Appendix 1

Derby City Council

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby City Council Better Care Fund

2019-20 Planning Template

Contents

2 Cover

Better Care Fund 2019-20 Template	
Health and Wellbeing Board:	Derby
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Who signed off the report on behalf of the Health and Wellbeing Board:	Andy Smith
Will the HWB sign-off the plan after the submission date?	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	14/11/2019

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3 Summary

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,047,589	£2,047,589	£0
Minimum CCG Contribution	£17,646,689	£17,646,689	£0
iBCF	£10,542,289	£10,542,289	£0
Winter Pressures Grant	£1,148,569	£1,148,569	£0
Additional LA Contribution	£269,682	£269,682	£0
Additional CCG Contribution	£0	£0	£0
Total	£31,654,818	£31,654,818	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,184,546
Planned spend	£5,386,951

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£10,977,612
Planned spend	£11,599,182

Scheme Types

Assistive Technologies and Equipment	£2,066,682
Care Act Implementation Related Duties	£7,490,532
Carers Services	£921,501
Community Based Schemes	£0
DFG Related Schemes	£2,047,589
Enablers for Integration	£3,805,916
HICM for Managing Transfer of Care	£784,934
Home Care or Domiciliary Care	£871,826
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£3,589,951
Intermediate Care Services	£4,248,477
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£1,001,663
Residential Placements	£0
Other	£4,825,747
Total	£31,654,818

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	**Early discharge planning**	Established
Chg 2	**Systems to monitor patient flow**	Established
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Established
Chg 4	**Home first / discharge to assess**	Mature
Chg 5	**Seven-day service**	Established
Chg 6	**Trusted assessors**	Established
Chg 7	**Focus on choice**	Established
Chg 8	**Enhancing health in care homes**	Established

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	597.6685162

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.809569378

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

4 **Strategic Narrative**

What is your approach towards integration of health and social care from:

When answering the sections below please highlight any learnings or changes you have undertook from the previous planning 2017-19

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	186

Introduction

The Derby City Better Care Fund (BCF) Plan 2019-20 is an extension of the 2017-19 plan that built upon previous iterations of the original 2015/16 plan. This latest version has been informed by:

•the development and implementation of the Derbyshire Sustainability and Transformation Plan (STP) known locally as Joined Up Care Derbyshire (JUCD);
•the Derbyshire Health and Wellbeing Strategy 2018-2023; and
•Organisational Plans (e.g. Council Plan, CCG Operational Plans).

The predominant focus of the Derby BCF continues to be on supporting the delivery of place-based population health and care across Derbyshire, and key workstreams that support urgent and emergency care.

The Vision

The overall vision of the Derby City Better Care Fund (BCF) is for individuals to be able to plan their 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 this vision 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 for as long as is appropriate.

The Approach

Over the past few years, BCF funded activity has supported the emerging community based support teams across Derby Place Alliance, as well as supporting the urgent care sector and our main acute hospital. The ambition remains that Integrated Care Teams will operate at Place level to bring together social care, primary care and community health services within defined place-based populations to prevent and/or reduce admissions to hospitals and care homes and provide greater support to people living in residential or nursing care. Across Derbyshire and Derby City this forms part of the Place workstream of the STP.

Within the acute sector, and within the hospital setting – there is already a BCF funded integrated discharge hub that aims to ensure discharges take place in a timely way and onto correct pathways, as well as working to avoid admissions in the first place.

Where people do need to be admitted to a hospital, close working between the hospital and community support teams means individuals have been increasingly better supported upon discharge, enabling them to return to their own homes sooner. Increased preventative care and community support at Place level is hoped to be able, in the long-term, to enable hospital providers to focus on providing specialist acute care whilst people are encouraged to live well better and take greater control over the management of their own conditions.

Derby's performance on both social care and NHS related DTOCs continues to be "top quartile", although engaging early with mental health delays remains an ongoing improvement required. During March 2019, Home First which is funded by the BCF won the LGC award for Business Transformation. This award recognised the transformation of the service to respond to the demands of acute pressures, and the improved outcomes for patients that this has delivered as a result. Daily demand and capacity data is now part of the routine information available to partners, assisting with planning and patient flows.

