# Derbyshire Better Care Fund 2017-2019 Narrative Plan

# Foreword

This narrative plan outlines the way in which the Derbyshire Better Care Fund (BCF) will operate during 2017 through to 2019. It builds on the 2015-16 and 2016-17 plans whilst reflecting the changes required to ensure that the health and social care system can continue to deliver services to meet the needs of the local population as detailed in the Derbyshire Sustainability and Transformation Plan (STP).

The overarching Vision and aim of the BCF for 2017-19 remains unchanged from the original 2015-16 plan and is mirrored by the changes proposed through the Derbyshire STP.

**Our vision for 2020:**

*"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

**NB:** **The BCF Planning Documentation was approved by the Derbyshire Health and Wellbeing Board at its meeting on 30 August 2017 (Minute Reference 48/17)**

# Summary of Pooled Budget

| Health & Wellbeing Funding Sources | | |
|---|---|---|
| | 2017-18 | 2018-19 |
| Total Local Authority Contribution (exc. iBCF) | £8,200,542 | £7,950,787 |
| Total iBCF Contribution | £18,218,693 | £24,906,166 |
| Total Minimum CCG Contribution | £53,425,428 | £54,440,511 |
| Total Additional CCG Contribution | £8,931,831 | £8,260,077 |
| **Total BCF pooled budget** | **£88,776,495** | **£95,557,542** |

| Summary of iBCF Spend | | |
|---|---|---|
| | 2017-18 | 2018-19 |
| Supporting the Care Market | £8,210,768 | £7,937,693 |
| Reducing Pressure on the NHS | £3,930,765 | £5,340,500 |
| Meeting Adult Social Care Needs | £6,077,160 | £11,627,973 |
| **Total** | **£18,218,693** | **£24,906,166** |

| Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool | | |
|---|---|---|
| | 2017-18 | 2018-19 |
| Community Health | £23,016,173 | £23,455,820 |
| Primary Care | £130,000 | £130,130 |
| **Total** | **£23,146,173** | **£23,585,950** |

| Summary of BCF Expenditure (Area of Spend) | | |
|---|---|---|
| | 2017-18 | 2018-19 |
| Mental Health | £2,372,096 | £2,372,096 |
| Community Health | £27,743,040 | £27,510,933 |
| Primary Care | £130,000 | £130,130 |
| Social Care (Inc. Reablement, Carers' Breaks Care Act, iBCF) | £58,531,359 | £65,544,382 |
| **Total** | **£88,776,495** | **£95,557,542** |

| BCF Expenditure on Social Care From CCG Minimum | | | |
|---|---|---|---|
| | 2016-17 | 2017-18 | 2018-19 |
| Minimum Mandated Expenditure on Social Care from the CCG minimum | | £30,249,735 | £30,824,480 |
| Planned Social Care expenditure from the CCG minimum | £29,717,787 | £30,279,256 | £30,854,562 |
| **Annual % Uplift Planned** | | **1.9%** | **1.9%** |
| **Minimum mandated uplift % (Based on inflation)** | | **1.79%** | **1.90%** |

# Contents


| Item | Page |
|---|---|
| Introduction and Background | 1 |
| Our Vision for Integration | 6 |
| Delivering the Vision | 9 |
| Managing the Programme | 23 |

# Introduction and Background

# BCF 2017-19: How it will work

**BCF and the STP**

The 2017-19 BCF Plan has been informed by both the Derbyshire STP and the original BCF 2015-16 plan. The intention is for the BCF 2017-19 to continue to support integration of health and care services to benefit the people of Derbyshire, rather than organisations, by ensuring that services can be sustainable whilst transformation take place. The main change for the BCF 2017-19 Plan is the alignment of the BCF expenditure to the STP Priorities, rather than BCF specific schemes. This will ensure consistency as the health and care system delivers the wider changes needed over the coming years.

**Other changes for 2017-19**

The Integration and Better Care Fund Policy Framework and Planning Guidance for 2017-19 have made a number of changes for local systems to take account of in their BCF Plans. In summary, the main changes are:

- Planning over two, rather than one, year;
- Reduction in national conditions attached to BCF delivery from 8 to 4;
- Inclusion of iBCF funding for Local Authorities;
- Removal of the two locally chosen metrics.

Whilst there have been changes, some elements have remained the same and benefitted from greater clarity:

- Funding for Social Care protection spending to be in line with inflation over the two year planning period;
- Disabled Facilities Grant (DFG) money to be passed to Housing Authorities unless an agreed plan is in place for alternative use of some of the funding;
- Confirmation on how funding is being spent on Care Act, Carers, Reablement, and the new improved BCF (iBCF) funding (paid directly to Local Authorities from Department for Communities and Local Government).

This narrative plan sets out how both the local needs and national requirements outlined above, will be delivered during the 2017-19 period.

# Introduction to our Local Health and Care Economy

## Overview

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

More detailed analysis is available in the following documents:

- BCF 2015/16 Part 1
- Derbyshire Joint Strategic Needs Assessment
- Derbyshire Health and Wellbeing Board Strategy 2015-2017
- Derbyshire Older People Market Position Statement 2015
- Derbyshire Learning Disability Market Position Statement 2015
- Derbyshire Sustainability and Transformation Plan (November 2016)

The following page provides a health profile summary of Derbyshire.

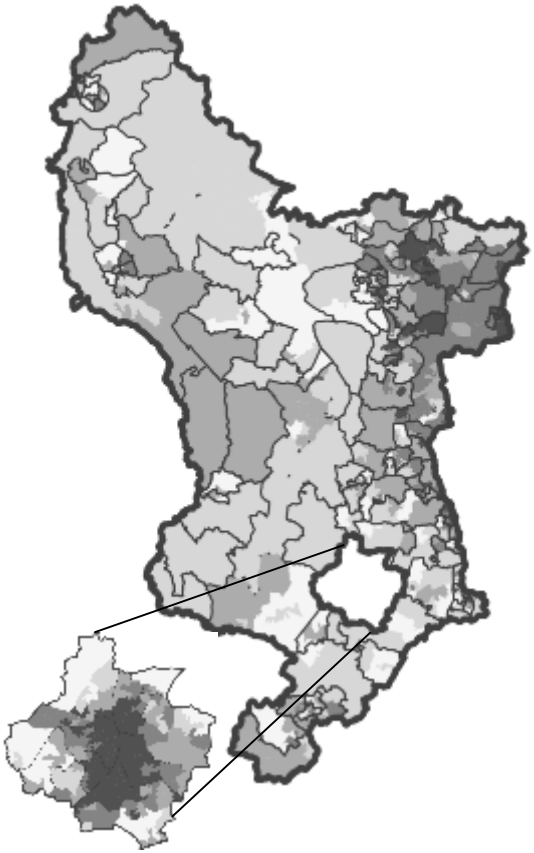
# Derbyshire Health Profile

**The health of people in Derbyshire is varied.**
**Life expectancy for men in some areas is 12.1 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 Derby and Derbyshire: darker wards represent areas of higher deprivation.**



