

# Public Document Pack



**Simon Hobbs**  
Director of Legal and  
Democratic Services  
County Hall  
Matlock  
Derbyshire  
DE4 3AG

Extension 38324  
Direct Dial 01629 538324  
Ask for Alisha Parker

PUBLIC

To: Members of Health and Wellbeing Board

Wednesday, 29 January 2020

Dear Councillor,

Please attend a meeting of the **Health and Wellbeing Board** to be held at **10.00 am** on **Thursday, 6 February 2020** in Members Room, County Hall, Matlock, DE4 3AG, the agenda for which is set out below.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'S Hobbs', written over a light blue horizontal line.

**Simon Hobbs**  
**Director of Legal and Democratic Services**

## **A G E N D A**

### **PART I - NON-EXEMPT ITEMS**

1. Agenda (Pages 1 - 2)
2. Declarations of interest and Apologies for absence  
To receive declarations of interest and apologies for absence (if any)
3. Minutes (Pages 3 - 10)  
To confirm the non-exempt minutes of the meeting of the Health and Wellbeing Board held on 3 October 2019.

4. Index of Multiple Deprivation (presentation)
5. Accommodation Strategies for Adult Social Care and Health (report) (Pages 11 - 16)
6. Report of NHS England / NHS Improvement and Derbyshire County Public Health on National Cancer Screening programmes commissioned for Derbyshire (excluding Glossop) (report) (Pages 17 - 26)
7. Offender Health Report (report) (Pages 27 - 42)
8. Better Care Fund Plan 2019-20 (report) (Pages 43 - 84)
9. Derbyshire Options for Integrated Care Partnerships Implementation (report) (Pages 85 - 88)
10. Issues Relating to Females in Contact with the Criminal Justice System (report) (Pages 89 - 92)
11. HWB Round up (report) (Pages 93 - 96)
12. Health and Wellbeing Board Air Quality Strategy (report) (Pages 97 - 120)
13. Derbyshire Sustainability and Transformation Partnership: Plan Update (report) (Pages 121 - 190)

## DERBYSHIRE HEALTH AND WELLBEING BOARD

**10am-1pm, 6 February 2020**

**Members Room, County Hall, Matlock, DE4 3AG**

### AGENDA

<b>Time</b>	<b>Time allocated</b>	<b>Items</b>	<b>Presenter</b>
10:00	10 minutes	1. Declarations of interest and Apologies for absence 2. Minutes of the last meeting held on 3 October 2019	Cllr Hart
10:10	20 minutes	3. Index of Multiple Deprivation (presentation)	Mick Evans
10:30	15 minutes	4. Accommodation Strategies for Adult Social Care and Health (report)	Ellen Langton
10:45	20 minutes	5. Report of NHS England / NHS Improvement and Derbyshire County Public Health on National Cancer Screening programmes commissioned for Derbyshire (excluding Glossop) (report)	Agnes Belencsak and Jane Careless
11:05	15 minutes	6. Offender Health Report (report)	John Simmons
11:20	10 minutes	7. Better Care Fund Plan 2019 – 20 (report)	Helen Jones
11:30	20 minutes	8. Derbyshire Options for Integrated Care Partnerships Implementation (report)	Ifti Majid
11:50	20 minutes	9. Issues Relating to Females in Contact with the Criminal Justice System (report)	Hardyal Dhindsa and Charlotte Dunkley
12:10	10 minutes	10. HWB Round up (report)	Helen Jones
The following items are for formal ratification following virtual approval			
12:20	5 minutes	11. Health and Wellbeing Board Air Quality Strategy (report)	Jane Careless
12:25	5 minutes	12. Derbyshire Sustainability and Transformation Partnership: Plan Update (report)	Vikki Taylor

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Agenda Item

**MINUTES** of a meeting of the **DERBYSHIRE HEALTH AND WELLBEING BOARD** held at County Hall, Matlock on 03 October 2019.

**PRESENT**

Councillor C Hart (Derbyshire County Council)  
(In the Chair)

L Allison	3D (Third Sector Support Derbyshire)
H Bowen	Chesterfield Borough Council
A Dale	Derbyshire County Council
D Gardener	DD CCG
T Hendra	Tameside & Glossop CCG
H Jones	Derbyshire County Council
J Parfrement	Derbyshire County Council
J Simmons	Healthwatch Derbyshire
T Slater	EMAs
B Smith	DD CCG
A Smithson	Chesterfield Royal Hospital
D Wallace	Derbyshire County Council
P Williams	Derbyshire County Council

Also in attendance – A Howlett (Derbyshire County Council), H Johnson (Derbyshire County Council), I Little (Derbyshire County Council), S Mahil (Joined Up Care Derbyshire), C Walker (Derbyshire County Council), and P Williams (Derbyshire County Council).

Apologies for absence were submitted on behalf of Councillor J Wharmby, and C Clayton (DD CCGs), H Dillistone (DD CCGs), M Dooley (Bolsover District Council), G Strachan (DD CCGs), and D Swaine (Bolsover and North East Derbyshire District Council).

**33/19**      **MINUTES RESOLVED** that the minutes of the meeting of the Board held on 11 July 2019 be confirmed as a correct record.

**34/19**      **JOINED UP CARE DERBYSHIRE STP REFRESH**      SM gave a presentation to the Board to discuss Joined Up Care Derbyshire's 5 Year Strategy Delivery Plan for 2019/20 to 2023/24.

Every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) was required to develop five-year Long Term Plan implementation plans, covering the period to 2023/24 by Autumn 2019. The report was to form the response for implementing the commitments set out in the NHS Long Term Plan with 2019/20 as the transitional year.

The plan would be outcome driven so that the citizens of Derbyshire had the best start in life, stayed well, aged well and died well. The refresh was to be informed and developed through strong engagement with people, patients, staff and wider stakeholders – this would drive the approach.

It was recognised that the 5 year plan was a requirement to demonstrate how the NHS Long Term plan would be implemented. A whole population approach would be taken to ensure that this was done with Local Authority partners. The focus would be on people not patients.

There were many health related problems that were due to increase over time as the average life expectancy increased. Because of this the levels of care and services provided needed to adapt.

There were challenges with being able to understand the financial implications of schemes. As well as getting the continued opportunity to transform and improve care, whilst at the same time making the system more efficient and then securing sufficient capital funds to support system ambitions.

Engagement with the Plan took place between April and September 2019 and ensured that a wide range of stakeholders, including staff, patients, their carer's and members of the public had the opportunity to help shape the plan. All work streams utilised either established engagement mechanisms, open meetings and/or confirm and challenge sessions with their stakeholders to test out thinking and priorities.

The aim was to be an Integrated Care System which was built around care close to home, where hospital beds were only used when someone could not be cared for safely in their own environment.

**RESOLVED** to note the presentation.

**35/19      SUPPORT, SERVICES AND PROVISION FOR CHILDREN AND YOUNG PEOPLE WITH HIGH NEEDS IN DERBYSHIRE**      PW and AH gave a presentation and presented a report to discuss the support, services and provision for children and young people with high needs in Derbyshire.

The Children and Families Act 2014 introduced changes for Local Authorities and their partners with regard to how children and young people with special educational needs and disabilities were assessed and supported. Derbyshire actively responded to the requirements specified in the Act with developments overseen by the Local Area SEND Strategic Board.

In November 2016 Derbyshire had its Joint Local Area SEND Inspection undertaken by Ofsted and CQC (Care Quality Commission). The inspection report had noted many strengths. The document had also highlighted a number

of areas for development which had been captured in the SEND Strategic Plan, with actions taken forward and progress monitored.

In 2017 the DfE allocated funding to Local Authorities to carry out a strategic review of high needs provision. The funding could also be used to help implement the outcomes of the review with Local authorities expected to publish the outcomes of the reviews in the form of strategic plans. The Council had already undertaken elements of development in this area.

This presented an excellent opportunity for the Council to create the capacity to undertake a comprehensive review of High Needs Provision in the local area, building on this work, and to make recommendations to further inform the Local Area Strategic Plan. This was timely, with the review to be undertaken two years on from the Local Area inspection.

Given the scale and scope of the project, it was considered that there were not sufficient resources in-house to deliver this review thoroughly. Through a robust tendering process the ISOS partnership were secured to facilitate the Strategic Review.

The report confirmed that several of the principles that had shaped the initiatives and had been introduced through the current SEND strategy echo those recognised to support effective practices seen by ISOS in other local areas through their national research. However, during the review, some concerns were expressed about the core systems and processes for accessing support.

There were six themes that were identified through the review with recommendations and actions which would be taken forward by the SEND Strategic Board to inform a refreshed SEND Strategy and a revised SEND Strategic Plan.

**RESOLVED** to endorse the outcomes and recommendations of the Special Educational Needs Strategic High Needs Review undertaken between September 2018 and May 2019.

**36/19**      **FUTURE IN MIND**      DG from the Derby and Derbyshire CCGs gave a presentation on the Future in Mind November 2019 Refresh. This was now the 5<sup>th</sup> and final year of the 5 year plan and the refresh was to be posted on the CCG website on 31 October 2019.

So far this year the CCG had targeted early intervention, digital interventions, and provided educational support. This had included Links to NHS Long Term Plan's call for NHS to continue to 'commission, partner with and champion local charities, social enterprises and community interest companies'. As well as a plan to develop models of early intervention on mild

to moderate mental health and emotional wellbeing issues, such as anxiety, behavioural difficulties or friendship issues, along with providing help to staff within a school and college setting.

Plans for the following year included aspirations to move to a 24/7 community focused service in urgent care by 2020/21. Children and young people experiencing a mental health crisis would be able to access the support they needed. Expanding timely, age-appropriate crisis services would improve the experience of children and young people and reduce pressures on accident and emergency (A&E) departments, paediatric wards and ambulance services.

The Eating Disorder services were keen to establish new elements including an intensive home based family offer for particular children, as well as the development of a 24/7 offer- furthermore, further planning should happen with adult commissioners regarding the 18-25 cohort to ensure they can access provision in line with current standards.

