The Derbyshire Better Care Fund:

2016/17 Refresh

DERBYSHIRE County Council
Improving life for local people

JoinedUpCare

NHS
Tameside and Glossop
Clinical Commissioning Group

NHS
Erewash Clinical Commissioning Group

NHS
North Derbyshire
Clinical Commissioning Group

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Hardwick Clinical Commissioning Group

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NHS
Southern Derbyshire
Clinical Commissioning Group

APPROVED BY HEALTH AND WELLBEING BOARD 12 MAY 2016

Foreword

This document is a narrative plan outlining the way in which the Derbyshire Better Care Fund (BCF) will operate in 2016/17 against a backdrop of wider health and social care system transformation. This plan affords an opportunity to reflect on what has been learnt and achieved during 2015/16, whilst looking ahead to the challenges in 2016/17 and beyond.

This plan aims to build on the original2015/16 plan and has, therefore, made minimal changes. Those changes that have been made have been done with the following intentions:

- To provide a clearer description of what the BCF is funding;
- To align the Derbyshire and Derby City BCF plans;
- To align the BCF plans with the wider system transformation.

The overarching Vision and aim of the BCF in 2016/17 remain unchanged from the 2015/16 plan:

Our vision for 2019/20:
"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together the services which will achieve the outcomes important to me."

Achieved through:

Focussing 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 2019/20 we want to place the local person at the centre of our actions:

Summary of Pooled Budget

Health & Wellbeing Funding Sources	
Total Local Authority Contribution	£7,337,721
Total Minimum CCG Contribution	£52,485,930
Total Additional CCG Contribution	£5,167,508
Total BCF pooled budget for 2016-17	**£64,991,159**

Summary of BCF Expenditure	
Acute	£1,306,945
Mental Health	£2,401,430
Community Health	£19,105,113
Primary Care	£1,549,000
Social Care (*Inc. Reablement* *Carers' Breaks* *Care Act*)	£38,689,508 (*£4,075,000* *£1,629,000* *£2,058,272*)
Other	£1,939,163
Total	**£64,991,159**

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool	
Mental Health	£2,401,430
Community Health	£16,206,605
Primary Care	£1,549,000
Social Care	£2,390,170
Other	£1,689,163
Total	**£24,236,368**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share	
Local share of ring-fenced funding	£14,915,013
Total value of NHS commissioned out of hospital services spend from minimum pool	£24,236,368
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£9,321,355**

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Introduction and Background

Introduction to our Local Health and Care Economy

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 implications for health and wellbeing services and future planning. Generally over the last 10 years the rates of death from all causes and the rates of death from cancer and heart disease and stroke have all improved and are close to the average for England; and on average the health and prosperity of residents is as good as anywhere else, or even a little better. However, there are very significant variations between the most and least deprived areas of Derbyshire and these are reflected in a range of statistics around health outcomes: People in the least deprived areas can expect to live 10 or more years longer than their fellows in the most deprived areas and to be in good health for many more of those years too.

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

In summary the key issues for Derbyshire are:

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

- BCF 2015/16 Part 1
- JSNA
- Derbyshire Health and Wellbeing Board Strategy 2015-2017
- Derbyshire Older People Market Position Statement 2015
- Derbyshire Learning Disability Market Position Statement 2015
- Joined Up Care Board Change Plan (South)
- 21st Century Plan (North)