Building on this strong performance, and the continued development of person-centred care and asset based/ strength based social care interventions remains a funding priority for the Derby City BCF during 2019-20.

Health profile 2018 update:
This approach to meeting the needs of place-based populations will, in time, help to reduce the levels of variation of health outcomes seen across Derby and Derbyshire, which are generally lower than the England average in some key areas. The Derby City and Derbyshire County Health Profiles for 2018 show the following:
•Life expectancy from birth in Derby City (M: 78.2, F: 82.7) is below the national average for England (M: 79.5, F: 83.1)
•The life expectancy gap is 10.2 years for men and 8.3 years for women when comparing the most deprived areas of the city to the least deprived areas in England
•In the city approximately 21% (10,700) children live in low-income families
•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. Excess weight in adults in Derby City (65.1%) is above the England average (61.3%)
•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 the city compared to the England average

A JUCD Prevention Strategy has recently been published which complements the existing Health and Wellbeing strategies and other strategies that exist as part of the JUCD programme, e.g. Mental Health, Sexual and Reproductive Health, and Child Health. These strategies are interdependent and taken together, provide a whole system approach to prevention across Derby City and Derbyshire.

The Workforce
In order to deliver person-centre care effectively, we need a workforce that is able to provide this. Although the BCF is not directly funded any infrastructure schemes designed to develop eth workforce, many of the staff teams involved in delivering BCF funded activity will benefit from the work of Joined Up Careers Derbyshire, formerly known as the Derbyshire Health and Social Care Talent Academy. This STP level initiative brings together local partner organisations to support the current and future health and social care workforce.
The following provides an overview of the work undertaken to-date and ongoing developments:

•Developing new roles to support the Derbyshire Model of Care – Hybrid roles (still in development) that will be delivered at Place levels offering person-centred approaches to caring for local residents and to free up time for clinical professionals to respond to more complex cases.
•A new Health and Care Support Worker Apprenticeship Pilot - The scheme, launched in September 2018, runs until 2020 and offers individuals a 15-month rotational apprenticeship scheme across health and social care organisations, including primary care and private and voluntary organisations. The positions have been hosted by University Hospitals of Derby and Burton NHS Foundation Trust and Derbyshire County Council.
•Place Alliance OD Programme - The Leading Across Boundaries programme has been ongoing since October 2018 to support Place Alliance members in delivering care and promoting health and wellbeing. The programme brings pathways together, identifying how collaboration can be further enabled in Derbyshire and understanding from citizens 'what matters to you'? rather than 'what's the matter with you'?
•System Workforce Dashboard - A system-wide dashboard which provides a visual, robust image of the current workforce position across the system in Derbyshire has been implemented. The dashboard inclusive of statutory NHS, Primary Care & Social Care data provides a base-line view of the current workforce, future workforce risks, new roles, integrated models of care and can also be used to track movements across the workforce.
•Workforce modelling programme – This has utilised a whole system partnership methodology focusing on specific workstreams of the STP to develop a Derbyshire workforce model. The aim is to develop the future workforce plan to establish Derbyshire as an attractive proposition for clinicians to train and remain. The development of place-based care with GP practices networked under principles of the Primary Care Network model will give greater stability and individual support to practitioners creating even closer links with Health Education England to triangulate our plans and develop a single Derbyshire training hub.
•Programme of work on GP Retention - There is an improved understanding of our workforce baseline following the GP Forward View monitoring survey. The aim will be to establish Derbyshire as an attractive proposition for clinicians to train and remain. The development of place-based care with GP practices networked under principles of the Primary Care Networks model will give greater stability and individual support to practitioners.

B) HWB level
(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS Voluntary and Community Sector)

The 2019-20 Joined Up Care Derbyshire (JUCD) System Operation Plan Overview, which the local BCF plan supports, has identified the following system priority for 'place' (the local approach to community-based population health and care support):
• To develop an integrated care model to meet the needs of local 'Place-based' populations. The care model will, over time support the delivery of the 'Derbyshire wedge' – the way in which we describe the shift in activity and resources from the acute sector to the community.