Looked after children were another priority as the looked after children's service was currently out to tender.

The aim with the Children and Young People's Mental health and Wellbeing Forum was to develop a CYPMHWF where the views of CYP, from a diverse range of backgrounds, could be strongly heard in commissioning decisions.

**RESOLVED** to note the presentation.

**37/19      TOBACCO CONTROL IN DERBYSHIRE      Tobacco**  
remained the single-most harmful legal substance to health. It was the leading cause of preventable deaths in Derbyshire, and was a major cause of ill health. Approximately 1 million cigarettes were smoked each and every day in Derbyshire, and tobacco use was responsible for 6 deaths a day in the County.

Smoking rates had declined in Derbyshire over recent years, and if the current trend continued then prevalence was likely to fall below 10% by 2024.

There was an extensive programme of work in place across the county to reduce the harm caused by tobacco use, but a recent Health Needs Assessment had highlighted opportunities to strengthen efforts to reduce the harms further.

Derbyshire was taking a system-wide approach to tackling smoking in pregnancy across the Local Maternity Services footprint. The recently established Smoking in Pregnancy Implementation Group (SIPIG) would deliver a coordinated approach to reducing smoking in pregnancy across the pregnancy pathway, both ante- and post-natally. As part of this work, Smoking

in Pregnancy champion midwife posts had been created for both University Hospitals of Derby and Burton and Chesterfield Royal Hospital. A partnership team from Derbyshire was successful in applying to the Design in the Public Sector programme in 2018, and this had allowed an innovative approach to be adapted to tackling smoking in pregnancy, and this was informing local action.

There was a need to strengthen local work to further reduce the impact of tobacco use on local communities and organisations. Further success would be through adopting a strategic approach to tobacco control, with a focus on the following key priorities:

- Recognise that the use of tobacco was an addiction, that needed treatment like other addictions
- Reduce uptake amongst young people
- Support smoke-free pregnancies
- Support smokers to quit, with a focus on those population groups with the highest rates
- Ensure staff who had contact with smokers had the skills and knowledge to advise them to stop using tobacco products, using consistent messages
- Increase public awareness of the harms of tobacco-use and support available to quit
- Reduce the impact of illicit and illegal tobacco

The Health and Wellbeing Board were asked to support the establishment of a multi-agency Tobacco Control Strategic Group to lead and co-ordinate tobacco control work across Derbyshire.

**RESOLVED** to (1) note the continued impact of tobacco use in Derbyshire; (2) note the current work planned to reduce the impact of tobacco use in Derbyshire, and support implementation of new work; (3) support a collaborative whole-systems approach to tobacco control, with strategic responsibility overseen by a newly-established group; and (4) agree an ambition to provide a focus and shared commitment for tobacco control efforts.

**38/19      HEALTH PROTECTION BOARD UPDATE**      DW provided an overview of the key messages that had arisen from the Derbyshire Health Protection Board, which met on the 2<sup>nd</sup> July 2019. The Board was a formal sub group of the Derbyshire County Health and Wellbeing Board and the Derby City Health and Wellbeing Board.

Derbyshire Health Protection Response Group had discussions around Emergency Preparedness, Resilience and Response (EPRR), Screening and Immunisation Programs, and Cervical Screening Program Detailed Report.

The board received an update and assurance report from the Screening and Immunisation team, which included work that the team were completing along with recently completed work and what they planned to do in the near future.

The Screening Quality Assurance Service (SQAS) visit had been undertaken at the University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) and Primary HPV screening work had continued across Derbyshire and Nottinghamshire. Stakeholders would continue to work collaboratively to address inequalities to ensure that all patients eligible to attend screening were supported to engage with the cervical cancer screening program.

The Health protection board received a summary report of IPC assurance by the CCG including updates on the following:

- MRSA Bacteraemia
- Clostridium difficile
- E.coli blood stream infections
- Meticillin Sensitive Staphylococcus Aureus (MSSA)

The board discussed recent incidents and outbreaks taking into account any lessons learnt. The group agreed to look at communication with new community groups around vaccination and the process for rapid communication with GP practices.

**RESOLVED** to note the update report from the Health Protection Board.

**39/19      HEALTHWATCH**      JS presented the Intelligence Report September 2019 to the Board. Their most recent work included the Ex-offender engagement and a report on Domiciliary Care.

Responses had been received from various reports produced by Healthwatch Derbyshire and updates on actions received to reports were included within the report.

Updates on a selection of earlier reports were posted. These included Dementia Services, the Chesterfield Royal Hospital Mystery Shop and Mental Health Information and Signposting in Erewash.

Healthwatch Derby and Derbyshire were in the process of planning a project to be run as a joint venture, aiming to investigate single homeless people's experiences of health and social care in Derbyshire, including Derby city.

The report also included useful tips and resources signposting to those with learning disabilities, learning disability carers and a good practice guide to consultation and checklist.

**RESOLVED** to note the report.

#### **40/19 UPDATE TO THE PROCESS FOR CHANGES TO THE PHARMACEUTICAL LIST IN THE HEALTH AND WELLBEING AREA**

The NHS (Pharmaceutical Services, Charges and Prescribing Amendment) Regulations 2016 required the Health and Wellbeing Board (HWB) to make representations on applications to NHS England for changes to the pharmaceutical list. The HWB representations were to be submitted to NHS England within 45 days of the date of the letter received. NHS England considered all representations that were received before deciding on whether the application was granted.

Applications to NHS England could include:

- Consolidations; community pharmacies on two or more sites proposed to consolidate to a single site.
- Relocations; proposals to move premises
- Additions; proposals for new pharmaceutical services

In addition to any other matter about which the HWB wishes to make representations, in the case of consolidations and relocations the response must indicate whether in the opinion of the HWB the proposal would or would not create a gap in pharmaceutical services if the application were granted.

As a response to an application within the requirement timescales was unlikely to be achieved within the routine schedule of HWB meetings the following process had been agreed.

1. Notification letter received from NHSE requesting HWB representation (45 days to respond)
2. Population Knowledge and Intelligence Team (KIT) undertake analysis of key considerations
3. Draft recommendation sent to Director of Public Health for review and decision
4. Director of Public Health had delegated responsibility from the HWB to sign off representation
5. Subsequent NHS England decision recorded in the quarterly Pharmaceutical Needs Assessment (PNA) supplementary statement (accessed here: <https://observatory.derbyshire.gov.uk/pna/>) and noted in the HWB round up report

Following review, the following changes were proposed to incorporate a notification to HWB members via email that an application has been received and invite comments on the analysis and recommendation.

If any application was considered particularly contentious or any notable risks were identified, a meeting to consider the key issues and any comments received on the proposal would be arranged. The meeting would consist of: the HWB Chair, Vice Chair and Director of Public Health and other officers/ members as appropriate. This group shall agree the response to be made to NHS England.

**RESOLVED** to approve the proposed update to the process for HWB representations on changes to the pharmaceutical list.

**41/19      DHWB ROUND UP**      DW had provided HWB members with a written report containing a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

**RESOLVED** to note the information contained in the round-up report.



## **DERBYSHIRE HEALTH AND WELLBEING BOARD**

**6 February 2020**

### **Report of Executive Director of Adult Social Care and Health**

## **ACCOMMODATION STRATEGIES FOR ADULT SOCIAL CARE AND HEALTH**

### **1. Purpose of the report**

The Health and Wellbeing Board are asked to endorse the following Adult Social Care and Health strategies and note they will form part of the evidence base utilised in Derbyshire's Joint Strategic Needs Assessment:

- Specialist Housing, Accommodation and Support Strategy 2019-2024
- Older People's Housing, Accommodation and Support Strategy 2018-2035

The Health and Wellbeing Board are also asked to note the development of the Working-age Housing, Accommodation, and Support Strategy 2020-2035, which will be presented to the next meeting of the Health and Wellbeing Board following a period of engagement with district, boroughs and other key health partners.

### **2. Information and analysis**

The two adult social care and health housing, accommodation and support strategies are available online at [www.derbyshire.gov.uk/accommissioning](http://www.derbyshire.gov.uk/accommissioning). The key themes and priorities from the strategies are summarised below for information.

#### **2.1 Specialist People's Housing, Accommodation and Support Strategy**

The strategic aims of this strategy are to reduce the number of people with complex needs living in hospital and institutional settings and those people placed in residential and institutional care outside of Derbyshire. There are approximately 100 people with behaviours that challenge services residing in NHS England Specialist Commissioned inpatient settings or long stay rehabilitation placements, often outside Derbyshire, who we wish to repatriate back to Derbyshire where they can be closer to their families and who will require specialist re-housing and support over the next few years. There is also evidence that some people return to hospital after only a short period

following discharge, due to a lack of specialist accommodation and enhanced support within the community.

There are also some people who are subject to Ministry of Justice s41 (Mental Health Act) restrictions and may need to initially step down into licenced accommodation, but then may require further step down accommodation and support under social supervision that is tailored to meet their needs.

Approximately 650 people under the age of 65 live in specialist residential care homes across Derbyshire and outside its borders, with an approximate cost of £32m per annum. The strategy aims to reduce the number of people with complex needs living in residential care and increase the number of people living independently in the community and will require all partners working together in a co-ordinated way.

The five year Specialist Accommodation and Support Strategy and accompanying draft delivery plan (see Appendix 1), is part of a wider transformation programme to improve community care for people with complex needs. It brings together previous specialist accommodation and support plans for people with mental ill health, Autism and learning disabilities. The 'Summary of opportunities to work with us' on Page 19 outlines the need for various types of accommodation for this cohort of people. Although the numbers are small, the delivery needs to be addressed through formal commissioned services and directly provided services, building local networks of support that link to health, housing, independent providers and the voluntary sector. Enabling care to take place closer to home supports the strategic aims of the Council Plan and the Joined-Up Care Derbyshire joint vision for health and social care.