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

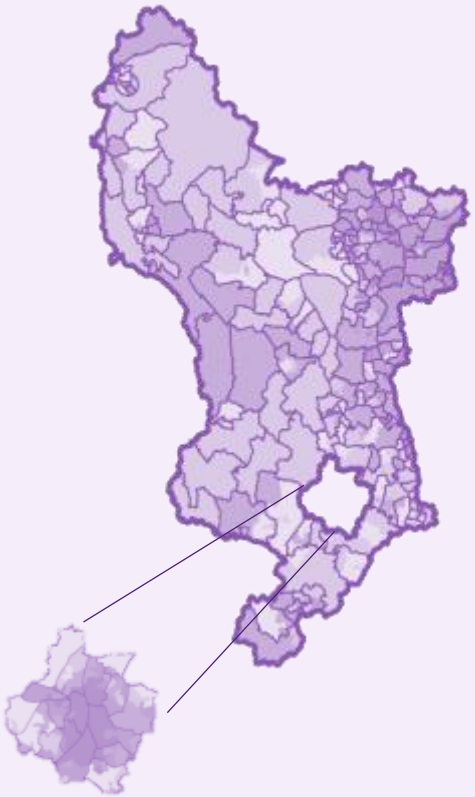
Derbyshire Health Profile

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

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

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

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



Source: Derby City and Derbyshire County 2014 Public Health Profiles

Review of 2015-16

In preparation for the 2016/17 BCF planning round the Programme Board undertook a self assessment using the tool developed by the national Better Care Fund Support Team. A full review against the six domains was undertaken with resultant actions being put in place for 2016/17. Against the domains the results were as follows:

Domain	Green	Amber	Red	Comments
1. Leading and managing a successful Better Care Implementation	3	3	0	Relationships and partnership working is good although there is some room for better communications of the message to other partner organisations.
2. Delivering excellent on-the-ground care around the person	2	4	3	Care co-ordination is embedded throughout. However, there remains work on development of Local Area Coordinators in the widest sense. There is also need for more work on the Summary Care Record.
3. Develop underpinning, integrated datasets and information systems	0	2	3	Whilst a lot of progress has been made, and this is a focus of the two main transformation programmes, it is acknowledged that more work is needed to achieve full integration.
4. Aligning systems and sharing risks and benefits	5	5	0	The Finance and Performance Sub-Group have made a lot of progress and this will provide a firm foundation for 2016/17
5. Measuring Success	7	6	1	Good work to-date but needs further development
6. Developing organisations to enable effective health and social care working relationships	1	11	2	Good relationships and partnership working are providing the basis for 2016/17. Work in developing the Sustainable Transformation Plan will allow this to be developed further.

Review of 2015-16 (Continued)

The self assessment tool provided the catalyst for reviewing the various schemes and lessons learnt during 2015/16. The BCF Programme Board reviewed the vision and outcomes required within both the North and South Transformation plans, linking these to the future integration agenda and emerging themes from the Sustainable Transformation Programme (STP). In summary the following key themes emerged:

2015/16 was a year of learning and developing:

- Consistency in leadership and our mutual decision making over the last 18 months – building and strengthening existing relationships
- Finance and performance – learning 'the rules' and working to understand how we demonstrate the impact of changes through metrics
- Understanding the actual and potential foundations for pooling budgets at scale – we have a Section 75 that works and we can build on.

Some operational successes:

- Equipment Services – new posts to clinically challenge decisions have reduced variation resulting in £310,725 savings in first six months
- Community Teams have developed at pace
- Greater support from social care within acute hospitals to assist discharge and ensure a joined up approach with community services
- Investments in Autism services have meant waiting lists will be reduced and further work can be done on developing the future model
- Workforce – investment in Advanced Clinical Practitioner training will assist 24/7 access to services.

Areas of learning and development:

- There was a need to disinvest or remove projects from the BCF that did not sufficiently contribute to the overall aims and objectives of the BCF Plan.
- There needed to be a more 'theme based' approach to schemes.
- Agreement to the continuation of existing spend for Carers, Integrated Community Equipment Services (ICES), Dementia and Autism.
- New area to be included would be wheelchairs
- Schemes for 2016/17 would be based around the individual i.e. wrap around services. Six schemes were identified:
    1. Enabling Self-Care
    2. Social Capital / Community Development
    3. Proactive Management of Care
    4. Reactive Integrated Care Services
    5. Diagnostic and Assessment Services
    6. Enablers / Infrastructure

Review of 2015/16 (Continued)

Performance in 2015/16

Metric	Trajectory	Status (Quarter 3 2015/16)
	↓	On track to meet year end reduction of 3.5% in Non-Elective Admissions
	↑	On track to surpass target of 82.5% of people still at home 91 days after reablement period.
	↓	On track to substantially reduce number of bed-days lost to delayed transfers of care.
	↓	On track to reduce number of admissions to residential/nursing settings but unlikely to achieve target
	↑	On track to increase the rate of dementia diagnosis in line with prevalence rates (currently 69.9%, target 68%)
	↑	Achieved target – 70% of respondents to GP survey felt they had enough support from local services/organisations to manage their long-term condition (target was 66%).