Source:: Derby City and Derbyshire County 2014 Public Health Profiles

# Derbyshire STP: Summary and Overview of the Gaps

**The Derbyshire Sustainability and Transformation Plan Summary:**

*Derbyshire's STP is called 'Joined Up Care Derbyshire'. It brings together eleven partner organisations and sets out ambitions and priorities for the future of the county's health and care.*

*All the organisations that provide health and care aim to work and plan much better together, focusing on new ways of working to:*
- *help keep people healthy;*
- *give people the best quality care; and*
- *run services well and make the most of available budgets.*

*Change is needed. People's lifestyles are very different now to what they were when the NHS was set up in the 1940s or even as recently as ten years ago. Our services need to adapt to keep up with the people they serve.*

*Growing numbers of people need treatment. An increasing number of older people have more than one ongoing complicated need, such as diabetes, arthritis, or breathing problems. New technology is available, which provides better support but costs more to run.*

**Overview of the Gaps:**

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the County:
- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist
- We have made significant progress with beginning to 'join up care'; however, there remain many opportunities to integrate care more effectively and consistently. We are still overly reliant on bed-based care
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap for the Derbyshire health system is £219m, with a further £136m gap across the two local authorities (LAs) - there are a number of factors that are driving this position To tackle the gaps requires transformational changes to the way in which care is provided. To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole

# Our Vision for Integration

# The Strategic Direction

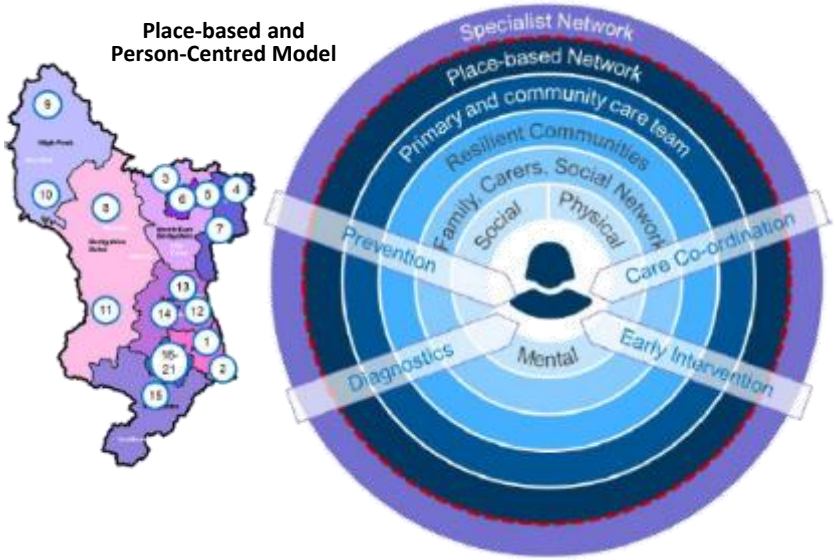
**The overall vision is:**
"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together the services which will achieve the outcomes important to me."

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.

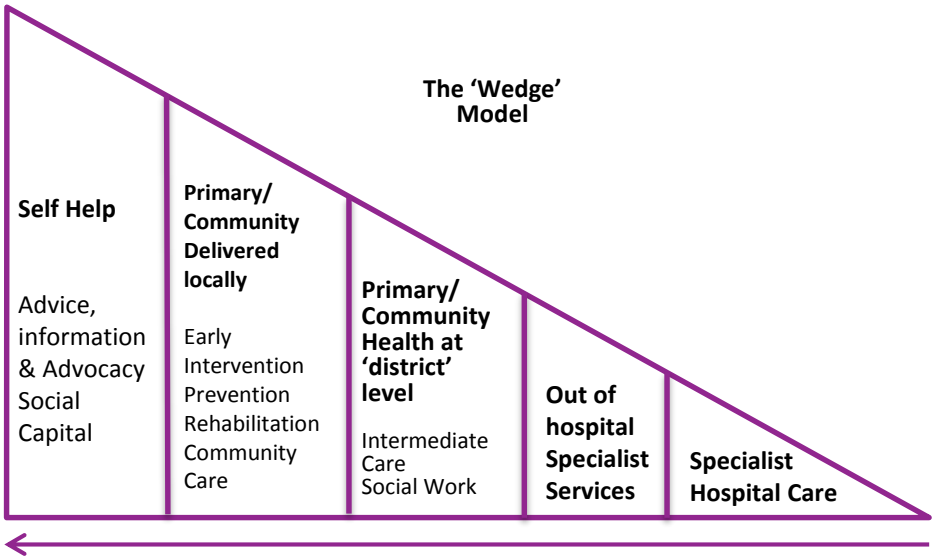
Community support teams will bring together social care, primary and community health services within defined 'places' (communities) to reduce admissions to hospitals and care homes. Where people do need to be admitted, close working between hospital and community clinicians will ensure they are supported 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 diagrams below illustrate what a place-based person-centred system will look like in Derbyshire against the current 'places' and the 'wedge' shows how this will be achieved through the movement of resources.

**Place-based and Person-Centred Model**




**The 'Wedge' Model**



# What this means for local people

**Pat, 53 years old, has terminal cancer.**

**How it is**
Pat has kidney cancer which has spread to her bones. She has broken a leg from a minor fall and was admitted to hospital. Pat also suffers from depression and at times feels suicidal following her diagnosis. She has no family and few friends as she has isolated herself because of her depression. She doesn't know who to turn to and feels lonely in hospital. She receives excellent cancer care when she is admitted, but receives no support for her mental health problems while on the hospital ward as all of her treatment relates to her cancer.
Pat does not know how to make things better to get the most out of her life.

**How it could be**
While in hospital the community team (physical and mental health) coordinate all professionals to put together care for when Pat returns home. Before leaving hospital Pat talks to a lead professional. As a result she knows her physical and mental health needs will be supported at home.

Pat's information is available to all professionals in the community using one electronic record. Pat is working with a local voluntary sector organisation which is providing a befriending service. The befriender helps provide a distraction from Pat's daily care routine and supports her in completing her bucket list of things she wants to do and say, and making plans for her funeral.