The strategy outlines details of a number of design standards and specialist accommodation requirements that are tailored to the needs of this complex cohort of people. Some existing provision could be re-shaped to better meet the design or quality standards and make them more sustainable and fit for purpose for the future. The key priorities identified to the equitable provision of accommodation for this cohort of individuals include;

- Increased provision of suitable, well located and affordable housing across the county for all client groups with complex needs
- Development of step down/step up/move on facilities for all client groups across Derbyshire
- An expansion in the supply of suitable and well located supported accommodation, most notably South Derbyshire, the High Peak, Ashbourne and Dronfield
- Accommodation design that can meet the needs of these client groups

The success of the strategy is dependent on the further development of integrated community specialist services and support. Proposals for better

joint working with the recently restructured Derby and Derbyshire Clinical Commissioning Group (CCG) are ongoing, including the development of enhanced community support services to improve outcomes for individuals.

## **2.2 Older People's Housing, Accommodation and Support Strategy**

Derbyshire's ageing population will result in the number of people aged 65 and over increasing by 58.5% by 2039. In the same period the number of people aged 90 and over will treble. Nationally and locally, life expectancy is increasing and this means that individuals are living for longer with more complex needs and need appropriate or specialist accommodation later in life. As a result, a new long-term approach to housing, accommodation and support to address the needs of older people is required and is detailed in the strategy attached as Appendix 2 to this report.

The Council and its strategic partners developed and agreed the 'Housing and accommodation for an ageing population: a strategic vision for Derbyshire to 2035', in 2018 and this has informed the development of this strategy. Adult Care worked in conjunction with the Housing, Learning and Improvement Network (Housing LIN), who are leading experts in modelling future housing need and advising local authorities on innovative care and support models, to develop this strategy. The detailed modelling outlines the need for various types of accommodation for older people to 2035 and the data modelling is also included in the attached strategy as a clear baseline for the need which needs to be addressed through both commissioned and directly provided approaches. Across Derbyshire there is varying supply and demand for various housing and accommodation so analysis is included at a locality level within the strategy.

The locality profiles outline a need for a range of additional housing and accommodation to support older people in all districts and boroughs. This includes from an Adult Social Care and Health perspective, housing with care or Extra Care, alongside residential and nursing care provision.

The engagement which informed the development of this strategy, concluded that the majority of people said that they wished to stay in their own home with appropriate care and support provided. A range of activities associated with re-shaping and transforming services which support people in their own home is outlined in the strategy to ensure that they have a more consistent and joined up approach.

Enabling care to take place closer to home supports the strategic aims of Joined Up Care Derbyshire, Derbyshire's joint vision for health and social care. For more specialist accommodation specifically tailored to the needs of older people, the strategy outlines a number of design standards and sets out

examples of innovative contemporary housing and accommodation that have the potential to be delivered in Derbyshire.

Other existing provision could be re-shaped to better meet the design or quality standards and make them more sustainable and fit for purpose for the future. The provision of a range of appropriate housing and accommodation for older people will contribute to facilitating timely hospital discharge, reducing length of stay in hospital, preventing hospital admissions and reducing the number of permanent admissions to residential care. In summary the modelling suggests the following supply and demand for housing for the period to 2035:

- An estimated undersupply of appropriate housing for older people, including a likely undersupply of older peoples' housing for sale (private retirement housing).
- An estimated undersupply of housing with care, both for rent and for sale in all areas.
- A minimal additional net need for residential care provision. In most areas there is no net additional need for residential care provision.
- An estimated undersupply of nursing care beds in all areas.

The strategy is intended to be the start of a dialogue with organisations interested in delivering housing and accommodation for older people to address identified gaps within the market in specific locations across Derbyshire. There are a number of elements where Adult Social Care and Health can be proactive in service delivery as well as through its market shaping and commissioning functions.

A five year implementation plan is included with the strategy outlining key activity and projects which need to take place. Many of these high level actions will require their own specific project management approach and governance. It is proposed that the implementation approach is reviewed on an annual basis to reflect the latest position in Derbyshire, track progress and also take advantage of any new opportunities, such as new funding streams.

Each opportunity will need to be further refined and developed via engagement with external partners and older people themselves. Throughout the strategy implementation, we will seek to maximise opportunities from external funding bodies and potentially pull additional inward investment into Derbyshire. The aim is to support a more commercially minded, enterprising and innovative attitude to how the recommendations are implemented. Liaison will take place with district and borough councils to ensure appropriate governance and oversight arrangements are in place for district specific proposals. New schemes, if appropriate, will be aligned with the One Public Estate Programme in Derbyshire so that public sector assets and land may be utilised to support our strategic ambition for innovative approaches to older people's housing and accommodation.

## **2.3 Working age Adults Housing, Accommodation and Support Strategy**

The Working-age Adults Housing, Accommodation and Support Strategy 2020- 2035 will consider adults with care and support needs aged 18 to 64 years old. This strategy will complete Adult Social Care and Health's suite of housing, accommodation and support strategies.

This commissioning strategy and delivery plan will bring together learning and experiences across the areas of mental health, learning disability and autism, physical disability and acquired brain injury. The strategy will recognise that living in safe, suitable and stable accommodation with access to appropriate care and support is linked to higher independence, improved wellbeing and better mental health.

The strategy will focus on those people who live independently in the community, or who require supported accommodation. It will identify actions that the Council and partners can take to ensure that suitable housing, accommodation and support is available so that people have alternatives to residential or specialist accommodation.

The strategy will outline a range of actions that will enable people to:

- Be supported to live in their own homes in the community with support from local services
- Be supported to live independently and with the right support to meet their specific needs and preferred outcomes
- Be offered a choice of housing that is right for them and enable them to maintain contact with family and friends
- Have a choice about who they live with and the location and community in which they live
- Be able to remain in their home where possible, even if their care and support needs change - not linked (not dependent)

Representatives from Adult Social Care and Health will be engaging with representatives from housing teams at district and borough authorities in the next few weeks to finalise locality profile information. Engagement will also take place with health partners to consider wider support that needs to be available within communities to enable people of a working-age to live as independently as possible.

## **3. Links to the Health and Wellbeing Strategy**

The strategies all contribute to the Health and Wellbeing Board priority to 'support our vulnerable populations to live in well planned and healthy homes'.

The data and evidence included in the strategies will form a key part of the Derbyshire Joint Strategic Needs Assessment and help to inform future decision making about the anticipated housing and support needs of the Derbyshire population. The purpose of JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning – the core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing

### **RECOMMENDATION**

The Health and Wellbeing Board is asked to:

- Endorse the Specialist Housing, Accommodation and Support Strategy and Older People's Housing, Accommodation and Support Strategy and note they will form part of the evidence base utilised in Derbyshire's Joint Strategic Needs Assessment.
- Note the development of the Working-age Housing, Accommodation, and Support Strategy 2020-2035 and the engagement activity with district, boroughs and key other key health partners which will inform the development of the final document.

**Helen Jones**  
**Executive Director – Adult Social Care and Health**  
**Derbyshire County Council**

## **DERBYSHIRE HEALTH AND WELLBEING BOARD**

### **Report of NHS England and NHS Improvement Midlands and Derbyshire County Public Health on National Cancer Screening programmes commissioned for Derbyshire.**

**6 February 2020**

#### **1. Purpose of the Report**

The purpose of this report is to:

- describe delivery in Derbyshire (excluding Glossop) of the national cancer screening programmes commissioned by NHS England and NHS Improvement Midlands (NHSE&I).
- provide assurance that the local screening programmes are delivering positive outcomes for eligible residents, including groups where uptake may be historically low.
- raise awareness of the performance, achievements and challenges associated with the local screening programmes and how Board members can support the work.

#### **2. Overview of Screening in Derbyshire**

##### **Background**

Screening identifies people who are at higher risk of a particular health problem, so that early treatment can be offered or information given to help them make informed decisions. Screening does not aim to identify a condition rather it determines an individual's risk of developing that condition. If an individual has a higher-risk result (a screen positive result) then further diagnostic tests are offered. Early identification of increased risk of developing a condition means better outcomes for the patient.

The UK National Screening Committee advises the NHS on which screening programmes to offer. Screening programmes are targeted at groups of people who are most likely to benefit from them - this may be specific age groups or defined populations.

Screening aims to reduce potential harms caused by disease or its complications to people who are currently healthy. Screening programmes save the lives of thousands of people each year, including approximately:

- 5,000 deaths prevented by cervical screening
- 2,400 bowel cancer deaths avoided through screening
- 1,300 women prevented from dying of breast cancer every year

##### **Local Commissioning arrangements**

Coverage is defined as the percentage of individuals in the population who are eligible for screening at a particular point in time, who have had a test with the screening interval. A woman's eligibility depends on them being in the screening age range. Uptake refers to the proportion of individuals accepting invites.

NHSE&I, through its Screening and Immunisation teams (SIT) are responsible for the commissioning of all National Immunisation and Screening Programmes described in Section 7A of the National Health Service Act (Appendix 1 provides a timeline overview of the current Section 7A programmes). In this capacity, NHSE&I are accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake & coverage levels as specified in Public Health Outcome Indicators and KPIs. NHSE&I are responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required. NHSE&I work in partnership with system leaders to improve screening pathways and outcomes, including CCG primary care leaders, health service providers, Local Authorities, and voluntary sector partners.

### **Local Governance arrangements**

Quality assurance is an important part of screening programmes. Given the scale of screening programmes any potential incidents could impact large numbers of people, involve several organisations or geographical areas, and impact public confidence. NHS screening programmes are underpinned by rigorous quality assurance and monitoring arrangements. Quality standards relating to screening are monitored and supported by Screening Quality Assurance Service (SQAS) Midlands & East. Local NHSE&I Screening Programme boards oversee the quality, safety and performance of screening programmes and oversee actions for improving the outcomes, support system working, and assess health inequalities work undertaken by each programme.

The Director of Public Health has a statutory duty to provide independent scrutiny and challenge of the arrangements of NHSE&I, as such Derbyshire County Public Health is an active member of each Screening Programme Board, seeking assurance, and providing challenging and support. In addition local arrangements are in place to ensure quarterly reporting to the Derbyshire Health Protection Board, (a sub group of the Health and Wellbeing Board) providing an overview of current challenges, risks and changes to programmes, as well as a rolling programme of detailed reports covering issues of inequality and equity of access.