New National Conditions for 2016/17

In developing plans for 2016/17 both delayed transfers of care (DToC) and the commissioning of out of hospital services have been central to our thinking. The STP will develop the place-based concept and will have community teams linked to populations and their specific needs. Plans to reduce emergency admissions and to reduce lengths of stay will be critical in achieving a sustainable health and social care economy. Plans for DToC are in place although require review, this is currently happening and is being overseen both at BCF Programme Board level and at transformation delivery groups and the System Resilience Group.

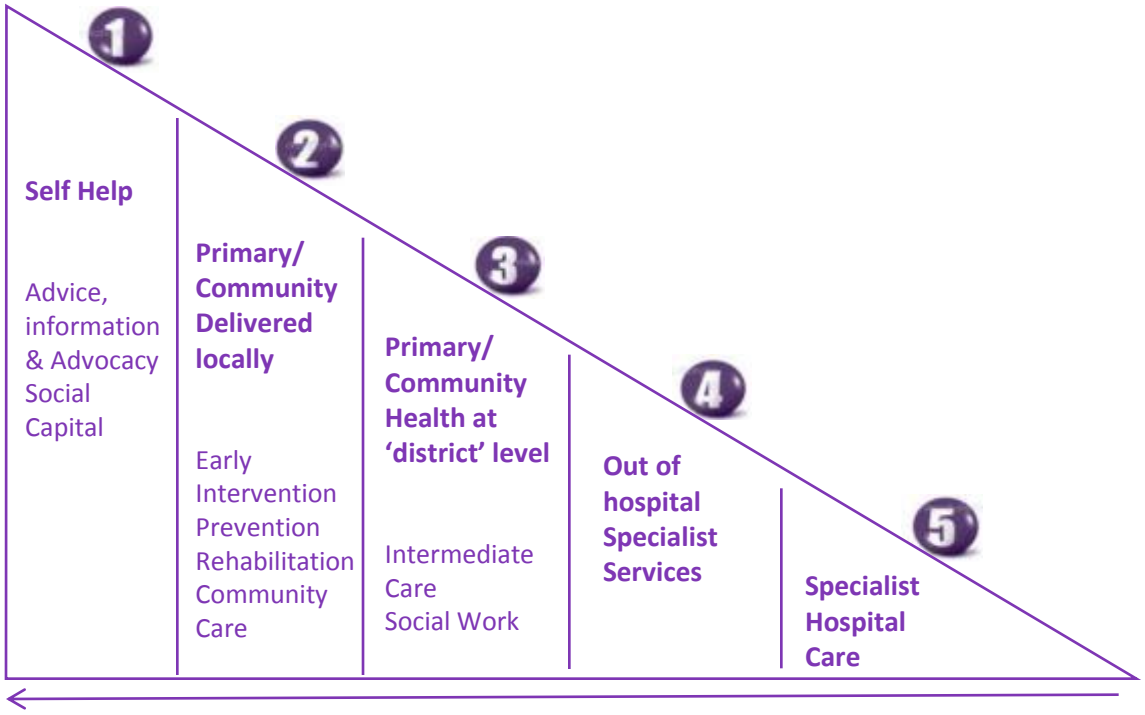
Our Vision for Integration

The Strategic Direction: The Wedge

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

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

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



Examples of what the transformation will mean for our citizens

Samantha, 15 years old, is being bullied at school

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

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

BEFORE	Samantha has tried to take her own life by jumping from a bridge. She has been admitted to hospital with multiple injuries. The clinicians are taking excellent care of her; focussing on her immediate medical needs. Samantha's family are fearful that she will try to commit suicide again and succeed.	Jo has been admitted to hospital after breaking both her legs in a minor fall. Jo is a full time carer to her son who has a mental health condition and is an alcoholic. Despite the support from her case worker, she is unable to be discharged to her home because it is not deemed safe.	Bob is on the Palliative Care Register with a Right Care Plan. He is being well cared for, but there is a long wait for the equipment he needs to enable him to stay at home. His condition is deteriorating and he is repeatedly being admitted to hospital. Bob is anxious about potentially dying in hospital.
AFTER	Samantha has thought about committing suicide. She has access to an online counselling service via her mobile phone and tablet which enables her to easily obtain confidential and professional support and guidance. Samantha feels safer and is empowered to make positive choices about her future; she no longer contemplates committing suicide.	Jo has been admitted to hospital. She is a full time carer to her son who has a mental health condition and is an alcoholic. The community team coordinate all the agencies to produce packages of care for both herself and her son. Jo is able to focus on her own health needs and be discharged safely to her home.	The community team has coordinated Bob's health and social care needs. He does not visit the hospital for routine appointments; care is delivered in his own home. Equipment is delivered on the same day as the assessment, whilst Telehealth enables healthcare professionals to remotely monitor his vital signs. Bob feels assured and more in control.

Derbyshire (including Derby City) Wide Planning

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

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

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

The STP, which will include the BCF, is being developed with, and based on the needs of, local citizens and communities . Clinicians, professionals, staff and wider partners will be central to the development of the STP.