This will be delivered through a range of activity highlighted below:
• Identify and stratify those at risk of admission to hospital, provide appropriate and timely interventions to avoid admission/escalation, use standardised multi-disciplinary approaches to develop personalised care planning and use all available community assets to support people (e.g. voluntary sector).
• Deliver personalised care through an integrated multi-disciplinary team approach.
• Care Homes - develop new model of primary and community care support to people in care homes utilising existing care home primary care Local Enhanced Services.
• Community Support Beds - Support identified bed and non bedded discharge pathways from an acute hospital admission
• Continuation and expansion of core delivery of integrated working focussed on the frailty cohort.

The anticipated impact of delivering these activities are that:
• Integrated Care Teams will be developed with enhanced assessment skills to reduce the need for people to have a hospital admission and support them to stay in their own homes wherever possible with appropriate support.
• As much care as possible is delivered in people's normal place of residence or their community, reducing the need for admissions to acute or long-term care settings.
• Care is planned and pro-active where possible and responsive when required.
• Providers collaborate to deliver care with clear accountability for improving outcomes.
• Maximised use of existing resources, target variation, link growth in community capacity to reduce need for admission.

Joint Commissioning
Following the merger of four CCGs into one covering Derby and Derbyshire, the existing People's Commissioning Board that operated with Derby City council and the former Southern Derbyshire CCG continues to meet as a subset of the Derby City Health & Well-being Board. This may however be overtaken as a local approach to Joint Commissioning is currently being reviewed across the STP footprint and therefore involving colleagues at Derbyshire County Council. A Joint Commissioning Group has been therefore been formed, comprising Officers from the new Derby and Derbyshire CCG, Derby City and Derbyshire County Council. This group is currently reviewing commissioned services and arrangements across the STP to develop a more strategic approach to commissioning that will provide a more coherent joined-up approach to commissioning in the future.

For the purposes of managing the BCF in Derby and Derbyshire there is a Joint BCF Programme Board which has, and continues, to oversee jointly commissioned services that were introduced via the original BCF in 205/16. This Board will continue to have oversight of these services until such time as a decision is made on the future strategic relationship required for commissioning which is being reviewed further in advance of any planning for the move to an Integrated Care System (ICS) and Integrated Care Partnerships (ICPs).

There are sixteen Primary Care Networks covering Derbyshire (including Glossop) and Derby City. These PCNs were only confirmed at the end of May 2019 but, moving forward, are an important building block of developing community services to support better delivery of hands-on, personalised, coordinated and more joined-up health and social care across the local system. The relationship, therefore, between Place Alliances and primary Care networks will be important to achieving the ambitions of the STP. Further details of PCNs in Derbyshire can be found here: http://www.derbyandderbyshireccg.nhs.uk/about-us/who-we-are/primary-care-networks/

Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)
The CCG continue to fund VCS infrastructure and condition specific activity from the VCS, however none of this is aligned to the BCF and currently sits outside of the BCF Plan. A review has been undertaken by the CCG with the aim of moving away from the traditional model of grant funding to a commissioned model. Within the BCF funded schemes however, there are several areas which are delivered either by VCS organisations as commissioned services, or that heavily align and support VSC activity – Local Area Coordination, the Healthy Housing Hub and Carers support are all fully embedded within the local VCS sector as a key element of our demand management strategy for health and social care. Their intervention have been successful in advoiding patient admissions to acute settings, as well as assisting with hospital discharges should someone have needed an admission. As such, a number of VCS organisations play a key role in the ongoing delivery of integrated working in Derby, and are key partners within the STP.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:	
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)	
Remaining Word Limit:	466

As a unitary, there are well established links with Housing colleagues, and our political Cabinet Lead covers both Housing and Social Care in their portfolio. The BCF supports the delivery of the Council's Housing Strategy through the provision and funding of Disabled Facilities Grants (DFG), Occupational Therapists and the Healthy Housing Hub. There are established operational and planning meetings involving Housing providers, Commissioners, Social workers and Occupational Therapists to ensure that new housing developments ,meet the needs of people with care needs. This has seen many successes such as integrating adaptations into the design of new build social housing to better match disabled residents to prospective new homes.