### **Local action to address inequalities**

While the concept of screening is inherently fair (i.e. it is offered to everybody in the target group), we know that some individuals are less likely to access screening, due to barriers including but not limited to; access, health literacy, or personal health beliefs.

Derbyshire Public Health have established close working relationships with NHSE&I to ensure that local population needs are understood and addressed by local screening services. The Public Health team have supported NHSE&I through the facilitation of system working, and have undertaken a range of projects to reduce inequalities and improve population outcomes.



In recognition of the need for effective local data to monitor coverage and inequalities, NHE/I Midlands have commissioned additional analyst support from Derby City Council for the population of Derbyshire County and City. This has enabled the development of dashboards for primary care, mapping of uptake of Breast Screening against screening sites, analysis of uptake for specific groups including those with learning disabilities and analysis as part of a detailed Bowel Health Equity Audit. Collaborative working with partners has enabled a range of projects to be undertaken across Derbyshire to promote screening, address inequality and improve access, many of which have been recognised both regionally and nationally as examples of effective system working. This includes;

- work to widen access to screening clinics in rural areas and supporting access to screening cross boundary where geography is a perceived barrier
- project to increase screening uptake amongst individuals with learning disabilities
- enhance screening services in prisons
- targeted work with GP practices,
- community engagement events,
- data analysis and health equity audit
- promotion of screening within LGBT community.

The SIT (Derbyshire/Nottinghamshire) have also developed close links with the STP, working with partners through the Cancer Prevention work stream to reduce inequalities and cancer mortality and morbidity, through improved screening coverage. Led by Public Health a detailed action plan has been developed to address known inequalities within Cancer Screening Programmes, based on local evidence and analysis. The plan utilises available evidence around the need for a multifaceted approach to increase screening coverage, including primary care support, community engagement, improving health literacy and system wide targeted promotional activities.

### **3. Screening Performance**

#### **Breast Screening**

Routine breast screening is offered to women aged between 50 and 70 on a three yearly basis. The screening programme is commissioned by NHS England and NHS Improvement Midlands and is delivered in line with the national service specification. The providers are University Hospitals of Derby & Burton NHS Foundation Trust via the South Derbyshire & South East Staffordshire Breast Screening Service and Chesterfield Royal Hospital NHS Foundation Trust known as the North Derbyshire & Chesterfield Breast Screening Service. Screening is delivered from the main sites and across a number of mobile screening sites.

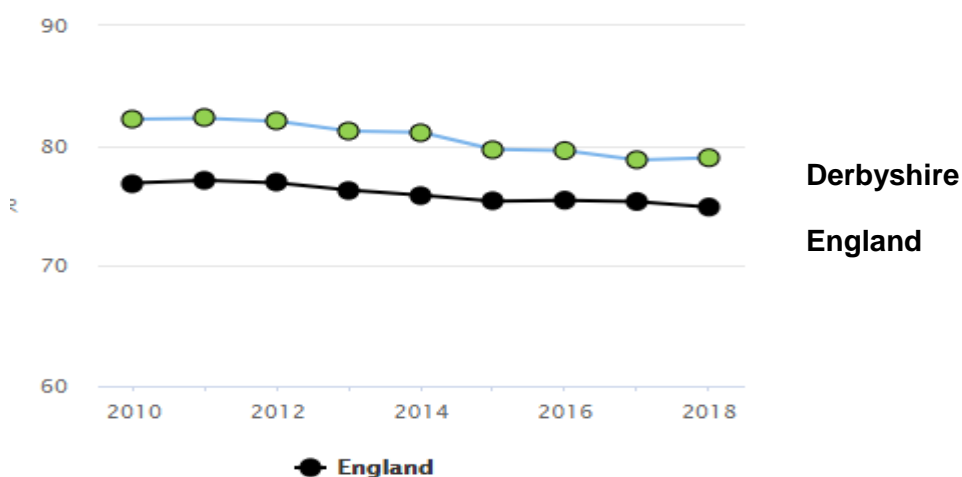
The national coverage of women aged 53-70 was 74.9% at 31 March 2018, and performance has remained largely static in the last 3 reporting years. This is above the NHS Breast Screening Programme's minimum standard of 70% with East Midlands reporting the highest coverage at 78.4%. In Derbyshire, the coverage for

Coverage is defined as the percentage of individuals in the population who are eligible for screening at a particular point in time, who have had a test with the screening interval. A woman's eligibility depends on them being in the screening age range. Uptake refers to the proportion of individuals accepting invites.

women aged 53-70 was 79%, above the England and East Midlands average and only one percent below the 80% achievable national target. Derbyshire is currently ranked 16:150 Local Authorities.

Uptake is known to be lowest amongst the most deprived communities, and women with learning disabilities. National evidence suggest the greatest decreases in screening have been seen amongst women aged 65-69 years. Evidence also suggests frequent non-attenders for screening include women from ethnic minority groups, specifically from Bangladeshi and Black African communities and bisexual women, followed by lesbian women. Women's reasons for non-attendance vary and can include feeling they are too busy, deterred by the pain or discomfort of having a mammogram, feeling fit and healthy and do not think they are at risk of breast cancer. There is also evidence that some women do not attend due to a fear of being diagnosed with breast cancer.

**Figure 1; Breast Screening Coverage 2018**



Source; Public Health England; Public Health Outcomes Framework C24a Breast Cancer Screening Coverage

The STP Cancer Prevention work stream is working collaboratively to reduce inequality and coverage variation in order to ensure screening is increased amongst those with greatest need, whilst also reversing the overall trend of static coverage rates. Actions taken by stakeholders:

- targeted work to raise awareness of Breast Screening,
- practice support visits to increase GP engagement,
- reasonable adjustment for patients with learning difficulties or physical disabilities,
- interpretation and translation service,
- accessible communication format and easy read leaflets,
- offering screening in prison setting.

Further analysis is planned for 2020 including the feasibility of Health Equity Audit to support more targeted work. Sending SMS text reminder is also included in the NHS E&I commissioning intention for 2020/21 and this was a recommendation of the 2019 Sir Mike Richards Review: Report of the Independent Review of Adult Screening Programme in England.

Coverage is defined as the percentage of individuals in the population who are eligible for screening at a particular point in time, who have had a test with the screening interval. A woman's eligibility depends on them being in the screening age range. Uptake refers to the proportion of individuals accepting invites.

Providers across Derbyshire perform well against the national standards for quality and performance. Following Quality Assurance visits, each provider receive a detailed report and based on the recommendations develop an action plan to address any issues raised during the visit. Following visits to the Derbyshire screening providers in 2016 and 2017 all recommendations have been implemented.

## **Cervical Screening**

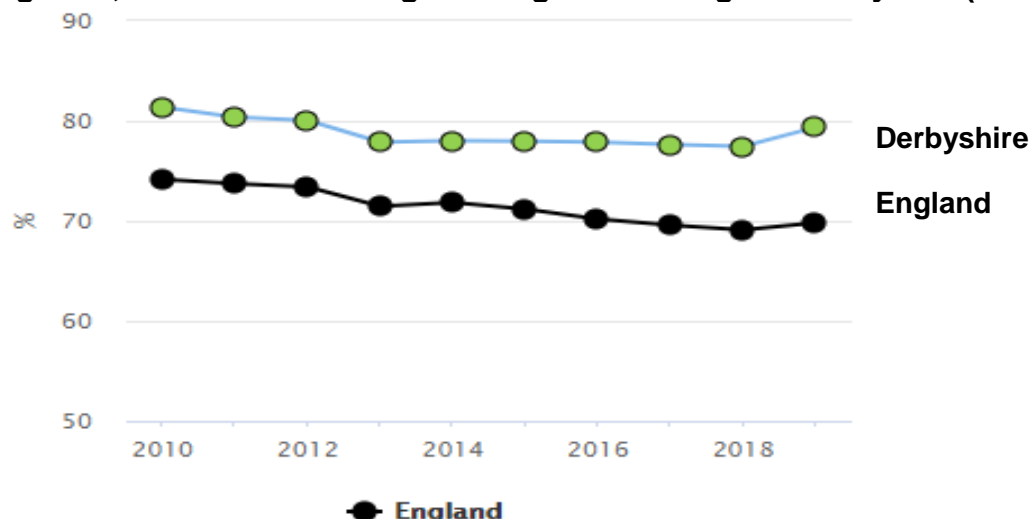
The aim of the NHS Cervical Screening Programme (NHSCSP) is to reduce the incidence of, and mortality from cervical cancer. Screening detects abnormalities within the cervix that could, if left untreated, develop into cancer. Eligible women between the ages of 24.5 and 49 for invited for screening every 3 years and women aged 50 – 64 every 5 years, by the National Cervical Screening Programme.

The screening programme is commissioned by NHSE&I and is delivered in line with the national service specification. The providers are Derbyshire GP practices (sample taking), Chesterfield Royal Hospital NHS Foundation Trust (Colposcopy). Derbyshire Community Health Services NHS Foundation Trust (Colposcopy) and University Hospitals of Derby & Burton NHS Foundation Trust (Colposcopy and Cytology).

