary teams.

To achieve this will require a range of initiatives and our ambition includes to:

- Introduce generic care workers able to provide social and health care support
- Support multi-disciplinary local community teams to deliver integrated care
- Provide support for people with dementia based on a social model across health and social care services
- Support local service leaders to understand and deliver integrated care across organisations.

**Value: £3.062m (£2.562m current S256)**

**c. Information sharing across Health and Social Care (S256)**

Work is well advanced to improve information sharing between local health and social care services. This is based on providing reciprocal access to relevant organisations systems, within existing information governance policies. Investment to implement this, including its use of the NHS number as prime identification for patients, includes the provision of the necessary hardware, software and on-going support for users:

**Value: £685K**

**d. Administration and performance monitoring of the pooled Better Care Fund**

The introduction of the Better Care Fund as a pooled £57m budget in 2015/16 will require careful management and oversight. The pool partners include 5 local Clinical Commissioning Groups and the County Council, which will host the pooled budget. S256 funding will be used 2014/15 to prepare for the pooled budget and it is proposed to continue to fund a Pooled Budget manager from 2015/15 onwards. This will be supplemented by additional performance management requirements in relation to the specific BCF measures and the delivery of integrated care.

**Value: £701K (£523K S256)**

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Services will be commissioned as appropriate

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Keogh – 7 day working
- Integrated Workforce Development

- County – Wide Community Nursing Review
- Big project across county

### 7 Day Working

Surrey County Council Adult Care Services found that over a 6 month period between Oct 2012 and March 2013 over 360 avoidable admissions were prevented at a weekday evening or weekend, 43% of the total number over that period. In addition the number of days where patients were delayed in hospital because they were waiting for adult care support fell by over 50% during that time. Also complaints relating to supported hospital discharges fell by over 80% compared with the same time during the previous year. There was also a general sense of improved outcome for patients.

### Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Delivery of Better Care Fund schemes as set out above

### Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The enablers will either be monitored as part of the Better Care Fund governance or as part of the South Unit of Planning and North Unit of Planning Transformation Programme and are monitored through the Programme's governance. The projects that make up this programme are managed via the individual CCG PMOs.

### What are the key success factors for implementation of this scheme?

- Information Sharing System level agreement on the framework, approaches and protocols for sharing patient information across all parts of the system
- Estates System wide coordination of opportunities and challenges relating to health and social care estate
- Workforce System level agreement on the approaches and mechanisms for enabling multi-agency working and team development both within the short term and medium to longer term
- Culture/OD Identify cultural / OD enablers that will help to foster stronger working relationships at all levels of organisations to deliver patient care
- Communications System wide plan for wider engagement and communications of the system plan and its implementation
- Finance and contracting financial planning to ensure delivery of the system plan - cross system and provider aligned. Alignment of contracting arrangements to enable the system changes.
- Clinical Governance Clinical and professional governance standards and processes to support integrated care