There have been improvements in the delivery and approach to DFG's in recent years to further integrate the housing offer for disabled people. The local DFG Guidance overall now takes into account the likely medium and longer term needs of the service user in terms of design and scope of the adaptation. This generally means considering future caring needs and/or additional equipment so ensuring adaptations are built to an adequate size in the first instance.
The Healthy Housing Hub which facilities minor repairs, adaptations and home improvements is now supported by the DFG capital programme, and works under £2,000 are now operated free of charge. Occupational therapists covering children and adults are funded and aligned to the team, with new approaches being trialled to improve the level of support available e.g - stair lift rentals are now offered for people who have significantly reduced life expectancy. Relocation Grants continue to be offered to help people move to an existing adapted, or adaptable, home, and allowances are made so that individuals can pay for further enhancements to large adaptations (for instance where an optional bedroom may be added to an approved bathroom extension). The results of these improvements are that the number of adaptations has increased, up from 176 in 17/18 to 222 in 18/19. This improvement is expected to continue in 19/20 and beyond.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	
Remaining Word Limit:	769

BCF and STP/ICS Alignment

The Derby City Better Care Fund pre-dated the development of Derbyshire STPs and also operates across a different footprint to these. This has, therefore, presented challenges in understanding how the different system led health plans fit together considering there are two Health and Wellbeing Board areas, two BCFs operating under one STP footprint. The overall model for delivering integrated care in Derbyshire is as follows:

• Primary Care Networks – delivering services to populations of c30,000-50,000 people with GP Practices working collaboratively along with other health and social care patterns to provide a more integrated neighbourhood response;

• Place – Eight Place Alliance areas which plan and deliver integration of health and care services to populations of between 250,000-500,000 people. Based on an effective population health management model to increase focus on more preventative services and reduce levels of variation / consistency in services and tackle inequalities;

• System – oversees the delivery of a vision and strategy developed by the Joined Up care Derbyshire Partnership Board. Will oversee the development of an Integrated Care Partnership amongst its local providers and over time streamline commissioning arrangements.

Notwithstanding the Derbyshire wide remit of the STP, the Derby Place Alliance (which is one of the Eight "Places") aligns with the Derby City HWB Board and Local Authority boundary, and the main acute Trust also operates within the Derby Place geography. This has enabled BCF activity to be positioned and aligned to developments within the Derby Place locality.

The 2019/20 BCF Plan for Derby will therefore continue to support the work of both the urgent care and mental health STP workstream (where interventions are Derby focused), but also the work of the Derby Place Alliance for community services – referred to in section (B) above. A number of BCF funded schemes and areas of activity remain pivotal in supporting the wider system in shifting the model of care into the community, with acute services focused more on specialist, urgent and emergency care services.

Successes for 1819 that are anticipated as continuing into 19/20 are:

• Continued reduction in non-elective admissions so that Derby continues to meet year-end performance

• The rate of permanent admissions to residential care for older people continues to reduce as a result of demand management approaches and also interventions designed to retain people independently for longer

• maintenance of low levels of DTOC

The IBCF and winter monies will continue to support BCF activity in terms of supporting NHS pressures, especially during winter, supporting the supplier market and continuing to meet demands for packages of care. The acute based Integrated Discharge "Hub" – which receives BCF and IBCF funding – will continue to support hospital discharges, managing and tracking patients through discharge pathways and organising health and social care input where required. More patients have been supported onto the best pathway for them than previously achieved and within reduced timeframes. It anticipated that in 19/20 efficiencies within the model will lead to increased

capacity, especially over winter, to continue to maintain patient flows out of the hospital. This is evidenced by the consistently low DTOC rates for all providers in Derby.