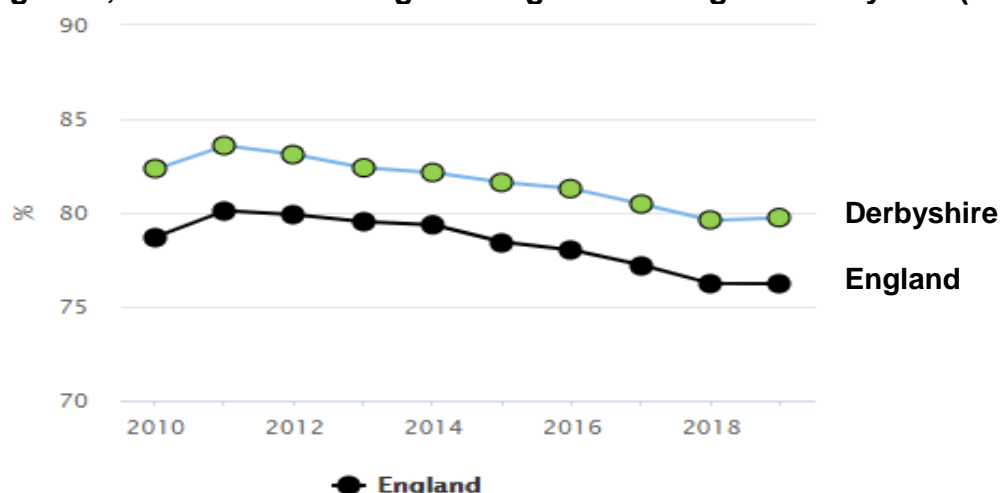
Human Papilloma Virus (HPV) plays a crucial role in the development of cervical cancer. It has been detected in 99.7% of cervical cancers. Finding abnormal changes early means they can be monitored or treated, so they are prevented from turning into cervical cancer. A new primary HPV screening test was introduced across Derbyshire in July 2018, which is based on the detection of HPV in the screening sample.

National standards set out that at least 98% of women should receive the result of their screening test in writing within 14 days of the sample being taken. Meeting with this standard had been a challenge prior to the implementation of primary HPV screening. This standard improved significantly over the last year. In November 2019, 68 % of women in Derbyshire receive their screening result within 2 weeks and 98.8% of them within 3 weeks as a result of the hard and dedicated work of the screening laboratory.

Derbyshire County achieves the highest cervical screening coverage for women aged 25-49 years across the Country, at 79.4% which nearly meets the 80% target. The figure showed 2% increase in 2019; the first time since 2013. Coverage for women aged 50-64 years is 79.75% in Derbyshire, the 6<sup>th</sup> highest in the Country, above the East Midlands and England average of 78.3% and 76.2% respectively. Uptake has also seen a decrease in previous years in this age group, in line with National trends, however is now showing signs of stabilising.

**Figure 2; Cervical Screening coverage women aged 25-49 years (2019).**

Source: Public Health England; Public Health Outcomes Framework C24b

**Figure 3; Cervical Screening coverage women aged 50-64 years (2019)**

Source: Public Health England; Public Health Outcomes Framework C24c

Uptake is known to be lowest amongst the most deprived communities. National evidence suggests frequent non-attenders for screening include women over 50, younger eligible women (i.e. those 25-30 years), women from ethnic minority groups, as well as lesbian and bisexual women (10 times lower). People with learning disabilities are 45% less likely to be screened for cancer compared to their counterparts without learning disabilities. Emotional barriers (fear, embarrassment and anticipated shame) and low perceived risk are sighted as contributing to lower cervical screening coverage. The lowest uptakes are geographically spread but include communities within the south of North East Derbyshire and north of Amber Valley, Erewash towns and Shirebrook area.

Coverage is defined as the percentage of individuals in the population who are eligible for screening at a particular point in time, who have had a test with the screening interval. A woman's eligibility depends on them being in the screening age range. Uptake refers to the proportion of individuals accepting invites.

The STP Cancer Prevention work stream is working collaboratively to reduce inequality and coverage variation in order to ensure screening is increased amongst those with greatest need, whilst also reversing the overall trend of static coverage rates specifically in women aged 50-64 years. Targeted work to raise awareness of Cervical Screening, practice support visits and work with NHSE&I and PHE regional teams to support a Cervical Screening Health Equity Audit is currently underway.

Providers across Derbyshire perform well against the national standards for quality and performance. University Hospitals of Derby and Burton NHS Foundation Trust Quality Assurance visit in 2018 stated “Overall, there is evidence of a high-quality cervical screening service offered at Derby, with data across all professional areas showing good performance against national standards”.

## **Bowel Screening**

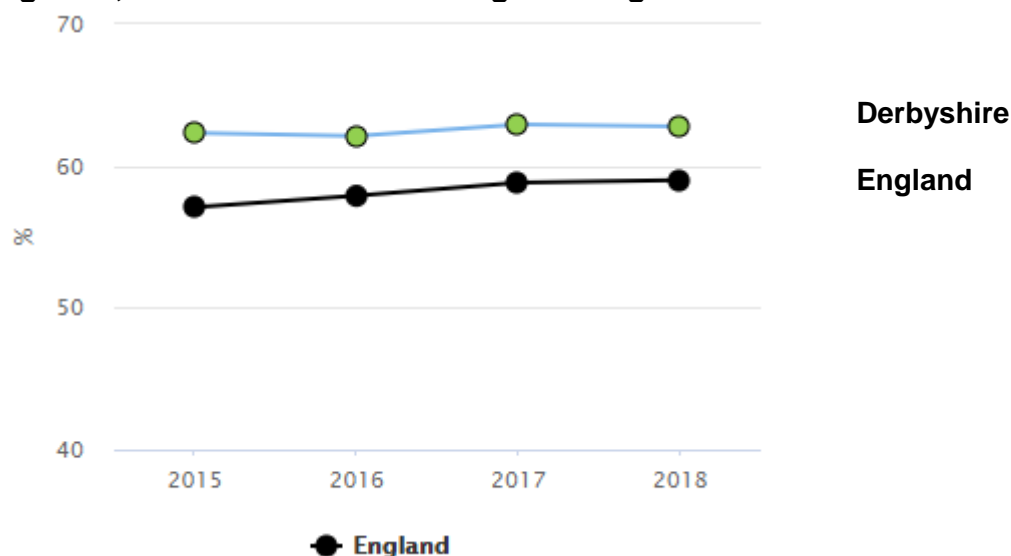
Bowel cancer is a common type of cancer in both men and women. Around one in 20 people will get it during their lifetime. Screening can help to detect bowel cancer at an early stage, when it is easier to treat, and has shown to reduce deaths from bowel cancer by 25%. It can also be used to check for and remove small growths in the bowel called polyps, which can turn into cancer over time. Almost nine out of ten cases of bowel cancer occur in people aged 60 or over.

There are currently two types of test used in the Bowel Cancer Screening Programme. These are:

- Bowel scope screening – a test where a thin, flexible tube with a camera at the end is used to look for and, if found, remove polyps inside a patient’s bowel. Currently, some men and women aged 55 are invited for a one-off bowel scope screening appointment.
- The faecal immunochemical test (FIT) (formerly faecal occult blood test (FOBT)) – a kit that patients use to collect a small sample of faeces in a pot which is sent by post to the laboratory to check for blood, which could be caused by cancer. This is a new test that was introduced nationally during 2019.

All men and women aged 60 to 74 are invited for bowel cancer screening biennially and are sent a home test kit in the post. Men and women aged 75 or over can self-refer for a screening home test kit. In Derbyshire (excluding Glossop), the Eastern Bowel Hub situated at the Queens Medical Centre, Nottingham, send invitations and testing kits to the eligible population. People found to have abnormal tests are then referred to the North and South Derbyshire Screening Centres for further assessment with most going on to have a colonoscopy.

Derbyshire County achieves coverage of 62.8% (national achievable target is 60%), compared to East Midlands average of 60.9%, ranking 17<sup>th</sup> in the County. Coverage has remained relatively stable in recent years, however is expected to increase with the introduction of FIT testing.

**Figure 4; Bowel Cancer Screening Coverage 2018**

Source; Public Health England; Public Health Outcomes Framework C24d

The STP Cancer Prevention work stream is working collaboratively to reduce inequality and coverage variation in relation to bowel screening. In 2018 a detailed Health Equity Audit was undertaken by NHS England North Midland SIT (Derbyshire/Nottinghamshire), Local Authority Public Health and the Bowel Screening Hub to provide a greater understanding of uptake across Derbyshire County and City. The Bowel Health Equity Audit demonstrated that certain population groups are less likely to take part in bowel cancer screening than others. This included, lower socio-economic backgrounds, BME communities, the younger screening cohorts, men, and those with learning disabilities. Geographical areas of lower uptake and greatest inequality were also identified and included market towns and communities within:

- Erewash
- Chesterfield
- Bolsover

The findings of the health equity audit highlighted the need to utilise evidence based interventions including face to face health promotion and telephone advice, GP endorsement letters and targeted interventions with primary care. Following the publication of findings, stakeholders have worked to engage a range of providers to undertake targeted promotion of screening to key groups, provide primary care support visits and develop targeted communications methods. Further work is planned for 2020 following a bid for Cancer Alliance funding to undertake targeted community engagement around bowel screening. The project has been recognised regionally and nationally being shared at National Public Health England conference and published, as well as informing guidance on access to data for screening and used as an example of best practice regionally.

A telephone advisory service is already run by the Bowel Hub and all GP practices are signed up the GP endorsement project. Screening is offered in prison settings; accessible communication format and easy read leaflets are available for individuals by request.

Coverage is defined as the percentage of individuals in the population who are eligible for screening at a particular point in time, who have had a test with the screening interval. A woman's eligibility depends on them being in the screening age range. Uptake refers to the proportion of individuals accepting invites.

The Hub are working with Learning Disability nurses in Nottingham to increase the attendance of this patient group. Learning from the project will be shared in due course to support the implementation in other areas.

The Screening Quality Assurance Service (SQAS) visited North Derbyshire Screening Centre in January 2015 and South Derbyshire Screening Centre in November 2015. Both screening centres were commended for their high quality of service provision and many areas of good practice were highlighted.

The Eastern Bowel Hub is a high performing service that regularly meets the programme standards, and has good systems in place to monitor if improvement is required. The Hub successfully completed their first SQAS visit in September 2017 which demonstrated good quality service provision, and maintained their UKAS accreditation in May 2018.