**Joe, 83 years old, developed dementia after a stroke.**

**How it is**
Joe is partially sighted, has hearing loss, and is fearful of going out. He is spending more time in bed and less time doing everyday activities. Joe's wife, Barbara, worries about this. He receives care from several different specialist teams and has a care plan from each service. But his physical and mental health needs aren't coordinated. He'll often have visits from different services in the same day. This causes confusion and often leads to aggressive behaviour from Joe. Barbara has asthma and finds it increasingly hard to deal with Joe's mood swings and physical deterioration. She feels nobody understands as each professional only helps with one part of Joe's needs. Information is not coordinated and she is constantly asked the same questions about Joe. She doesn't really know who to ring and which care plan to follow.

**How it could be**
The community team (physical and mental health) coordinate Joe's health and social care needs in one 'wellbeing plan'. Joe has been encouraged to set small achievable goals and this helps him recognise progress he makes. Adaptations and equipment have reduced Joe's falls risk and given Barbara peace of mind. She has learned to offer him simple choices and is receiving support herself. They attend a physical educational course together, alongside other people like them, to help them manage their wellbeing and get advice from others in a similar situation.

Joe and Barbara feel more positive and are happy maintaining their independence at home. They know who to call if they need help and the care plan covers all their needs.

# Delivering the Vision

# Progress so far

This section outlines how the BCF will work towards delivering the vision during 2017-19 in the context of the wider system changes that have alluded to in the introductory section and learning from the past two years of delivering the BCF programme. It includes:

- ***Summary of the Derbyshire STP*** – the 'plan on a page giving high level overview if the STP
- ***Transforming the workforce*** – proposals for the changes needed in the system-wide approach to workforce recruitment, development and retention;
- ***Funding contributions*** – how specific elements of the BCF Pooled Budget have been allocated;
- ***Metrics*** – summary of performance against the national BCF metrics for 2016-17 and targets for 2017-19.

**Learning from 2016-17**

2016-17 should be viewed as a year of consolidation. It was the second year that the BCF had been operating after its first full year of learning and development in 2015-16. Improvements were made to the management of the programme through improved monitoring of finances, schemes, and a revised risk register to provide programme delivery assurance..

***Successes***

- Equipment Services – improvements that began in 2015-16 continued into 2016-17 with over £800,000 of efficiencies realised over the year;
- The number of people whose long-term care needs were met in a residential setting continued to decrease in line with the BCF plan;
- The number of people who were still at home 91 days after completing a period of reablement also improved markedly during the year.

***Challenges***

- The number of emergency admission to hospitals increased to their highest rate in two years during 2016-17; and
- The number of bed days lost to delayed transfers of care were much higher than planned.

**Looking ahead to 2017-19:**

Recruitment continues to be a challenge across Derbyshire. The Council, along with health partners, has developed a Talent Academy to try and address these employment challenges.

Wider system reorganisation will require the Local Authority to be responsive to potential impacts arising from a restructure of four of the County's Clinical Commissioning Groups and the alignment of NHS Providers towards an Accountable Care System.

# Performance so far

| Metric | Reporting Period | Q1 | Q2 | Q3 | Q4 | Year End |
|---|---|---|---|---|---|---|
| 1. Non-Elective Admissions (NEAs) General and Acute - actual number | 2014/15 | 21,081 | 20,795 | 21,723 | 21,141 | **84,739** |
| | 2015/16 | 22,264 | 21,816 | 22,529 | 22,786 | **89,394** |
| | 2016/17 | 21,888 | 21,479 | 22,135 | 22,441 | **87,943** |
| 2. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (Rate per 100,000 population) | 2014/15 | 182.5 | 183.1 | 200.1 | 232.1 | **797.8** |
| | 2015/16 | 193.4 | 189.1 | 183.6 | 178 | **744.1** |
| | 2016/17 | 192.1 | 184.8 | 150.1 | 161 | **688** |
| 3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | 2014/15 | 81.6% | 86.6% | 79.0% | 87.1% | **83.6%** |
| | 2015/16 | 84.1% | 89.4% | 82.4% | 73.6% | **73.6%** |
| | 2016/17 | 88.4% | 86.0% | 84.8% | 83.0% | **83.0%** |
| 4. Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). | 2014/15 | 859.3 | 703.8 | 644.6 | 605.0 | **703.2** |
| | 2015/16 | 641.6 | 596.8 | 655.3 | 830.2 | **681.0** |
| | 2016/17 | 825.4 | 854.3 | 982.9 | 885.7 | **883.3** |

# Derbyshire STP: 'Plan on a Page'

## The summary below provides a high level overview of the Derbyshire STP:

**(1) The gaps**

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the County:

- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist
- We have made significant progress with beginning to 'join up care'; however, there remain many opportunities to integrate care more effectively and consistently. We are still overly reliant on bed-based care
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap for the Derbyshire health system is £219m, with a further £136m gap across the two local authorities (LAs) - there are a number of factors that are driving this position

**To tackle the gaps requires transformational changes to the way in which care is provided.**

**To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole.**

**(2) Our priorities**

Five priorities form the core of our Sustainability and Transformation Plan:

- **Place-based care:** We will accelerate the pace and scale of the work we have started to 'join up' care to operate as a single team to wrap care around a person and their family, tailoring services to different community requirements across our 21 places.
- **Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing
- **Urgent Care**: Transforming urgent care provides our single greatest opportunity to address fragmentation and unwarranted variation
- **System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers
- **System management**: Our organisations' leaders will come together to manage the Derbyshire system through an aligned leadership and governance approach

**(3) Impact & Implications**

Delivering our STP will help us to:

- ***For the people of Derbyshire***: meet our aims to keep people: (i) **safe & healthy** – free from crisis and exacerbation; (ii) **at home** – out of social and health care beds; and (iii) **independent** – managing with minimum support. We will begin to **address lifestyle issues** related to poor health and will **improve access** to urgent and routine care.
- ***Achieve a financially sustainable system***: the combined impact of the priorities described will enable us to achieve **a financially balanced health system by 2020/21**.

***We will significantly change the 'shape' of the system:***

- **£247m more care delivered through Place** (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings
- Major changes to the workforce – **2,500 more staff delivering place-based care** (c.10% of our current workforce)
- Reduction of bed-based care – **535 fewer beds** (c.400 acute; 300 within Derbyshire system)
- And, changes to the physical configuration of place-based services

**(4) Next steps**

Delivering the STP:

- The work over the next five years to deliver our STP is part of and consistent with our ongoing journey – more place-based care to reduce the current reliance on institutional care. We will accelerate the pace and scale of these changes to have the necessary transformational impact
- We now begin the transition from planning into delivery (including through the revised 2 year contracting process)
- During the next 6 months we will:
  - Establish our system delivery team
  - Define and implement revised 2 year contracts monitored through the system-based architecture
  - Commence delivery of a number of high impact transformation schemes to support immediate sustainability
  - Continue our localised engagement programme focussing on staff, stakeholders and our local population.