The IBCF and winter monies in particular will continue to be used to assist with having a social care presence at the “front door” of the hospital and to make greater links with other BCF funded admission avoidance schemes such as Carers support and the Healthy Housing Hub. Equipment and OT support will also continue to be used to aid discharges and prevent admissions from people living in the community.

As the development of the ICS and ICP progresses in year, the BCF schemes are anticipated to be included in workstreams dependent on the focus of activity. This is at a very early stage in Derby, but there is likely to be a Derby geographical ICP to align with the Council and Place boundary.

BCF Governance

The Derby Health and Wellbeing Board has delegated BCF assurance to the joint Derby/Derbyshire BCF Programme Board as a delegated sub-group. This Board will continue to be used to oversee the management and monitoring of the Derby and Derbyshire BCFs and comprises representatives from the two CCGs covering Derbyshire, and Derbyshire County Council. BCF national returns will also be reported via the Board to the Health and Wellbeing Board at least annually.

5 Income

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Derby	£2,047,589
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,047,589**

iBCF Contribution	Contribution
Derby	£10,542,289
Total iBCF Contribution	**£10,542,289**

Winter Pressures Grant	Contribution
Derby	£1,148,569
Total Winter Pressures Grant Contribution	**£1,148,569**

Local Authority Additional Contribution	Contribution
Derby (Integrated Community Equipment Service)	£269,682
Total Additional Local Authority Contribution	**£269,682**

CCG Minimum Contribution	Contribution
NHS Derby and Derbyshire CCG	£17,646,689
Total Minimum CCG Contribution	**£17,646,689**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

	2019/20
Total BCF Pooled Budget	**£31,654,818**

6 Expenditure

Running Balances	Income	Expenditure	Balance
DFG	£2,047,589	£2,047,589	£0
Minimum CCG Contribution	£17,646,689	£17,646,689	£0
iBCF	£10,542,289	£10,542,289	£0
Winter Pressures Grant	£1,148,569	£1,148,569	£0
Additional LA Contribution	£269,682	£269,682	£0
Additional CCG Contribution	£0	£0	£0
Total	£31,654,818	£31,654,818	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£5,184,546	£5,386,951	£0
Adult Social Care services spend from the minimum CCG allocations	£10,977,612	£11,599,182	£0