#### **4. Recommendation**

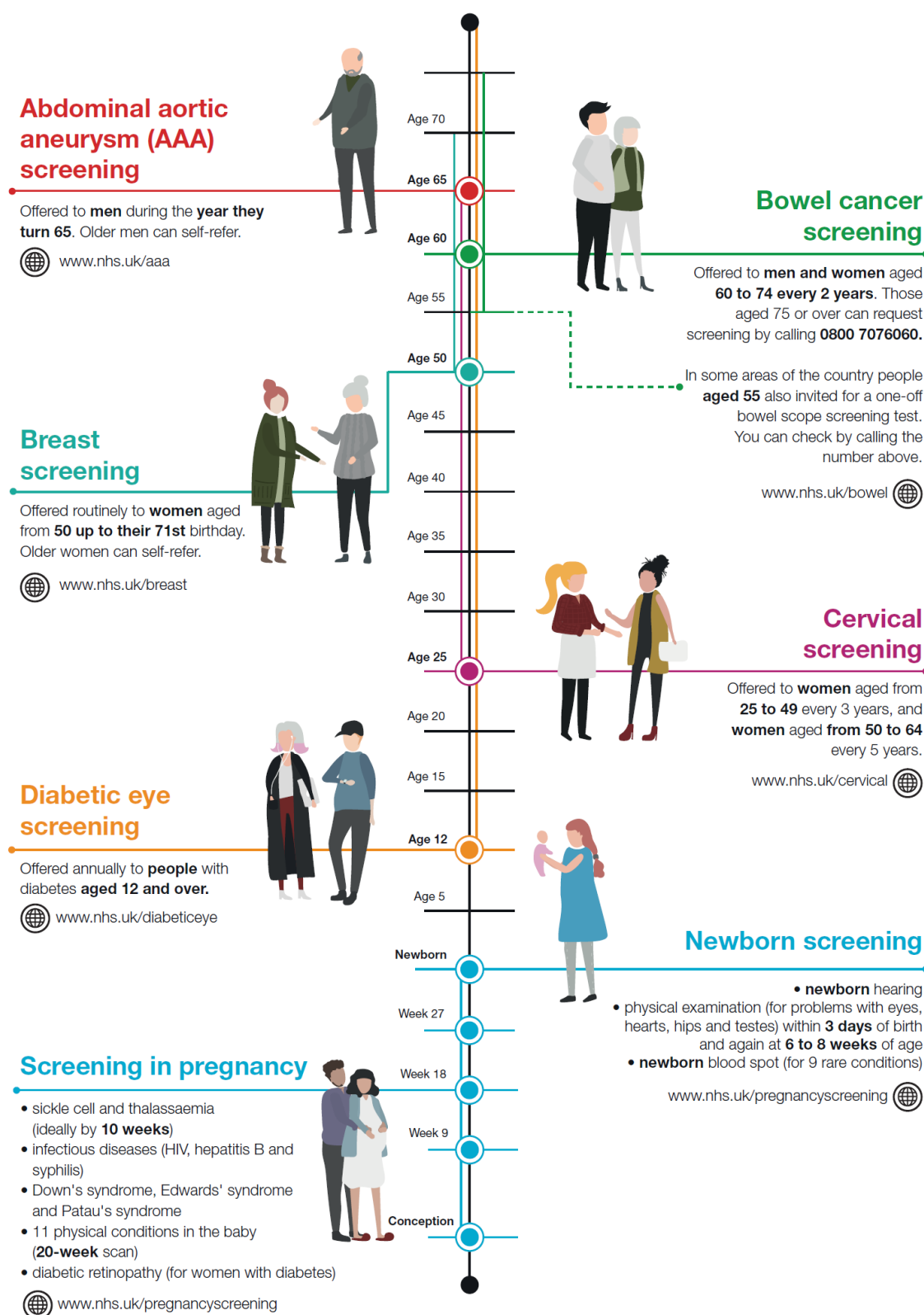
Members of the Health & Wellbeing Board are recommended to:

- a) consider the arrangements, achievements and challenges relating to the local screening programmes in Derbyshire
- b) contribute to successful delivery of the screening programmes by:
  - 1. promoting local and national screening messages to their staff and service users, in particular those from under-served communities.
  - 2. supporting initiatives to increase uptake and address inequalities in collaboration with the local screening and immunisation teams.

<p><b>Agnes Belencsak</b>  <b>Screening and Immunisation Lead</b>  <b>NHS England and NHS Improvement Midlands</b></p>	<p><b>Jane Careless</b>  <b>Public Health Lead</b>  <b>Derbyshire County Council</b></p>
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## Appendix 1

## Population screening timeline



Coverage is defined as the percentage of individuals in the population who are eligible for screening at a particular point in time, who have had a test with the screening interval. A woman's eligibility depends on them being in the screening age range. Uptake refers to the proportion of individuals accepting invites.





# Offender Health Report

Experiences of offenders using health services in Derbyshire



**Date:** 9 December 2019  
**Author:** Hannah Morton  
**Job Title:** Insight and Intelligence Manager

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## 1. Thank you

Healthwatch Derbyshire would like to thank all participants who gave their time to talk to us about their experiences of using the health services whilst being involved within the Youth Offending Service in Derby/Derbyshire and/or following release from prison. We also extend our thanks to the National Probation Service, Community Rehabilitation Company, Derby City Youth Offending Service and Derbyshire County Youth Offending Service, who supported and cooperated with this engagement activity.

## 2. Disclaimer

The comments outlined in this report should be taken in the context that they are not representative of all youth offenders and adult ex-offenders who have experience of health services in Derbyshire, but nevertheless offer a useful insight. It is important to note that the engagement was carried out within a specific time frame and therefore this only provides a snapshot of patient experience collected at that point in time. The report outlines the genuine thoughts, feelings and issues that youth offenders and adult ex-offenders have conveyed to Healthwatch Derbyshire. The data should be used in conjunction with, and to complement, other sources of data that are available.

## 3. Background

Healthwatch Derbyshire is an independent voice for the people of Derbyshire. We are here to listen to the experiences of Derbyshire residents and give them a stronger say in influencing how local health and social care services are provided.

We listen to what people have to say about their experiences of using health and social care services and feed this information through to those responsible for providing the services. We also ensure services are held to account for how they use this feedback to influence the way services are designed and run.

Healthwatch Derbyshire was set up in April 2013 as a result of the Health and Social Care Act 2012, and is part of a network of local Healthwatch organisations covering every local authority across England.

The Healthwatch network is supported in its work by Healthwatch England who build a national picture of the issues that matter most to health and social care users and will ensure that this evidence is used to influence those who plan and run services at a national level.

## 4. Rationale for the report

To ensure a diverse range of individuals are able to share their views on local health and social care services, Healthwatch Derbyshire undertake targeted pieces of work, paying specific attention to those who may otherwise struggle to be heard. We were asked by the Derbyshire Criminal Justice Board to undertake engagement with ex-offenders and within the youth offending service to understand more about the health services that people have used.

### 4.1 Definitions

According to Rethink Mental Illness (2017):

- “The National Probation Service (NPS) is a statutory criminal justice service. They supervise high risk offenders who have been released into the community

- Community Rehabilitation Companies (CRCs) are private sector companies. They supervise medium and low risk offenders who have been released into the community and are also responsible for providing resettlement services in prison and the community
- Probation officers supervise offenders when they are released into the community, they can work for either the NPS or CRC.”

Furthermore, Derbyshire County Council (DCC) explain that, “The Derbyshire Youth Offending Service (YOS) works with young people and their communities to tackle youth crime. It supervises and helps young people aged 10 to 17 who have committed offences and works with them to help prevent further offending”.

For more information please visits:

- <https://www.rethink.org/advice-and-information/rights-restrictions/police-courts-and-prison/prisons-planning-for-release/>
- <https://www.derbyshire.gov.uk/social-health/children-and-families/youth-offending-service/youth-offending-service.aspx>

## 5. What we did in brief

To collect consistent information, a series of questions (prompt sheets) were developed to provide a framework for discussions. The prompt was based around the themes shared with us by the Derbyshire Criminal Justice Board, which were:

- Navigating services
- Experience of using primary care
- Health literacy.

Prior to the engagement, the prompt was shared with the Derbyshire Criminal Justice Board to ask for comments to ensure that the feedback received from participants would be valuable and be used to influence future service delivery.

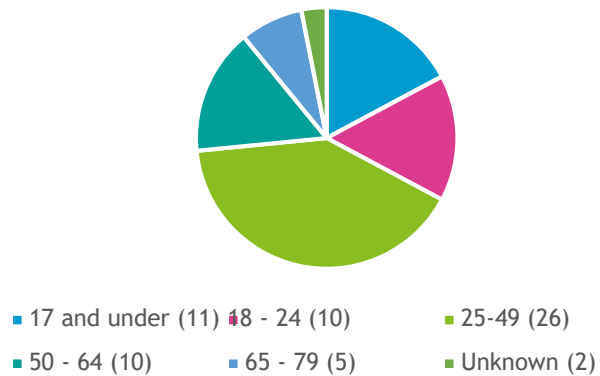
### 5.1. Methods of engagement

The engagement was carried out by Healthwatch engagement officers (EOs) between May and August 2019.

EOs spoke to 64 ex-offenders and youth offenders in total about their experiences of health services in Derbyshire. Our EOs visited NPS, CRC and YOS offices to be able to talk with people before and after their appointments.

The chart below shows the age of the participants:

Age of participant

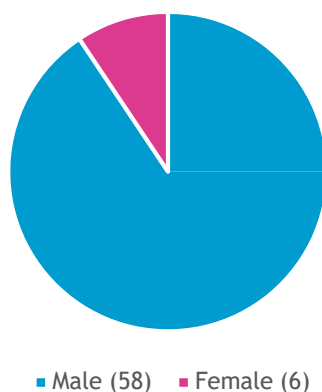


The table below shows what service the participant was using:

Name of service	Number of participants
Youth Offending Service - Derby City	4
Youth Offending Service - Derbyshire County	9
Community Rehabilitation Company	11
National Probation Service	40
Total	64

Gender of participants:

Gender



## 6. Key findings

- Most YOs had registered with a GP and dental surgery and, although a large proportion of adult ex-offenders had registered with a GP, only half had registered with a dental surgery as this was not viewed as a 'priority'
- Many adult ex-offenders felt there was limited support for people with mental health issues, and felt there should be more emphasis on preventing mental ill health and ensuring people are signposted to appropriate support
- Some adults ex-offenders felt when they asked for help with their mental health they were often provided with medication, rather than offered support to help deal with any underlying issues
- YOs appeared to have no difficulties with finding and understanding health related information and support, whereas adult ex-offenders often relied on their probation officer or GP
- Adult ex-offenders felt there should be more information provided to offenders on release from prison, as many felt unprepared as they were unsure what to do, or where to go with regards to healthcare services
- Majority of the YOs were happy with the health of their lifestyle, however many adult ex-offenders explained they felt unhappy with their lifestyle due to poor diets and mental health.