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

Workforce

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

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

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

Our Vision for Integration
Workforce (Continued)

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

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

Evidence Base to Support Change

Understanding our populations

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

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

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

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

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

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

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

Delivering the Changes

Learning from 2015/16

Moving from individual schemes …..

1 Self-help, Prevention and Community Resilience/ Proactive Intervention and Support	2 Integrated Community-based Support/Integrated Episodes of Care	3 Reducing Admissions to Hospital and Care Homes and Delayed Discharges/Specific Components of Care	4 Enablers	5 Care Act Implementation
• Telecare • Support self-care (Stroke) • Supporting People with Dementia • Day opportunities for PWLD • Falls Recovery • Falls Prevention • Carers • Autism • Dementia Support • Welcome Home Scheme • Sitting Service	• Parity of Esteem • Delayed Transfers of Care • Memory Assessment Service • Chesterfield Royal Acute Reablement & Pull Teams • RAID • Pulmonary Rehabilitation • Reablement & Intermediate Care • Community Support Teams • Integrated Care Team • CHHECT • GP Over 75s	• SPA • Early Supported Stroke Discharge • Primary Care Support to Care Homes • Reducing Premature Mortality • Integrated Community Equipment Service	• Integrated workforce development • Administration and performance • Information sharing • 7 Day Working • Expansion of RISC • Patient Feedback • Infrastructure developments	• Care Act implementation • Social Care grant • Disabled Facilities Grant • Payment for Performance
£7.49m	£25.58m	£9.67m	£5.86m	£12.89m

Total Pooled Budget: £61.489m

Learning from 2015/16 (Continued)

To themes which allow better performance monitoring and are more aligned to integrated care….

1 Enabling Self-Care	2 Social Capital / Community Development	3 Proactive Management of Care	4 Reactive Integrated Care Services	5 Diagnostic and Assessment Services	6 Enablers / Infrastructure
Initiatives in place that enable people to take more control of their lives in their normal place of residence. E.G. Derbyshire Dementia Support Service	Initiatives that enable people to build their own care solutions in their community. E.G. Carers support services, VSPA	Initiatives to proactively identify and manage people at risk of admission to hospital settings. E.G. Community Support Teams, Care Home Support (Health)	Initiatives to support the flow through the system and to prevent readmissions and permanent admissions to care settings. E.G. Community IV Service	Services that are provided at a scale above local teams. E.G. Mental Health Enablement and Community Crisis Response, Mental Health Liaison, Parity of Esteem	Supporting mechanisms E.G. Data Sharing / Information Governance, Dignity Campaign, BCF & Transforming Care Programme Management
£17.669m	£2.257m	£7.726m	£28.811m	£4.613m	£3.913m

Total Pooled Budget: £64,991,159 minimum contribution is £52,485,930.