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
2	Community Nursing	Community nursing services deliver care in the home for patients with a broad range of nursing needs. The needs are not acute in nature but will prevent situations deteriorating.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Med	Med	Med	Med	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£818,660	Existing
2	Integrated Teams (Community Support Teams)	The Integrated Teams comprise of Community Matrons and Care Co-Ordinators who work closely and proactively with the whole primary care team as well as strengthening the links to the wider Integrated community teams functioning in other levels of care	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Med	Med	Med	Med	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,112,100	Existing
2	Evening Nursing Services	The service provides nursing care to adults who require nursing care within their own	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Med	n/a	n/a	n/a	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£352,479	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
		home due to an urgent problem related to a long term chronic disease/condition or as a result of an acute episode of ill health. This includes assessment and treatment of patients with nursing needs																		
2	Community Matrons	Community Matron Programme provides a proactive, holistic approach to managing patient's long-term conditions that is centred on primary care	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Med	Med	Med	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£610,358	Existing
2	Community Therapy	The Community Therapy Teams (physiotherapy and/or occupational therapy)aim to provide highly skilled assessment and intervention to patients with physical problems	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Med	Med	n/a	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£269,441	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
		affecting their functional abilities																		
3	Clinical Navi-gation Service	The service will accept and triage referrals, improve co-ordination, assessment and provide care delivery through both health and social care services in order to support patients to receive clinically appropriate care at home or as close to home as is possible	Integrated Care Planning and Navigation	Care Coordination				Med	High	n/a	n/a	Comm-unity Health		CCG			NHS Community Provider	Minimum CCG Contribution	£426,913	Existing
1	DICES – add-itional	Provides a range of equipment from simple aids for daily living to more complex pieces of equipment enabling people to stay in their home environment.	Assistive Technologies and Equipment	Community Based Equipment				Low	High	n/a	Low	Comm-unity Health		CCG			Private Sector	Additional LA Contribution	£269,682	Existing
1	Property Adapt-ions	Provision of Disabled Facilities Grants	DFG Related Schemes	Adaptations				Low	Med	Med	Med	Social Care		LA			Local Authority	DFG	£2,047,589	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
2	Demo-graphics (system pressures)	care packages	Other		Demographic growth, age and complexity			High	High	High	High	Social Care		LA			Local Authority	iBCF	£4,825,747	Existing
2	Provider fee pressures - Living Wage, specialist rates, overnight costs	contribution towards fee inceases for care packages	Enablers for Integration	Fee increase to stabilise the care provider market				Med	High	High	High	Social Care		LA			Private Sector	iBCF	£3,544,942	Existing
2	Review-ing team - new cases	assessments for high cost care packages	Care Act Implementation Related Duties	Other	social work assessment and support planning			Med	High	High	High	Social Care		LA			Local Authority	iBCF	£308,189	Existing
2	Trans-itions team	additional capacity for social work	Care Act Implementation Related Duties	Other	social work assessment and support planning			Med	High	High	High	Social Care		LA			Local Authority	iBCF	£179,777	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
3	Hospital social work team	Dedicated hospital social work teams working across acute providers.	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/ Multi-Agency Discharge Teams				High	High	High	High	Social Care		LA			Local Authority	iBCF	£729,380	Existing
3	DOLS, best interest and mental capacity assessments	additional capacity for social work	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)				Low	Med	Med	Low	Social Care		LA			Local Authority	iBCF	£300,484	Existing
2	Arboretum House	integrated assessment hub	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	100.0	High	High	High	High	Social Care		LA			Local Authority	iBCF	£653,770	Existing
1	DICES	community equipment	Assistive Technologies and Equipment	Community Based Equipment				Med	Med	Med	Med	Comm-unity Health		CCG			Private Sector	Minimum CCG Contribution	£1,797,000	Existing
2	Social Care assess-ments and cost of care	social care assessments and care packages	Care Act Implementation Related Duties	Other	social care assessments and associated costs of care packages -			Med	Med	Med	Med	Social Care		LA			Local Authority	Minimum CCG Contribution	£5,356,414	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
					Residential, Nursing and Community Services															
2	Assess-ment & Support Planning Teams	social care assessments and care packages	Care Act Implementation Related Duties	Other	social work support and assessments			Med	Med	Med	Med	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,321,112	Existing
2	Bed Based Respite - Perth House	integrated assessment hub	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	600.0	High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,189,001	Existing
1	Carers Support	Number of services delivered to support Carers	Carers Services	Carer Advice and Support				Med	Med	Med	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£667,025	Existing
1	Healthy Housing /Handy Person	housing service aimed at vulnerable householders	Prevention / Early Intervention	Other	minor repairs, adaptations, home improvements			Low	Med	Med	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£433,151	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
3	Enablement & Intermediate Care - Home First	community based integrated assessment and reablement	Intermediate Care Services	Reablement /Rehabilitation Services		Packages	900.0	High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,046,641	Existing
1	Local Area Coordinators	Systematic effort, organised and led by public bodies in partnership with local people and communities, to ensure that people can prevent their ordinary needs from becoming major problems, avoid crisis and support themselves to maintain and strengthen their everyday citizenship	Prevention / Early Intervention	Social Prescribing				Med	Low	Med	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£324,864	Existing
1	Mental Health Enablement Workers x 6	Preventative & recovery focussed support to people living with a mental health condition	Prevention / Early Intervention	Social Prescribing				Med	Med	Med	Med	Mental Health		LA			Local Authority	Minimum CCG Contribution	£243,648	Existing
1	Out of Hours Emergency Care	additional capacity for night time support at intermediate care	Intermediate Care Services	Rapid / Crisis Response				High	High	High	High	Community Health		LA			Private Sector	Minimum CCG Contri	£162,432	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
	- Perth House/ Home First	services																bution		
3	Dementia Support	Advice and information support service for people living with dementia and their family / carers	Carers Services	Other	post diagnostic support			Med	Med	Med	Med	Mental Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£254,476	Existing
2	Social Care Commissioning	joint commissioning posts	Enablers for Integration	Market development (inc Vol sector)				Med	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£260,974	Existing
3	Home First Comm-unity Night Service	outreach capcaity for night time care at home	Intermediate Care Services	Reablement /Rehabilitation Services		Packages	120.0	High	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£196,633	Existing
1	Mental Capacity assessments	Preventative & recovery focussed support to people living with a mental health condition	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)				Med	High	Med	Med	Mental Health		LA			Local Authority	Winter Pressures Grant	£24,556	Existing
1	Track & Triage.	admin costs to track and monitor complex discharges	HICM for Managing Transfer of Care	Chg 2. Systems to Monitor Patient Flow				High	High	Low	High	Social Care		LA			Local Authority	Winter Pressures Grant	£6,442	Existing