## 7. What people told us

### 7.1 Primary care

#### ➤ Primary care registration

Majority of the youth offenders (YOs) we spoke to had registered with a GP (11), whilst two YOs were waiting for support from their probation worker or parent to enable them to register. In terms of dental registration, all (13) but one YO had registered with a dental surgery.

Similarly, for the adult ex-offenders 47 had registered with a GP whilst four had not, or were unsure if they were still registered with the same GP prior to their imprisonment. One adult shared a concern for ex-offenders who are released to unapproved accommodation as help would not be automatically received and it was felt that this is a big issue.

Furthermore, for dental health there appeared to be a fairly equal split of adults who had registered with a dental surgery (21) and those who had not (29) and one participant was unsure. Many participants who had not yet registered explained it is not at the top of their priority list and/or they have had no issues with their dental health yet.

One adult ex-offender explained, "They ensured I registered with a GP but no one ever mentioned a dentist or how to get your eyes tested. They do ask if you have drug and alcohol problems but not about any other sort of health problems".

#### ➤ Primary care experience

In terms of GP and dental experiences within the last six months, the majority of the YOs and adult ex-offenders we spoke to described their experience as positive.

Many adults appeared to be happy with the quality and continuity of care received by GPs but highlighted issues around long waiting times for appointments, not always feeling listened to and some comments suggest signposting to mental health support could be improved.

Sample of comments:

- “They are very good and book my appointments for me as I go and see them every month. I always see a female GP and I am always able to see the same one to talk over my mental health”
- “I regularly see one particular GP at the surgery and they are helpful to me, however there is not enough help for my mental health to make sure I get well”
- “I have been to the doctor and they have given me anxiety medication ... but they did not tell me anything about mental health support”
- “I like to see [named professional] but there is often a four week wait, he listens a lot more to me than other doctors”
- “... I have noticed a big difference as now GPs do not really listen, I feel like a number and not a person, you are now only about to talk about one issue per appointment yet I have many conditions and I find it upsetting as they are often interconnected ... ”
- “Only the last GP really listened to me, the others were just telling me I had constipation”.

#### ➤ Other healthcare experiences

A large proportion of adult ex-offenders used a pharmacy for prescriptions, with most experiencing a positive service.

In terms of other health services used by participants, there did not appear to be any themes amongst the feedback received.

Sample of comments:

- “I was admitted to Chesterfield Royal Hospital (CRH) four days after release from prison, I was released from prison with nowhere to go and was sleeping rough, I couldn’t walk and was admitted to CRH via ambulance and was in hospital for four weeks, the care was fantastic, they did not want to release me to no fixed abode but they needed the bed and were unable to find any support for me”
- “I go to the Royal Derby Hospital (RDH) to see people about my liver as I have problems with it as it is damaged. There are long waits to see the consultant and this worries me as I never know how long I will have to wait, the communication is poor around this and could be improved”
- “I have been waiting to see a psychiatrist since Christmas. My GP has tried their best to tell them it is urgent and I was told last week I am now at the top of the list. I was sent to IAPT services but they told me when I was too ill and they could not help me and it was an incorrect referral made by the GP”
- “I have tried to access mental health support since leaving prison but this has not been successful as full records have not been received from the prison healthcare service at HMP Whatton. My mental health is deteriorating ... and I feel I have been 'pushed from pillar to post' without getting anywhere”.

#### ➤ Mental health services

A number of adult ex-offenders felt there was limited support for people with mental health, with many explaining there needs to be more emphasis on prevention and putting support in place for people at an early stage, so symptoms do not progress and they do not end up in a crisis or self-medicating with smoking, drugs or alcohol.

Some adult ex-offenders also explained that when they have reached out for help for their mental health they have just been provided with medication and have not been offered support to deal with any underlying issues.

Sample of comments:

- “The mental health crisis team is not very good, they give out inconsistent messages. Different staff say different things and it is not all written down so they do not stick to the plan ... They never follow through with things nor contact you when they say they will contact you. Some just want to give you sedatives to get you to shut up. This does not work I need help not to be put to sleep”
- “More investment in mental health ... waiting for mental health support but there is a lack of a Community Psychiatric Nurses (CPN) and I have no personal support, I just have medication for it”
- “GPs do not care I have mental health issues and get low due to many physical health problems. I find it hard to talk to GPs about it ... National Probation Service (NPS) staff do not all refer to services as their focus is to prevent reoffending. They do not realise that a lack of healthy lifestyle and lack of support will impact on this target”
- “I saw many people in prison who were delusional and tried to kill themselves ... trying to access mental health services in the community is virtually impossible as I have had many symptoms and different diagnoses over the years ... for some services I am not serious enough and for others I am too difficult to treat and manage. All I ever wanted was one-to-one support to sort out Post Traumatic Stress Disorder (PTSD) resulting from childhood abuse, as this was not treated when I was aged 10 so it led to a serious mental illness (SMI) and offending. There is a massive gap in services to treat people with PTSD”
- “There is still a long way to go to reduce the stigma of people needing help for mental health, especially men. My life went out of control when a relationship broke up and lost my job, house everything. I appreciate all the support I have got from probation and have linked to drug and alcohol support. There should be more money put into prevention and awareness raising of the impact of drug taking. Most of my old friends who worked used cocaine every weekend but they did not see themselves as drug addicts. It is a macho thing and that you have spare money to throw around and a lot of my friends do it because they are trying to make them feel better about themselves and their lives as there is something missing”
- “Since I have been involved with the criminal justice system it has been very shocking to see how many people have mental health problems. This should have been sorted out when they were children as there are so many people who are not well and so if they got the help they needed they would not have been involved in crime. There should be more emphasis and support from workers to improve your whole life e.g. smoking, drinking, drugs, exercise, diet etc rather than just focus on the crime as these are often a factor why people do things as there are gaps in their lives”.

## 7.2 Health information

### ➤ Findings and understanding health related help and support

Majority of the YOs we spoke to explained they had no difficulties finding out where to go for health related help and support and felt they understood the information they received. One YO explained they relied on their mother for help and support and another explained they would just go to the Emergency Department.

There were mixed responses from adult ex-offenders with regards to knowing where to go for health related help and support. A huge proportion relied on their probation officer for the information, whilst others explained they would go to a GP.

A number of adult ex-offenders felt there should be more information provided to offenders on release from prison, as people can be in prison for many years and the healthcare system can change rapidly, which results in ex-offenders not knowing where to go.

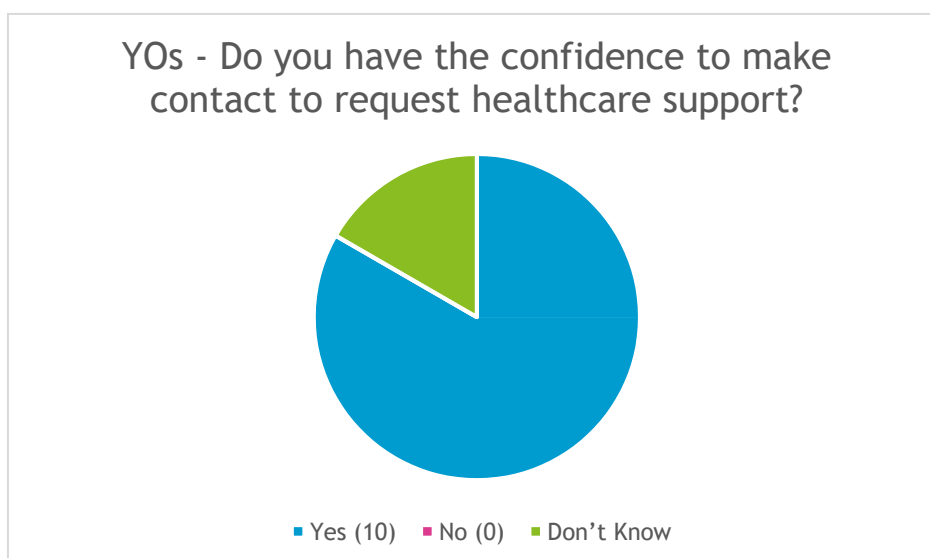


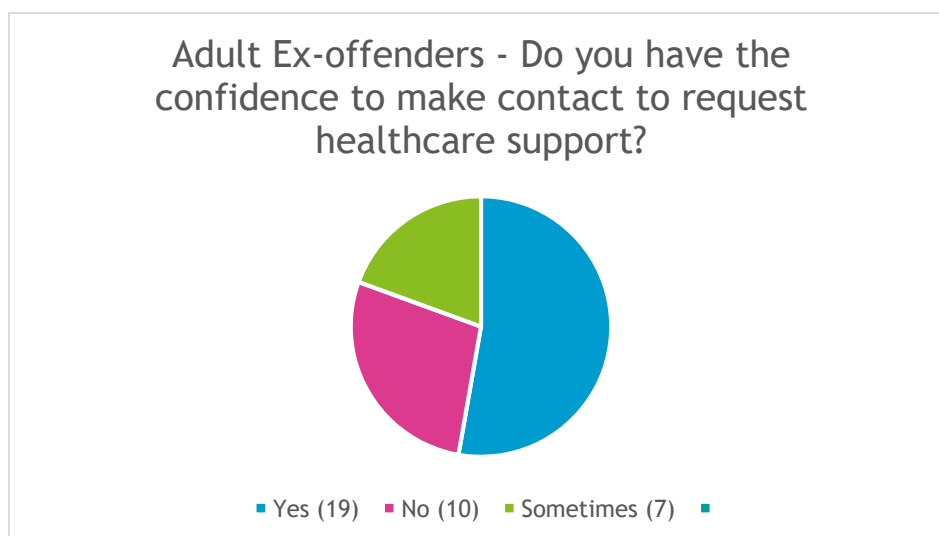
Furthermore, in terms of understanding the information received around healthcare the majority of the adults raised no issues, although a few comments were made around the complicated patient information leaflets within medication boxes.