Additional CCG's contribution is £5,167,508 mainly for integrated equipment services and wheelchairs

Additional Local Authority contribution is £7,337,721 for integrated equipment service and Disabled Facilities Grant

Looking ahead to 2016/17

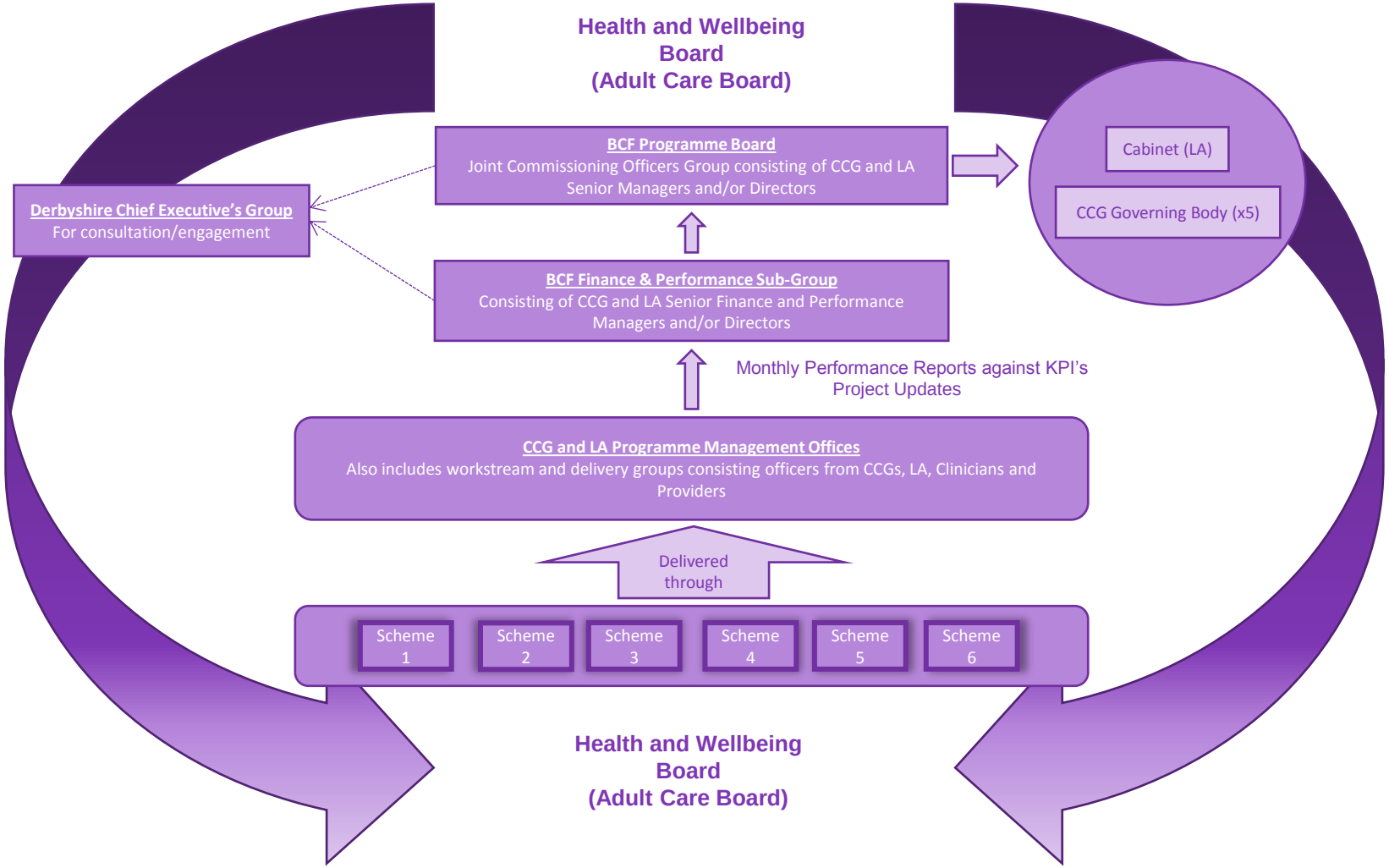
As part of the BCF 2016/17 planning process, the BCF Programme Board identified new and/or additional areas of expenditure that could be included. A set of principles for identifying new services to be aligned to a pooled budget was agreed to ensure that all service funding was appropriate to the aims and vision of the BCF.