<b>Scheme ref no.</b>
5
<b>Scheme name</b>
Care Act Implementation
<b>What is the strategic objective of this scheme?</b>
This scheme relates to the new duties resulting from the care and support reforms set out in the Care Act: National Conditions – 7 iv); and v) Carer specific support – see above.
<b>Overview of the scheme</b> Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none"> <li>- What is the model of care and support?</li> <li>- Which patient cohorts are being targeted?</li> </ul>
<p>£2.802 - is the current indicative Derbyshire 'Ready Reckoner' Care Act BCF implementation funding for the following areas of activity:</p> <ul style="list-style-type: none"> <li>• Carers</li> <li>• Information, advice and support</li> <li>• Safeguarding</li> <li>• Assessment and Eligibility</li> <li>• Veterans</li> <li>• Law Reform</li> <li>• Advocacy</li> <li>• Impact of DWP policies</li> <li>• Care Act capital investment</li> </ul> <p>The implementation of the Care Act in Derbyshire is being overseen through a formal project management approach. The Adult Care Portfolio Board is chaired by the Cabinet Member for Adult Care and includes all the members of the Adult Care Senior Management Team; there is a clear reporting structure for the Board. The responsibilities of the Board include our Integrated Care Programme and the Care Act Implementation Programme. In addition, a number of cross-cutting enablers have been identified; these have identified project leads for: workforce development, communication and informatics/ ICT.</p> <p>A dedicated Care Act programme coordinator is in post and leads have been identified for core thematic topics:</p> <ul style="list-style-type: none"> <li>• Prevention</li> <li>• Safeguarding, including the Adult Safeguarding Board</li> <li>• Information, Advice and Advocacy</li> <li>• Deferred Payments</li> <li>• Charging for Care</li> <li>• Ordinary Residence and Cross Border Placements</li> <li>• Care Markets, including market shaping and provider failure</li> <li>• Financial cost the Care Act implementation</li> <li>• Workforce Development, including briefing and training</li> <li>• Young People in Transition, including Support &amp; Aspiration</li> <li>• Housing, including DFGs</li> <li>• Carers' Assessments and Support</li> <li>• Support for Offenders</li> </ul> <p>The implementation programme is building on existing work, for example in relation to provider failure and market shaping. Scoping work was undertaken for all the themes, this has covered:</p>



1. The changes that will be required to policy, procedures and practice;
2. As far as possible, the numbers of clients affected by the changes;
3. The likely cost to Adult Care of the proposals in 2015/16 and the full year effect; and as required, for example, the financial cost of the Care Act implementation, further modelling has taken place.

Full use is being made of the regional and national support available to support the Care Act implementation.

Carer-specific resources has been identified from two sources within the Derbyshire BCF plan:

- c) The Care Act implementation allocation: £1.038m to:
  - I. Put carers on a par with users for assessment
  - II. Introduce a new duty to provide support for carers
- d) The NHS Funding for Carers element of the BCF: £1.962m

Current work is taking place to refresh the Derbyshire Carer's strategy; our intention is to use this as a framework to commission support for carers that, in addition to the implementation of the Care Act duties in relation to carers, will improve outcomes and achieve our local vision for integrated health and social care services – as set out in Section 2 above.

**Total Value: £12,148m:**

- **This is made up of £2.02m social care grant, £2.802m Care Act, £3.2m DFG & £4.126m existing equipment budget**

### **Payment for Results**

The amount included in the Better Care Fund (BCF) Contingency Fund for Derbyshire is £4.87m; see the Payment for Performance tab 5. in Part 2 of the plan. This has been calculated by using an indicative price for non-elective admissions of £1,490.

**Value: £4.87m**

### **The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Derbyshire County Council will commission the Care Act implementation and the carer-specific support. As set out above, the Derbyshire Carers' Strategy is currently undergoing a re-refresh and final decisions on the model of support will be made by April 2015.

### **The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The implementation of the Care Act will be based on national and regional guidance

### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

### **Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Derbyshire County Council has made extensive use of the national and regional modelling tools (for example, Surrey and Lincolnshire) to model the likely financial implications of

implementing the Care Act. In addition, the council is currently taking steps to prepare for funding reform, including: understanding likely demand, awareness-raising, capacity-building, and early assessments.

The Act introduces new duties on, or requirements of, local authorities in relation to:

- Duty to promote wellbeing and embedding individual wellbeing at the heart of all of care and support arrangements;
- Duty to prevent, reduce, and delay needs; with an enhanced focus on prevention; this is a universal duty and applies equally to those not receiving services and their carers;
- Duty to provide information and advice; that is also a universal duty, with tailored information and advice for specific groups;
- New duties to act in partnership with others and with a focus on integration with health;
- Duty to facilitate the local market – market shaping and managing provider failure;
- Strengthened rights for carers, including a duty to provide assessments;
- Duty to adhere to a new national eligibility system with a minimum threshold;
- Duty to provide an independent advocate where someone has substantial difficulty being involved in the process and there is no one to act on their behalf;
- The introduction of the cap on care costs and the extension to the financial limits – requiring an understanding of all self-funders;
- New deferred payments scheme;
- Duty to promote integration with NHS and other services (including housing);
- Duty to assess young people and their carers in advance of transition from children's to adult services, where they are likely to need care and support as an adult and where of significant benefit;
- Each local authority responsible for prisoners in custodial settings in its area; principle of equivalence with those in the community e.g. aids & adaptations applies;
- Enhanced safeguarding: new duty for local authority to carry out enquiries where risk of abuse or neglect and “financial abuse” is explicitly included in definition;
- Continuity of care: when someone moves area, the new local authority must provide information before the move, assess the person's needs, and then arrange to meet their needs on the day of arrival based on the previous care and support plan;
- Local authorities must keep a register of adults who are severely sight impaired and sight impaired in their area.