# Transforming the Workforce

The future supply of the health and care workforce has been identified as a critical issue for future service delivery across Derbyshire. The turnover of staff in some parts of the system is high and often staff will move from one employer to another for small benefits in terms and conditions. In particular, health employers attract a high number of applicants from the social care sector which only creates pressures in social care.

The Derby City/ Derbyshire Talent Academy Programme Board has been established to oversee the delivery of the Strategy and Action Plan.

The Derby City/ Derbyshire Talent Academy Programme Board will bring together health, social care and key stakeholders so that the aims and objectives of the Talent Academy can be identified and delivered.

The Talent Academy Programme Board will be responsible for establishing and supporting the collaborative Derby City/ Derbyshire Health and Social Care Talent Academy across the City/County to co-ordinate a range of activities designed to meet the three Programme Deliverables set out below:

1. Attraction and Recruitment
2. Traineeships and Apprenticeships
3. Retention and Progression

The outputs will include:

- Increasing the profile of careers in health and care
- Engaging with schools and other education providers, Job Centre +, Princes Trust etc.
- Supporting traineeships and work experience
- Building up apprenticeship and higher apprenticeship numbers
- Increasing the numbers of people entering the health and social care workforce
- Ensuring that people joining health and care have the right skills and values
- Working across our future and existing workforce to train and develop people for a career in health and care
- Articulating the range of career pathways for care workers
- Preparation for the workforce changes that will be required as a result of the Derbyshire-wide STP.

<u>Other issues within scope:</u>

- High levels of employment in certain geographical locations
- Maintaining existing staffing levels to meet turnover
- The programme will need to consider how it works with wider partners e.g. Skills for Care, to improve perceptions of caring as a career.

# Funding Contributions

**Overview**

The 2017-19 BCF comprises a Pooled Budget made up of contributions from the five NHS Clinical Commissioning Groups within the Derbyshire Health and Wellbeing Board area, and Derbyshire County Council. The total pooled budget for 2017-18 is £88.777m compared to £64.951m in 2016-17. A summary of the pooled fund is provided at the beginning of this plan, and an overview of how the Pool is being spent in line with the STP priorities is provided on the next page.

**Specific funding requirements:**

Within the BCF Pooled Budget, provision has to be made to ensure that funding has been allocated and agreed for use against a number of specific components, namely:

- Care Act duties - £2.058m has been allocated each year for 2017-19 for use by Derbyshire County Council to ensure it continues to fulfil its duties in delivering the Care Act
- Carers - £1.962m has been allocated, as in previous years, for the carer-specific support services that will deliver the aims of the Derbyshire Carers Strategy 2016-19;
- Reablement - £5.967m has been included with the plan for delivery of reablement services
- Disabled Facilities Grant - £5.966m has been allocated for DFGs in 2017-18 and £6.451m for use in 2018-19. During 2017-19 the DFG allocation will continue to be passported to District and Borough Councils as in previous years, whilst improvements are made in Prevention, Assessment and Delivery areas of the DFG.
- iBCF - £18.219m has been allocated to Derbyshire County Council for 2017-18 and £24.906m for 2018-19.

# Expenditure by STP Priority Area

| | 1) Prevention and Self-management | 2) Place-based Care: Proactive | 3) Place-based Care: Reactive | 4) Learning Disability and Autism | 5) Enablers |
|---|---|---|---|---|---|
| | Initiatives in place that enable people to take more control of their lives in their normal place of residence. | Services look after and focus on people in their community, rather than being offered in a way that suits organisations and revolves around buildings. | Initiatives to support the flow through the system and to prevent readmissions and permanent admissions to care settings | Specialist services organised to make sure everyone, including those at risk of high cost institutional care, is enabled to secure their rights, independence, choice and inclusion. | Supporting mechanisms E.G. Data Sharing / Information Governance, Dignity Campaign, BCF & Transforming Care Programme Management |
| | Includes:<br>• Carers services<br>• Disabled Facilities Grant<br>• Health and Housing<br>• Local Area Coordinators | Includes:<br>• Community / Neighbourhood Teams (Matrons, Nursing, Therapy)<br>• Supporting the Care Market | Includes:<br>• Intermediate Care<br>• Reablement<br>• Community Specialist beds<br>• Dementia Support and reablement Services | Includes:<br>• Autism Pathway Development<br>• Transforming Care Programme Integrated Support Service (1 Year) | Includes:<br>• Care Act duties<br>• Talent Academy<br>• Programme Management |
| **2017-18** | **£17,282,893** | **£50,548,966** | **£16,452,180** | **£1,184,758** | **£3,307,699** |
| **2018-19** | **£18,240,796** | **£56,697,419** | **£16,817,615** | **£450,000** | **£3,351,713** |

# iBCF

**Overview**

Prior to the announcement of the additional funding for Local Authorities at the Spring Budget 2017, Derbyshire County Council knew what budget savings were required over the subsequent three year period and the need to make reductions in social care support to achieve this. In addition the Local Authority, along with health partners, was aware of what support was needed to help reduce pressures on the NHS (specifically in relation to DToCs) and to support the care market in Derbyshire to maintain stability but was not in a financial position to enact this support.

The additional funding, therefore, has enabled the Local Authority to defer or remove some of the savings to social care support that would have had to have been made to ensure continuation of core service provision. It has also allowed for the implementation of investment into additional activity to support both the NHS and care market locally.