Areas which were considered for inclusion, and those for further development from 2015/16 were:

- Wheelchairs - it is envisaged that similar efficiencies can be made with this service by adopting lessons learnt from the successes of the revised Integrated Community Equipment Service. This is in addition to exploring PHBs for wheelchairs etc.
- Disabled Facilities Grants (DFGs) – work will be undertaken to ensure that the systems in place for referring, processing and delivering DFGs are operating effectively. Additional work will also be undertaken to look at identifying efficiencies in the access and delivery of services aimed at keeping people in the community for as long as possible i.e. Assistive Technology, DFGs, Wheelchairs, and Community Equipment.
- Services for Carers will be funded at same level for 2016/17 as in 2015/16, with a review of commissioned activity to take place during the year (which links to a Countywide review of Voluntary and Community Sector funding across the health and social care system).
- Local Area Co-ordination in Derby City has been evaluated by the University of Warwick and yields a 4:1 social return on investment. This is making a difference to self-management and a new service will be rolled out in Amber Valley during 2016/17.
- Dementia Support will become a complete care pathway from Diagnosing Well, to Living Well to Dying Well that supports carers within the home.
- Development of more integrated social care teams as a result of “breaking the cycle” system analysis.

BCF Governance

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



BCF Metrics and Risk Management

Metrics

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

The FPSG also track expenditure on a monthly basis and make recommendations to the Programme Board for any over/underspends. This ensures that the rules of the S75 agreement are adhered too, particularly at year end.
Minutes of the meetings and copies of the dashboard are available.

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

Risk Management

The risks were identified in the original BCF 2015/16 Plan (Section 5). Risks of individual schemes are reviewed by the appropriate PMO or Delivery Board. Overall scheme risks are reviewed by the BCF Programme Board. However, we recognise that this is an area for development and that risk management has been more emergent that robust and structured. For 2016/17 we need to ensure that risks are regularly monitored. One risk identified is the lack of clear and consistent messages to partner organisations and staff on the impact of the BCF. This will be an action point with regular communication, updated websites etc.

Risk Sharing (See also page 35)

It was agreed in 2015/16 that there would be no risk-sharing agreements put in place in relation to the BCF (as detailed in Section 75 agreement). Instead management of risk, as outlined above, is the responsibility of the relevant lead commissioner(s). The situation will remain the same in 2016/17. Consideration for risk sharing in respect of Delayed Transfer of Care (DToC) has been considered but not actioned due to the contracting arrangements now in place with providers and a wider analysis of DToCs to inform the local DToC plan