			Link to Scheme Type description			Planned Outputs		Metric Impact Low/Medium/High				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New / Existing Scheme
1	Mental Health Social Worker	Preventative & recovery focussed support to people living with a mental health condition	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/ Multi-Agency Discharge Teams				High	High	High	High	Mental Health		LA			Local Authority	Winter Pressures Grant	£49,112	Existing
2	Domiciliary care packages	cost of care packages	Home Care or Domiciliary Care			Hours of Care	37,392.0	High	High	High	High	Social Care		LA			Private Sector	Winter Pressures Grant	£871,826	Existing

7 High Impact Change Model

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including: - Current performance issues to be addressed - The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan - Anticipated improvements from this work
Priorities for the HICM were reviewed during 2017-18 via the Joined Up Care (STP) Derbyshire Board. As a result of this three High Impact Change areas were identified and recommended to the BCF Programme Board as being the priorities for improving performance during 2017-19. These were: • 4 - Home first / discharge to assess • 6 - Trusted assessors • 8 - Enhancing health in care homes Work to progress Changes 4 and 6 progressed well during this timeframe, with both achieving the intended positions as at the end of March 2019. However, progress against Change 8 was not achieved as expected and is a performance issue to be addressed during 2019-20. This is, in part due to the disruption caused during the merger of four of the CCGs serving Derbyshire (particularly in respect of workforce and capacity of staff) along with changes being made to the Derbyshire STP workstreams which are now being reflected in the latest STP refresh to be submitted in Autumn 2019. Further improvements will be needed within services to ensure that Change areas 4 and 6 continue to perform well, particularly in the light of increasing numbers of delayed transfers of care during the first part of 2019-20 – partly in response to continuing rise in non-elective admissions. This should be viewed against a backdrop of continued investment into community services to try and provide health and care support to people to remain as independent as possible. The BCF Programme Board will not be developing a new action plan for the remainder of 2019-20. This is due to a number of factors including the anticipated revision to the HICM and the outcome of the revised STP plan for Derby and Derbyshire. This does not mean there won't be any further improvements – the BCF will continue to support people to remain in their own homes and manage their own conditions for as long as is appropriate, and support the NHS to reduce pressures on its services. The successful Discharge to Assess work continues with further developments planned across the South of the County and in the City to better understand the levels of demand and ensuring the current Pathways for discharge will be fit for purpose in the future. A system wide dashboard has also been implemented and continues to be refined to support the operational delivery planning that is replacing the traditional seasonal planning approach.

	Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Early discharge planning	Established	Established	
Systems to monitor patient flow	Established	Established	
Multi-disciplinary/Multi-agency discharge teams	Established	Established	
Home first / discharge to assess	Mature	Mature	
Seven-day service	Plans in place	Established	
Trusted assessors	Established	Established	
Focus on choice	Established	Established	
Enhancing health in care homes	Established	Established	