**Use of the iBCF in 2017-19:**

| Reduce Budget Savings to Protect Social Care | | Supporting the Care Market | Support to Improve System Flow & Support Hospital Discharge | Preventative Services (inc Public Health and Health and Housing) | Enablers (System and Service Redesign to increase capacity) |
|---|---|---|---|---|---|
| We expect to see, at minimum, a maintenance in the average caseload for Social Work staff | | We expect to see a reduction in social care attributable DToCs.<br><br>We would also expect to see a sustainable care market in Derbyshire providing similar levels of home care provision and care home placements as in 2016-17 | We expect to see a reductions in social care attributable DToCs and in average length of stay for emergency admission (over 65+) | Reductions in emergency admissions due to falls;300 eligible, high risk households will receive warmth, wealth and health interventions | Implementation of upgraded IT systems to support improved data sharing between health and social care. |
| **2017-18** | **£5,840,000** | **£8,210,768** | **£2,535,765** | **£1,395,000** | **£237,160** |
| **2018-19** | **£11,351,652** | **£7,937,693** | **£3,473,500** | **£1,867,000** | **£276,321** |

# Metrics: Performance and Targets

Targets for 2017-19 have been set by the BCF Programme Board in line with current local performance trends and national expectations. Targets for the Non-Elective Admissions target have been set nationally.

| *Residential Admissions* | | Actual 15/16 | Planned 16/17 | Outturn16/17* | Planned 17/18 | Planned 18/19 |
|---|---|---|---|---|---|---|
| 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 | 744.9 | 743.7 | 654.7 | **683.4** | **647.1** |
| | Numerator | 1,213 | 1,237 | 1,089 | **1,158** | **1,118** |
| | Denominator | 162,882 | 166,333 | 166,333 | **169,452** | **172,768** |

Targets for 2017-19 have been set to continue the year-on-year decrease in the number of people having long-term needs met in a care setting, in line with the overall direction of travel of the BCF Plan.

*The 2016/17 outturn reported at year end was 654.7, however, due to data lag the actual figure was 707.

| *Re-ablement* | | Actual 15/16 | Planned 16/17 | Outturn16/17 | Planned 17/18 | Planned 18/19 |
|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual % | 73.61% | 85.3% | 83.2% | **84.9%** | **86.1%** |
| | Numerator | 396 | 390 | 273 | **360** | **365** |
| | Denominator | 538 | 457 | 328 | **424** | **424** |

In setting targets for 2017-18 and 2018-19 the expectation is to see a year-on-year increase in line with the wider planning intentions to provide more community based services to support people to remain independent.

| *Delayed Transfers of Care** | | Actual 15/16 | Planned 16/17 | Outturn16/17 | Planned 17/18 | Planned 18/19 |
|---|---|---|---|---|---|---|
| Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). | Annual rate | 680.9 | 710.6 | 884.8 | **757.3** | **769.4** |
| | Numerator | 4,290 | 4,500 | 5,604 | **4,822** | **4,921** |
| | Denominator | 629,776 | 633,273 | 633.273 | **636,650** | **639,626** |

*Targets set on a quarterly basis, figures provided here represent whole-year performance.

DToC targets have been set in line with national expectations for Derbyshire to achieve no more than 8.5 bed days delayed per day per 100,000 aged 18+. The figures supplied here are in the equivalent BCF reporting format of bed days delayed per 100,000 population aged 18+ (shown as an average across the year).

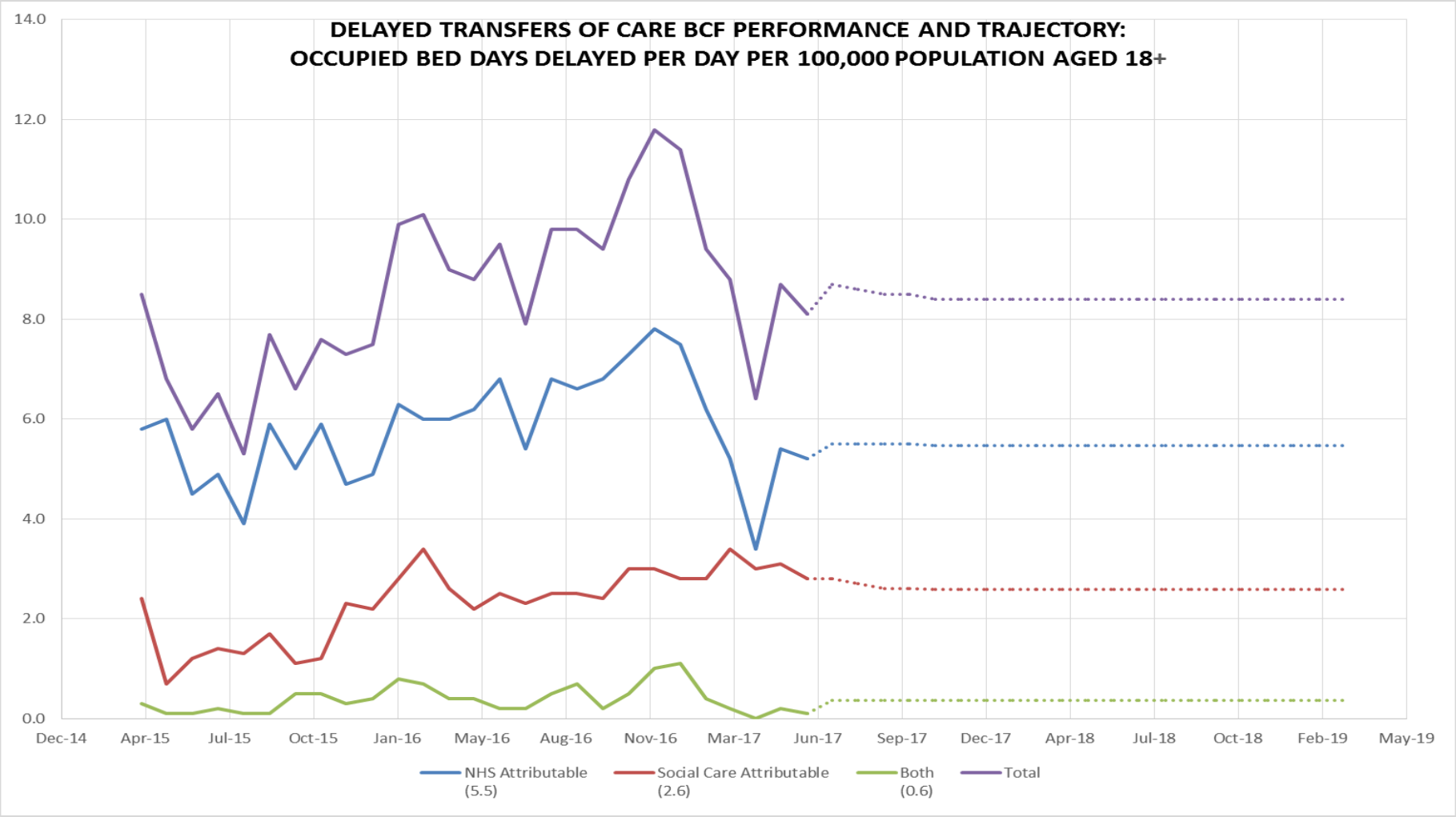
# Metrics: Performance and Targets (Continued)