BCF High Level Risks 2016/17

Risk	Mitigation	Current Rating (16+)
Strong System Leadership and whole system thinking is not evident.	• Chief Executives Group (including Strategic Directors from LA) are working with EMLA to review principles of working together, behaviours, hopes, fears etc • On-going OD will take place to support system leaders • Clear messages and a direction of travel will be communicated via the STP process and the Leadership Group	
Social Care cuts affect delivery of targets and ability to fund preventive services.	• 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	
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 and in-line with the STP	• A move towards place-based systems and capitated budgets • As part of the current transformation programmes and the STP there is on-going work by Directors of Finance to take a 'whole system approach' • Work continues with national bodies – Monitor, NHSE etc. • Assessing the impact of a move to block contracts and clear, open book risk share agreements	
The time lag and lack of funding to train and develop new staff and implications on existing workforce to have the skills required to deliver the new community based models of care e.g. Advanced Clinical Practitioners, Care Workers etc	• Developing workforce requirements and working with HEEM to establish training needs • Work has taken place to quantify the scale of the challenge and the financial implications • Workforce plan has been developed • Better Care Fund Programme Board approved additional funding for Advanced Clinical Practitioner training - £250K across the county • System of support programmes for teams during times of change in order to assist staff and develop an environment for cultural changes to take place. • Development of an academy for Care Workers – developing a career pathway	
Impact on the Voluntary and Community Sector has not been fully scoped.	• A Derbyshire wide review of the VS has taken place • Contracts will ensure that KPI's are in-line with BCF and STP outcomes • Assessment of impact is carried out jointly between health and social care	

Progress so Far

Successes and Audits

Successes are outlined on **pages 7-9**. These were presented to the County Health and Well Being Board on Thursday 10th March 2016.

Throughout the year a key area that has shown progress although still is not meeting the target is the reduction of permanent admission to nursing and residential homes. During quarter two the fact that we were not meeting the target was highlighted and an audit was undertaken , this included:

- Contacting North Yorkshire as a comparator to see how they are keeping residential admissions low. Their response was that they have increased the number of Extra Care places, which do not show as an admission.
- Discussions also took place with Northamptonshire County Council.
- Meetings took place with colleagues from both DCC and SDCCG to complete the audit. Representation from the North Unit of planning was requested.
- A desktop audit of 12 representative cases. Some useful learning points were found. These have been acted upon.

The BCF programme as a whole is part of an on-going audit.

Key Challenges

The Challenges Faced in 2016/17

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

- Impact of the CSR – local authorities, nurse training etc.
- Financial pressures on local authorities and the potential impact on cuts to the voluntary sector whilst meeting service demands and Care Act 2014 requirements.
- The emerging STP and what this will mean for service redesign, organisational form, citizens and staff
- Alignment of city/county BCF plans
- Ensuring that everyone has a common understanding of what place based care includes and does not include
- Understanding the data (health needs, activity, patient surveys, etc.) at the place based level, but also work with individuals to understand the outcomes and services that **matter to them** – they may tell different stories
- Transforming primary care at pace and scale
- Support local teams need to work across their traditional boundaries – joint messages from organisations, assurance that funding flows will be sorted, clarity as to what is expected to be delivered by place based care
- Workforce issues – skill gaps, recruitment issues and the need to work in different ways
- System leadership – the need for whole system thinking and not a 'fortress mentality'
- Move to different ways of contracting and the changing role of commissioners i.e. from the detail to the strategic overview
- The scale and pace at which changes are required
- Capacity within the system to make changes

National Conditions Update

Review of National Conditions

Position Update

National Condition	Update	Actions for 2016/17
Plans to be jointly agreed	• Plans have been developed and agreed by all parties • The BCF minimum spending level is agreed • An additional £5.2m has been added for integrated equipment (existing) and wheelchairs (new) • All stakeholders involved • The BCF is an integral part of the STP • Workforce issues are covered by the Workforce Enabler Group as part of system transformation	• Look at further areas for future pooled budgets e.g. continuing healthcare • Continue to engage with stakeholders as the STP emerges • Continue to work closely with workforce group – quarterly updates as a minimum
Maintain provision of social care services	• All conditions met • All demonstrated within templates • Carer support included	• Demographic information looks at population need for all services • Place based systems will include social care
7 day services	• Plans are in place for 7 day services – links to UECN and SRG • Most services already available 7 days although there remains an inconsistent approach across the city/county • Transformation plans include details of 7 day services related to specific areas of work.	• Work towards equity across the city/county • Continue work with NHSE on implementing 7 day services and clinical standards.
Better data sharing	• Derbyshire work well together with a clear vision. • The two Derbyshire Units of Planning can make it difficult to align projects and this can make measurement and comparison difficult. • Informatics Enabler Group to support the two transformation programmes of which the BCF is a part. • IG work stream which has made significant progress. • The technical issues appear to be overcome and the MIG will assist • Cultural and IG issues remain the main problem.	• Continue work on IG issues via the transformation programme enabler group. • Develop a clear county wide data sharing strategy and communications plan. • Continue work on solving cultural issues related to data sharing. • Continue development of NHS Number as identifier in systems.