Overall, we anticipate:

A more comprehensive package for carers

More personalised care for clients and carers

A more diverse and heterogeneous provider-base at a more localised level

A better understanding of the care system by self-funders

A better understanding of self-funders by the care system

#### **Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A project management portfolio approach has been adopted; including a programme coordinator and identified leads for each of the thematic areas. A monthly Portfolio Board meets, chaired by the Cabinet Member for Adult Care, and receives highlight reports on progress and agreed KPIs. The Board is also responsible for the Integrated Care Programme and Budget Cuts Programme in Adult Care.


#### **What are the key success factors for implementation of this scheme?**

- Successful implementation of the Care Act
- To commission support for carers that, in addition to the implementation of the Care Act duties in relation to carers, will improve outcomes for them. The re-refresh of the Carer's Strategy will include an action plan with identified outcome and output measures. These

will be regularly reported to the Carers' Joint Commissioning Board, which includes carers and carer organisations and to the Adult Care Board – see Governance Structure Section 4) *PLAN OF ACTION*

## ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

<b>Name of Health &amp; Wellbeing Board</b>	Derbyshire
<b>Name of Provider organisation</b>	East Midlands Ambulance Service
<b>Name of Provider CEO</b>	Sue Noyes
<b>Signature (electronic or typed)</b>	 19/9/2014

For HWB to populate:

<b>Total number of non-elective FFCs in general &amp; acute</b>	<b>2013/14 Outturn</b>	93895
	<b>2014/15 Plan</b>	92,504
	<b>2015/16 Plan</b>	89,952
	<b>14/15 Change compared to 13/14 outturn (*)</b>	-2%
	<b>15/16 Change compared to planned 14/15 outturn (*)</b>	-3%
	<b>How many non-elective admissions is the BCF planned to prevent in 14-15?</b>	835 (This is in the BCF for Quarter 4 14/15)
	<b>How many non-elective admissions is the BCF planned to prevent in 15-16?</b>	2432 (This is in the BCF for Quarter 1-3 15/16)

(\*) Please note that the figures above do not match part 2 of the BCF template due to annex 2 requiring financial year periods. Part 2 of the BCF template requires calendar year periods.

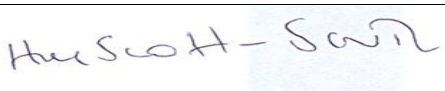
For Provider to populate:

	Question	Response
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1.	<b>Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?</b>	Yes
2.	<b>If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?</b>	N/A
3.	<b>Can you confirm that you have considered the resultant implications on services provided by your organisation</b>	<p>EMAS worked with commissioners in the East Midlands during 2013/14, to produce detailed commissioning intentions for 2014/15. The strategic direction is informed by national guidance published in 2013 on urgent and emergency care; the most recent being Keogh (November 2013).</p> <p>The strategic headline within the document is how EMAS moves to act as the coordinating NHS organisation at the centre of the urgent and emergency care system, either providing care directly or signposting/referring patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.</p> <p>Several schemes that have been developed over the years are in place to support this: enhanced clinical support within the Emergency Operations Centre (EOC); GP acute visiting service; falls teams; and care home projects. To further incentivise the continued reduction in conveyance to emergency departments, commissioners included a £1m CQUIN scheme within the contract for 2014/15.</p> <p>Within the commissioning intentions, is an intention for the lead commissioner and EMAS to work with CCGs and Health and Well Being Boards in support of the Better Care Fund (BCF) to support delivery of the aims and objectives.</p>