The Delayed Transfer of Care monthly targets split by attributable organisation for 2017-18 are provided below. These figures differ marginally from the July 2017 draft DToC target submission. Targets have been amended to reflect revised figures published in August 2017 for NHS and Social Care organisations in the NHS Midlands and East region.

| | 17-18 plans | | | | | | | | | 18-19 plans | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
| NHS attributed delayed days | 1084.2 | 1084.2 | 1049.2 | 1084.2 | 1044.1 | 1078.9 | 1084.1 | 979.2 | 1084.1 | 1049.2 | 1084.1 | 1049.2 | 1084.1 | 1084.1 | 1049.2 | 1084.1 | 1049.2 | 1084.1 | 1088.7 | 983.3 | 1088.7 |
| NHS East Staffordshire CCG | 10.1 | 10.1 | 9.8 | 10.1 | 9.8 | 10.1 | 10.1 | 9.2 | 10.1 | 9.8 | 10.1 | 9.8 | 10.1 | 10.1 | 9.8 | 10.1 | 9.8 | 10.1 | 10.2 | 9.2 | 10.2 |
| NHS Erewash CCG | 123.7 | 123.7 | 119.7 | 123.7 | 119.1 | 123.1 | 123.7 | 111.7 | 123.7 | 119.7 | 123.7 | 119.7 | 123.7 | 123.7 | 119.7 | 123.7 | 119.7 | 123.7 | 124.2 | 112.2 | 124.2 |
| NHS Hardwick CCG | 135.4 | 135.4 | 131.0 | 135.4 | 130.4 | 134.7 | 135.4 | 122.3 | 135.4 | 131.0 | 135.4 | 131.0 | 135.4 | 135.4 | 131.0 | 135.4 | 131.0 | 135.4 | 135.9 | 122.8 | 135.9 |
| NHS North Derbyshire CCG | 412.5 | 412.5 | 399.2 | 412.5 | 397.2 | 410.5 | 412.5 | 372.5 | 412.5 | 399.2 | 412.5 | 399.2 | 412.5 | 412.5 | 399.2 | 412.5 | 399.2 | 412.5 | 414.2 | 374.1 | 414.2 |
| NHS Nottingham West CCG | 8.7 | 8.7 | 8.4 | 8.7 | 8.4 | 8.6 | 8.7 | 7.8 | 8.7 | 8.4 | 8.7 | 8.4 | 8.7 | 8.7 | 8.4 | 8.7 | 8.4 | 8.7 | 8.7 | 7.9 | 8.7 |
| NHS Southern Derbyshire CCG | 331.6 | 331.6 | 320.9 | 331.6 | 319.4 | 330.0 | 331.6 | 299.5 | 331.6 | 320.9 | 331.6 | 320.9 | 331.6 | 331.6 | 320.9 | 331.6 | 320.9 | 331.6 | 333.0 | 300.8 | 333.0 |
| NHS Tameside & Glossop CCG | 50.8 | 50.8 | 49.2 | 50.8 | 49.0 | 50.6 | 50.8 | 45.9 | 50.8 | 49.2 | 50.8 | 49.2 | 50.8 | 50.8 | 49.2 | 50.8 | 49.2 | 50.8 | 51.1 | 46.1 | 51.1 |
| | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| **Select any additional CCGs (if required)** | | | | | | | | | | | | | | | | | | | | | |
| NHS Mansfield and Ashfield CCG | 6.9 | 6.9 | 6.7 | 6.9 | 6.7 | 6.9 | 6.9 | 6.3 | 6.9 | 6.7 | 6.9 | 6.7 | 6.9 | 6.9 | 6.7 | 6.9 | 6.7 | 6.9 | 7.0 | 6.3 | 7.0 |
| NHS Eastern Cheshire CCG | 1.7 | 1.7 | 1.7 | 1.7 | 1.6 | 1.7 | 1.7 | 1.5 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.5 | 1.7 |
| NHS Nottingham North and East CCG | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 |
| NHS West Leicestershire CCG | 1.7 | 1.7 | 1.7 | 1.7 | 1.6 | 1.7 | 1.7 | 1.5 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 | 1.6 | 1.7 |
| NHS Bassetlaw CCG | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 |
| | | | | | | | | | | | | | | | | | | | | | |
| Social Care attributed delayed days | 551.9 | 532.2 | 497.1 | 513.6 | 493.6 | 510.0 | 512.5 | 462.9 | 512.5 | 496.0 | 512.5 | 496.0 | 512.5 | 512.5 | 496.0 | 512.5 | 496.0 | 512.5 | 514.7 | 464.8 | 514.7 |
| | | | | | | | | | | | | | | | | | | | | | |
| Jointly attributed delayed days | 73.1 | 73.1 | 70.7 | 73.1 | 70.7 | 73.1 | 73.4 | 66.3 | 73.4 | 71.1 | 73.4 | 71.1 | 73.4 | 73.4 | 71.1 | 73.4 | 71.1 | 73.4 | 73.7 | 66.6 | 73.7 |
| | | | | | | | | | | | | | | | | | | | | | |
| **Total Delayed Days** | 1709.2 | 1689.5 | 1617.0 | 1670.9 | 1608.4 | 1662.0 | 1670.1 | 1508.4 | 1670.1 | 1616.2 | 1670.1 | 1616.2 | 1670.1 | 1670.1 | 1616.2 | 1670.1 | 1616.2 | 1670.1 | 1677.1 | 1514.8 | 1677.1 |
| | | | | | | | | | | | | | | | | | | | | | |
| **Population Projection (SNPP 2014)** | 635,882 | 635,882 | 635,882 | 635,882 | 635,882 | 635,882 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 638,956 | 641,638 | 641,638 | 641,638 |
| | | | | | | | | | | | | | | | | | | | | | |
| **Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)** | 268.8 | 265.7 | 254.3 | 262.8 | 252.9 | 261.4 | 261.4 | 236.1 | 261.4 | 252.9 | 261.4 | 252.9 | 261.4 | 261.4 | 252.9 | 261.4 | 252.9 | 261.4 | 261.4 | 236.1 | 261.4 |

# Metrics: Performance and Targets (Continued)

The chart below shows performance of DToCs split by attributable organisation in Derbyshire from 2014-15 to present day along with the targets outlined on the previous page. The targets are expressed as bed days delayed per day per 100,000 population aged 18+.