Position Update (Continued)

National Condition	Update	Actions for 2016/17
Ensure a joint approach to assessments and care planning – accountable professional	• The 2015/16 submission provides the detail of named accountable professionals.	• Continue to progress this area as we move towards place based systems
Agreement on the consequential impact of the changes on providers that are predicted to be substantially affected by plans	• All providers were party to the original submission • Modelling work has taken place as part of the main transformation programmes • Providers are integral to the work of project groups • Finance Enabler Group is assessing impact on all providers with representation from all Directors of Finance	• Move towards capitated budgets • Different contracting methods and risk sharing agreements • System wide agreement to changes via the STP
Agreement to invest in NHS out of hospital services (including social care)	• Community teams are a key area of expenditure • Reablement and intermediate care are included • Both pro-active and reactive services included • All service redesign underpinned by modelling and review of demographic needs	• Further develop co-located and integrated teams • Increase the level of pro-active community care • Move further work into the community as appropriate
Agreement to local action plan to reduce DTOC's	• Separate Local Plan has been developed to address this condition.	• Implement local plan including effective monitoring of relevant BCF work to reduce Delayed Transfers of Care. • System target to keep total days delayed as a percentage of total occupied days at 3.5%.

Review of Metrics

2016/17 Metric Targets

A review of 2015/16 performance was provided at slides 6-8. Additionally, in setting new targets for the metrics in 2016/17 the BCF Programme Board have done so based on forecasting of year-end performance continuing into 2016/17. Target for NEAs were not required to be set by HWBs in 2016/17.

Residential Admissions

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	835.5	664.9	754.5	**737.8**
	Numerator	1,332	1,090	1237	**1237**
	Denominator	159,435	163,944	163,944	**167,670**

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

Reablement

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	87.1%	82.5%	85.3%	**85.3%**
	Numerator	385	198	390	**390**
	Denominator	440	240	457	**457**

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

Delayed Transfers of Care

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Annual rate	985.9	966.4	714.0	710.1
	Numerator	6,173	6,088	4,500	4,493
	Denominator	626,117	629,946	629,946	632,781

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

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

2016/17 Metric Targets (Continued)

Dementia Diagnosis

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

Locally determined metric continuing for 2016/17. Target based on CCG operational plans.

Patient Experience

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

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

Financial Risk

Risk sharing agreements

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

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

2016/17 – creating a financially sustainable system

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

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

This approach would include:

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

Approval and Sign-Off

Timeline

The final sign-off and approvals process for the BCF Plan 2016/17 was:

- 10 March 2016 – Narrative Plan Summary presented to the Health and Wellbeing Board to provide assurance of planning and timescales to be achieved.
- 15 April 2016 – Final Draft of Narrative, Delayed Transfer of Care, and Expenditure Plans approved by the BCF Programme Board
- 27 April 2016 – Final Expenditure Plan Submitted to NHS England and National Better care Support Team with Narrative and DToC Plans submitted to Regional BCF Assurance Team
- 12 May 2016 – All Final Plans approved by Health and Wellbeing Board
- Section 75 agreement to be refreshed in line with updated plan and signed by responsible persons prior to 30th June 2016 deadline.

All planning for the Derbyshire BCF 2016/17 has been undertaken in conjunction with wider NHS planning.

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