**ANNEX 2 – Provider commentary**

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

<b>Name of Health &amp; Wellbeing Board</b>	Derbyshire County
<b>Name of Provider organisation</b>	Derby Hospitals NHS Foundation Trust
<b>Name of Provider CEO</b>	Sue James
<b>Signature (electronic or typed)</b>	pp 

For HWB to populate:

<b>Total number of non-elective FFCes in general &amp; acute</b>	<b>2013/14 Outturn</b>	93,895
	<b>2014/15 Plan</b>	92,504
	<b>2015/16 Plan</b>	89,952
	<b>14/15 Change compared to 13/14 outturn</b>	-2%
	<b>15/16 Change compared to planned 14/15 outturn</b>	-3%
	<b>How many non-elective admissions is the BCF planned to prevent in 14-15?</b>	835 (this is the BCF for Quarter 4 14/15)
	<b>How many non-elective admissions is the BCF planned to prevent in 15-16?</b>	2432 (this is the BCF for Quarter 1-3 15/16)

(\*) please note that the figures do not match part 2 of the BCF template due to annex 2 requiring financial periods. Part 2 of the BCF template requires calendar periods


For Provider to populate:

	<b>Question</b>	<b>Response</b>
1.	<b>Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?</b>	The BCF strategy for Derbyshire county describes an approach that resonates with the Trust's vision of integrated care in an out of hospital setting. It is important that the modelling takes account of demographic growth and changes in non- elective flows such as vascular surgery and hyper acute stroke. DHFT is fully committed to work collaboratively to develop the detailed plans to deliver the BCF strategy
2.	<b>If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?</b>	

3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	No
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## ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

<b>Name of Health &amp; Wellbeing Board</b>	Derbyshire
<b>Name of Provider organisation</b>	Chesterfield Royal Hospital NHS Foundation Trust
<b>Name of Provider CEO</b>	Gavin Boyle
<b>Signature (electronic or typed)</b>	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	<b>2013/14 Outturn</b>	93,895
	<b>2014/15 Plan</b>	92,504
	<b>2015/16 Plan</b>	89,952
	<b>14/15 Change compared to 13/14 outturn (*)</b>	-2%
	<b>15/16 Change compared to planned 14/15 outturn (*)</b>	-3%
	<b>How many non-elective admissions is the BCF planned to prevent in 14-15?</b>	835 (This is in the BCF for Quarter 4 14/15)
	<b>How many non-elective admissions is the BCF planned to prevent in 15-16?</b>	2432 (This is in the BCF for Quarter 1-3 15/16)

(\*) Please note that the figures above do not match part 2 of the BCF template due to annex 2 requiring financial year periods. Part 2 of the BCF template requires calendar year periods.

**For Provider to populate:**

	<b>Question</b>	<b>Response</b>
1.	<b>Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?</b>	The Trust has been working with our Lead Commissioner, the 21st Century Board and the HWB on the development of the BCF proposal and understands that the above activity has been collated for the whole of Derbyshire. These activity levels are based on assumptions about demand and the impact of admission reduction plans for the whole county. It must be understood that there is a degree of risk in calculating these numbers. The Trust will work with the Lead Commissioner to understand what proportion of this total activity relates specifically to this Trust.
2.	<b>If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?</b>	
3.	<b>Can you confirm that you have considered the resultant implications on services provided by your organisation?</b>	As described above the Trust will work with the Lead Commissioner to understand the direct impact on this Trust, as yet this work has not been concluded. As part of the North Derbyshire Unit of Planning work, schemes have been discussed which will have some impact on non-elective admissions and although the precise impact is not yet known the Trust has begun to implement plans to reduce inpatient capacity and is developing strategies within the wider health community to mitigate the effects of vacant capacity within the acute trust in the longer term.