# Managing Transfers of Care

Implementation of the High Impact Change Model for Managing Transfers of Care is being undertaken at a system level with regular reporting through the A&E Delivery Board. Below is a high-level assessment, by the A&E Delivery Board for Derbyshire, of current status and planned targets against the 8 high impact change areas.

| Change Area | Status | Risks & Mitigations | Target (March 2018) |
|---|---|---|---|
| **1: Implement early hospital discharge planning** | **Established:** | **Risk 1:** Lack of Primary Care engagement to undertake joint discharge planning<br>Mitigation: Engagement with CCG Place leads.<br><br>**Risk 2**: Lack of Community Nursing capacity to support potential increase in activity<br>Mitigation: Monitor activity and available capacity, escalate capacity issues to CCG leads. | **Mature** |
| **2: Implement system to monitor patient flow** | **Plans in Place/ Established:** | **Risk 1:** lack of engagement from staff due to number of changes being introduced at pace<br>Mitigation: Provide robust support to resolve any problems. | **Mature** |
| **3: Implement multidisciplinary discharge teams** | **Established** | Teams established in Chesterfield Royal Hospital NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust and links with external Acute providers that regularly discharge residents back into Derbyshire. | **Exemplary** |
| **4: Home First/Discharge to Assess scheme in place** | **Established** | **Risk:** Lack of robust transport service to facilitate timely discharges.<br>**Mitigation:** Transport audit underway to understand what the transport issues are which are impacting on discharges and discuss findings with lead Commissioner. | **Mature** |

# Managing Transfers of Care (Continued)

| Change Area | Status | Risks & Mitigations | Target (March 2018) |
|---|---|---|---|
| **5: Seven-day service in place** | **Plans in Place/ Established** | **Risk 1:** Lack of capacity in Community Services to provide robust 7 day services<br>**Mitigation** - Work with patients and families and apply strength-based principles when assessing needs to include patients own established networks to support discharge packages as per D2A<br><br>**Risk 2:** Inability to readily share patient information across organisations/services to facilitate safe and timely admissions/discharges & transfers and support implementation of trusted assessor model.<br>**Mitigation:** Review IT systems and identify potential opportunities to improve the transfer of patient information. | **Mature** |
| **6: Trusted Assessor models in place** | **Plans in Place** | **Risk 1:** Potential reluctance from staff across all health and care settings to accept Trusted Assessor principles<br>**Mitigation:** Ensure robust training & support in place to address issues & concerns in a timely manner – task and finish group established to build on work already undertaken to develop Trusted Assessor principles across the STP. | **Mature** |
| **7: Promoting choice and self-care for patients** | **Established/ Mature** | **Risk:** Lack of nursing and residential care home capacity.<br>**Mitigation:** Monitor delayed discharge reasons and provide evidence to Commissioners/Providers to ensure appropriateness of referrals. | **Exemplary** |
| **8: Enhanced health and care services in care homes** | **Established/ Mature** | Care Home 'Surge' learning from Hardwick CCG shared with commissioners and providers across the STP. Highlighted findings of impact of support provided to care homes to reduce non-elective admissions, reduce polypharmacy – further evidence required before establishing system-wide . | **Exemplary** |

# Managing Transfers of Care (Continued)

The services being funded through the BCF have been mapped to the 8 High Impact Change areas to demonstrate how they are supporting the system-wide implementation.

| Scheme | 1: Implement early hospital discharge planning | 2: Implement system to monitor patient flow | 3: Implement multidisciplinary discharge teams | 4: Home First/ Discharge to Assess scheme in place | 5: Seven-day service in place | 6: Trusted Assessor models in place | 7: Promoting choice and self-care for patients | 8: Enhanced health and care services in care homes |
|---|---|---|---|---|---|---|---|---|
| **1) Prevention and Self-management** | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| **2a) Place-based Care: Proactive** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **2b) Place-based Care: Reactive** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **3) Learning Disability and Autism** | | | | ✓ | | | ✓ | |
| **4) Enablers** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |

The iBCF alongside the main BCF will be predominantly focussed on reducing Delayed Transfers of Care, and ensuring that people can remain living at home with support or independently. This includes:

- Additional Social Worker capacity to support transfers of care from non-acute hospitals and additional management capacity to ;
- Additional funding to support VCS services providing Home from Hospital services (including a service supporting homeless people with safe discharge from hospital);
- Discussions with local care market providers has resulted in increased payments for providers of care homes and home care as well as retainer payments to ensure packages of care can be maintained whilst a person is in hospital.

Monthly DToC meetings are now taking place between social care and non-acute and mental health providers to highlight and resolve lengthy delays – this work has already seen the volume of lengthy delays discussed each month decrease.

A Peer Review has also been planned for September 2017 with East Midlands ADASS to look at non-acute and mental health delays to provide learning opportunities and highlight good practice across Derbyshire.

# Progress against the 2016-17 National Conditions:

For 2017-19 the number of national conditions imposed upon the Better Care Fund has been reduced to three from eight in 2016-17. Below is an update on the progress against those national conditions no longer required for 2017-19

| National Condition | Update |
|---|---|
| Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate. | *Delivery of 7-day services is being implemented through the Derbyshire STP and its relevant thematic workstreams – particularly in relation to the Urgent Care Workstream (and also outlined in CCG Operational Plans).*<br><br>*Most of the relevant services are already available 7 days although there remains an inconsistent approach across the county.* |
| Better data sharing between health and social care, based on the NHS number | *Derbyshire County Council's Adult Care are undertaking a major data cleansing process to make ensure alignment of client records to the NHS spine. This work will also ensure that Information Governance processes are adhered to with regards to the holding of a client's NHS number.*<br><br>*Adult Care can only hold the NHS number for those receiving a direct care service and those who are being assessed or receiving long term support.* |
| Ensure a joint approach to assessments and care planning – accountable professional | *This work has been undertaken as part of the Discharge to Assess Pathway developments across the STP Footprint and is being managed through the STP process.* |
| Agreement on the consequential impact of the changes on providers that are predicted to be substantially affected by plans | *The revised plans for 2017-19 have been discussed with partners as part of their development. This has included engagement with the A&E Delivery Board and BCF Programme Board and Finance an Performance Sub-Group.* |
| Agreement to local action plan to reduce Delayed Transfers of Care | *This work has been superseded by the implementation of the Discharge to Assess Pathways across Derbyshire which is being delivered through the Place STP workstream.* |

# Managing the Programme

# Overview

The Derbyshire Better Care Fund is managed by a Programme Board on behalf of the Derbyshire Health and Wellbeing Board. Full details of the governance arrangements are provided in the Governance page below. It is underpinned by a Section 75 (NHS Act 2006) agreement which allows for the pooling of NHS and Local Authority budgets.