8 Metrics

8.1 Non-Elective Admissions

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	There are a range of programmes of work that include reducing non elective admissions as an objective with interventions planned at different stages of the pathway that may lead to admission. At high level these include the following: Prevention – The provision of information to the public regarding services and accessibility is undertaken system wide to ensure that we are able to more effectively manage demand targeting specific issues and causes, for example dealing with weather extremes that can trigger exacerbations of conditions. Increased social connectedness utilising the investment into social prescribing. Access – from 1st October there will be 100% coverage of extended access (ie until 8pm) for GP practices plus improved accessibility through the NHS app for booking. Improvements in access, triage and responsiveness of urgent nursing needs in the community (as a component of integrated responsive provision) Reducing demand – there is a programme of actions co-ordinated and delivered through Place-based working targeting the need to reduce NELS. Actions include ensuring options in a local area as an alternative to conveyancing, reducing falls, care home support based progressing elements of the Enhanced Health in Care Homes framework. There are also condition specific actions targeting service changes to increase care outside of hospital

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	12.0	The ambition in Derby is to maintain DTOC levels at, or below, the current target. This will prove challenging as performance has at times been below plan, even though overall in 18/19 the DTOC targets were met. The main pressures on achieving the target relate to rising demand for social care support, family expectations in relation to onward moves from hospital and the availability of out of hospital NHS services. Despite increasing pressure on acute services there has not been the correlating increase in capacity in out of hospital services which means that at times, delays cannot be avoided. Integrated working, funded by the BCF and IBCF has been and will continue to mitigate this as far as possible. A system wide plan Operational Plan for 2019-20 is currently being developed which replaces the previous seasonal plans e.g. Winter. This reflects the acknowledgement by system partners that seasonal variations alone are not causing the levels of demand seen in previous years. Instead, demand upon services has remained at high levels for a sustained period of time. The IBCF and Winter Pressures Grant will continue to fund a number of initiatives set out in the first year of funding in 2018-19. This will include providing support to the system to enable people to both remain as independent as possible and leave hospital in a timely manner. Examples of uses of the funding include: • Provision of additional care packages to help people leave hospital in a timely manner • Provision of dedicated social work resources at acute Trust access points to support decision making on admissions and reduce demand. • Provision of a community night service to support people who may need over night support at home to facilitate a hospital discharge or avoid an admission • Dedicated resources within the integrated discharge hub. • Social work resource to engage in the work associated with Long length of Stay Patients (LLOS)

8.3 Residential Admissions

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	597	598	The planned figure for 2019-20 is the almost the same as in 2018-19. The intention is, at the very least, to maintain performance at this level. The aim remains to manage demand through community based rather residential placements and hence the target will be to maintain existing performance at a time of rising demand. Preventative interventions at the earliest stage of contact with adult social care, Carers assessments and Local Area Coordination remain key planks for the strategy to manage demand, whereby people will be supported to remain independent for as long as possible. Permanent admission into residential care will therefore only be considered where there is no alternative to safely care for someone in their home, or some other community setting such as Extra Care Housing. Work will continue within the acute setting to ensure that assessments outside of hospital take place before anybody is admitted to long term care following a stay in hospital.
	Numerator	250	255	
	Denominator	41,876	42,666	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England; https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2016basedprojections
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.0%	81.0%	The planned figure for 2019-20 is less than in 2018/19 as this target was not met. Given rising demand for support following hospital and also patient acuity, the success rate of Reablement services has not been as originally anticipated. This has been the case for at least 12 months now and therefore a more realistic target is being proposed. Discharge pathways remain integrated, as does the assessment and support delivery that is provided in bed or non bedded capacity. Interventions outside of the BCF will be trialled in 19/20 to see whether a prolonged period of assessment and therapy support make an impact in improving the rates of people who remain at home 91 days after leaving hospital.
	Numerator	200	846	
	Denominator	230	1045	

9. Confirmation of Planning Requirements

Better Care Fund 2019/20 Template

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes	none
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes	none

	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes	none
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes	none
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes	none
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes	none

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on?Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated)Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box)Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter?**Has funding for the following from the CCG contribution been identified for the area?**- Implementation of Care Act duties?- Funding dedicated to carer-specific support?- Reablement?	Yes	none
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes	none
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes	targets have been set that reflect the likely impact of planned interventions, and also constraints currently within the local system