**The BCF Programme Board**

The Board comprises members of the five Clinical Commissioning Groups, Derbyshire County Council (Adult Care and Public Health), and a District and Borough Council representative.

The purpose of the Board is to ensure that the vision described in the BCF plan is delivered at pace and scale across Derbyshire. The Board is accountable and reports to the Derbyshire Health and Wellbeing Board, the Derbyshire Adult Care Board, the CCGs' Governing Bodies and the Council's Cabinet. It is also responsible for capturing and sharing learning.

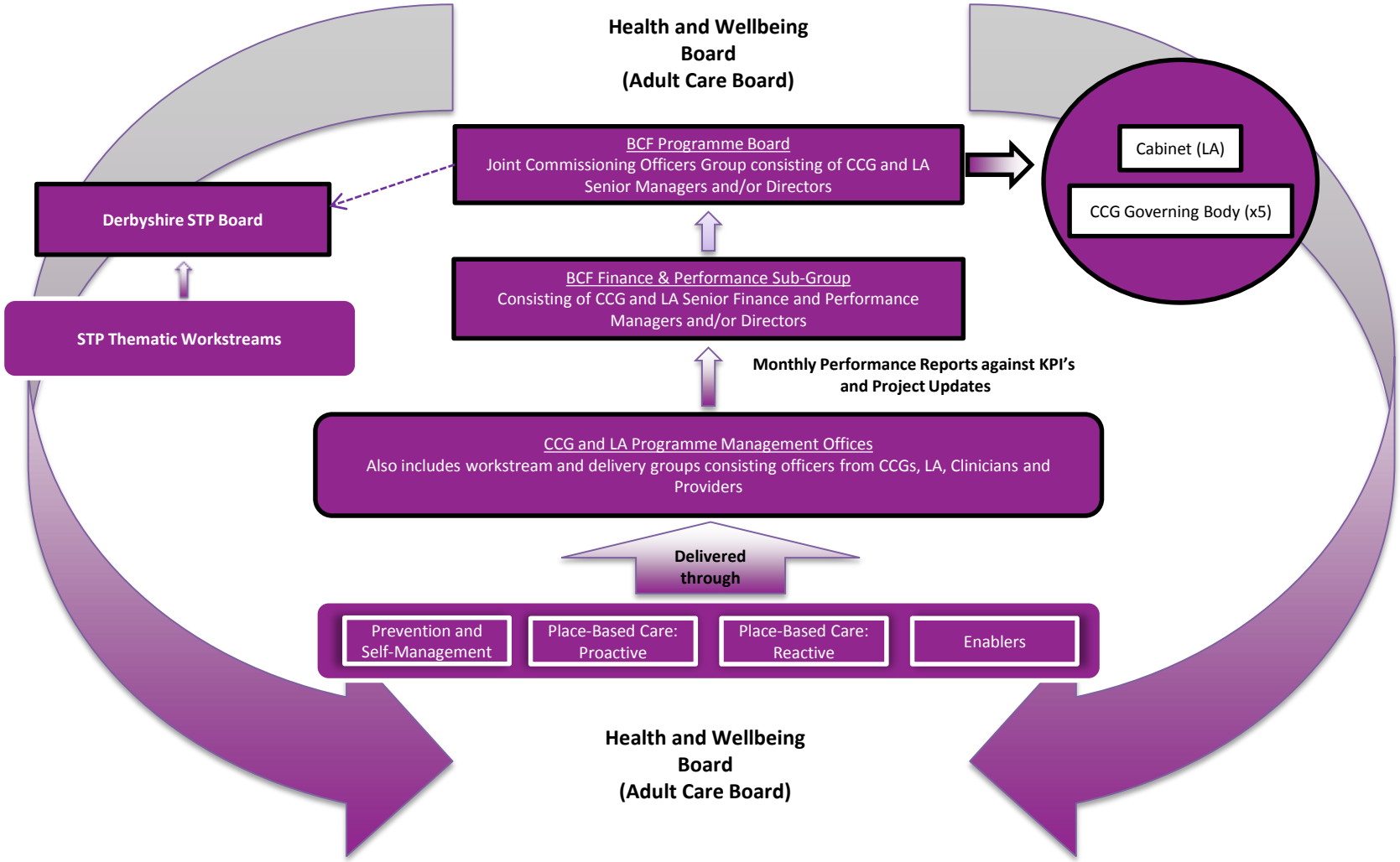
**BCF Finance and Performance Sub-Group**

The purpose of the Sub-Group is to ensure that the Derbyshire Better Care Fund programme is monitored at scheme level and risk managed to support the delivery of the Programme. This is undertaken through monthly monitoring of finances, metrics and risk, and quarterly monitoring of scheme performance. The Sub-Group is accountable and reports to the BCF Programme Board.

The following sections provide more details on the Governance, Risk Management, and Risk Sharing of the BCF Programme.

# Governance

The governance of the BCF is described in the original submission - BCF 2015/16 Part 1. The diagram below shows the current governance arrangements which will continue to evolve as wider system changes occur to support the delivery of the STP



# Risk Management

The BCF Programme Risk Register was reviewed and updated in 2016-17 to focus more on the programme itself, rather than wider system level risks. The revised register has been split into four domains covering the main aspects of the BCF Programme:

- National Metrics
- National Conditions
- Finance
- Delivery of Plan

There are currently 16 risks, split across the four domains, on the register of which two are high-risk (scoring 12+) in relation to achieving aims of the plan. These are:

- Non-Elective Admissions; and
- Delayed transfers of Care

The register outlines the appropriate mitigations in place bring each risk down to an appropriate level of control.

Governance of the register has also been improved with regular monitoring of the register by the Finance and Performance sub-group and quarterly reporting to the BCF Programme Board on an exception basis. The responsibility of risks relating to expenditure lies with the relevant lead commissioner(s).

# Risk Sharing

It was agreed as part of the 2015-16 BCF Plan 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.

**The STP finance and efficiency gap**

The Derbyshire STP has identified a financial gap across the local health system of £219m, with a further £136m gap across public health, children and adult services in both Local Authorities. The STP primarily focuses in improving the NHS part of the financial challenge, which is driven by a number of factors:

1. Resources are not keeping pace with rising demand and costs;
2. Underlying structural financing issues;
3. Increasing productivity is challenging
4. Inefficient care models are driving up costs and imposing significant opportunity costs
5. Duplication of functions across health and care organisations
6. Inefficient use of estate;
7. Perverse payment and incentive arrangements

# For more information contact:

Graham Spencer
Better Care Fund Programme Manager
email: Graham.Spencer@derbyshire.gov.uk
Tel: 01629 532 072