Sample of comments:

- “I discussed with my probation officer who is supporting me to access healthcare and get the right paperwork to register”
- “I ring the probation officer for information, I go to them for most things”
- “I go to the GP to find things out”
- “I go to the GP to find things out as I like talking to people face to face. If people give me leaflets with numbers to ring I would not do it”
- “When in prison especially for many years, the professionals do not make it clear how much things have changed back in the community”
- “It took a while to get things sorted as when you are released after ten years a lot of things have changed”
- “It is hard to know where to find the right information and help for wellbeing and mental health as I know I need help to get me out and improve how I feel”
- “There are some issues when there is complex language on the tablets and leaflets but I do not mind asking if I do not understand”
- “You are given lots of leaflets with information on but really you need help to make the calls and make the initial visit to places. You need people to talk things through rather than giving you stuff to read on your own”
- “It was okay but a lot of the registration forms and health forms are very complicated and they do not need to be like this. Many people ‘kick-off’ when given things, it may just be because they do not understand it but time is not given to people to explain things. Illiteracy is a huge issue that I saw in prison especially the young people I saw inside”.

➤ Confidence to make contact to request healthcare support





Sample of comments:

- “I am confident to go to appointments but not sure how to make them” (YO)
- “I had been inside for ten years and so it was hard. The help from the hostel staff was invaluable” (adult ex-offender)
- “It is hard to motivate yourself when you feel depressed. Also I do not like having to telephone people as I find this induces anxiety. I prefer to contact people by email or on line” (adult ex-offender)
- “Sort of. After ten years you are used to being told what to do exactly and when to do it. It was confusing even for me” (adult ex-offender)
- “I am not always confident to ask. It depends on the person and how I feel about them”
- “Sometimes it depends on how I am feeling” (adult ex-offender).

➤ **Suggestions to improve health information for ex-offenders**

1. To be made aware of out-of-hours support
2. To better prepare offenders prior to release from prison
3. To provide information on all aspect of health i.e. GP, dentists, opticians and pharmacists
4. To provide online communication (or via email) for ex-offenders to be able to arrange appointments
5. To use less complicated language in information leaflets
6. For professionals to take the time to make sure people have understood what has been said.

### 7.3 Information, help and support whilst in prison

➤ **Were you told about how to use health services when released?**

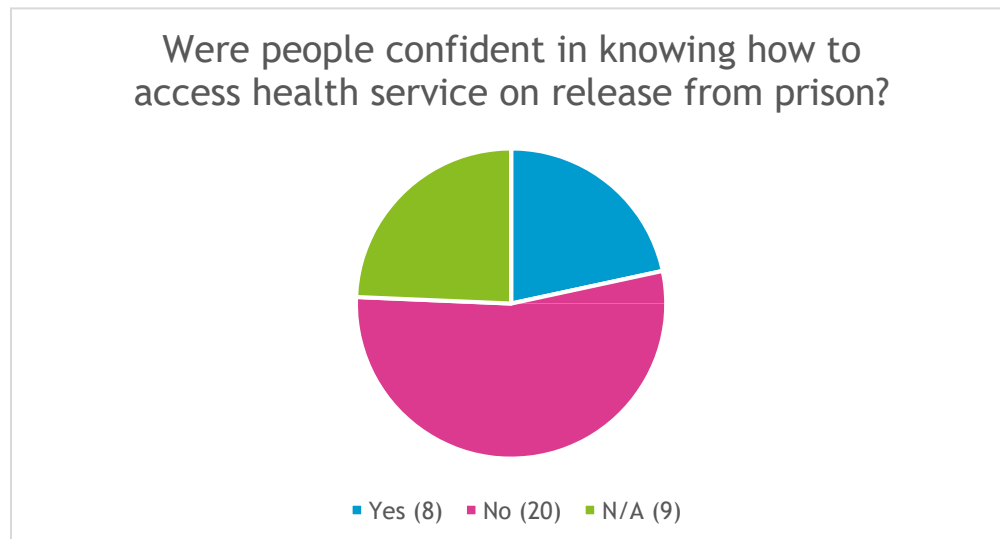
A large proportion of adult ex-offenders explained they did not receive a sufficient amount of information around how to use health services once released from prison.

Sample of comments:

- “No on how to access healthcare i.e. a GP or dentist. I did meet with a mental health worker prior to release who provided information and a number to call for support and advice and arranged my first prescription”

- “No ... I received no information on how to access healthcare or where to go for support”
- “I was told very little before being released ...”
- “I was told nothing about how to use health services when released, they just read through the license conditions”
- “I was not told anything about what to do about dental problems ... or help for mental health, or even a GP. I was just told to get my things and then I was out after signing a piece of paper that I didn’t really understand”
- “Staff need to remember that it is such a big thing being released especially after ten years, so you cannot take it all in and then remember it all”
- “I was given quite a lot of information, I was lucky as I was sent to an approved hostel which meant they made sure I had registered with a GP and got all my medication sorted. It would have been very hard to do this for myself after so many years inside as it was so confusing ...”
- “This does not happen at all in my experience, maybe in smaller prisons but in a big prison there are too many prisoners for workers to spend time with and do what they should ...”.

➤ **Confidence in knowing how to access health services on release from prison**



Sample of comments:

- “No ... but fortunately was released into approved accommodation so I got help from the workers there”
- “I did not know what to do on release and did not really have the confidence as it was all a bit too much to take in when you have just been released”
- “Not everything, someone needs to check things through with you and maybe have a list to work through. You are just thinking about what will happen when you get out not about all the other stuff and the practicalities. The pressure and stress really increases when you are about to be released when you have been in for so many years”
- “I went into prison as a child and came out as an adult, I was never given any help, support or advice by staff to let me know how much things had changed and how I needed to look after myself and how to register with a doctor etc ...”.

➤ **Suggestions to improve health information on release from prison**

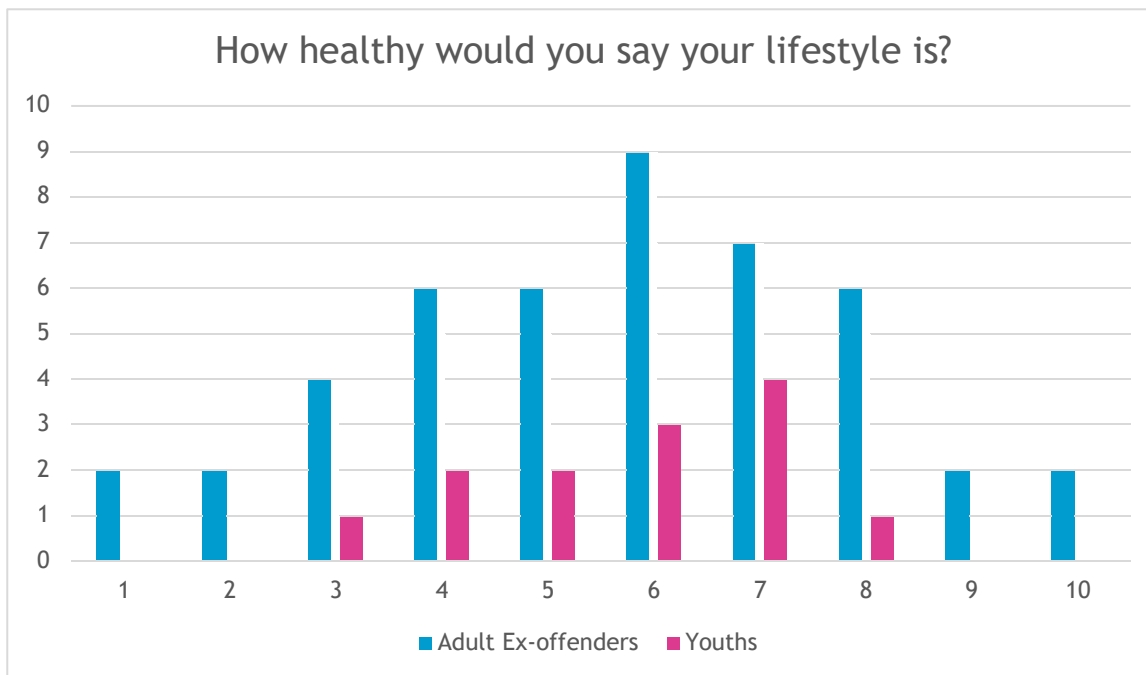
1. More support around mental health

## Offender Health report

2. To receive sufficient information on release from prison in an accessible format
3. To be prepared and know what to do on release from prison
4. Less paperwork on release from prison so people have the time to read through the information they are given and digest it
5. Clear information around healthcare and better communication on release from prison.

### 7.4 Health and well-being

- **Rate how healthy your lifestyle is on a scale 1 - 10 (1 being really unhealthy and 10 being very healthy)**



Majority of the YOs were happy with how healthy their lifestyle was. However, many adult ex-offenders explained how unhappy they were due to poor diets and mental health.

Sample of comments:

- “I eat too much of the wrong foods and I drink too much carbonated drinks. It’s not easy where I live, I am in a hotel room and have no cooking facilities”
- “I am not happy, my mental health prevents me from being at a place where I can make the changes that are probably needed as I know I should not drink or smoke and I should eat good things”
- “I am not happy with my mental health and feeling anxious”
- “I am okay but would like to get fitter and exercise more but it is expensive when you have little money”
- “Not happy, I would like to be more healthy but I don’t not know what to do”
- “I was fit when I left jail and I have since put on weight, in jail I had a purpose but outside I have nothing”.

- **Suggestions to improve health and wellbeing of ex-offenders**

1. To have support to get back to ‘normality’, for example suitable housing and work
2. Better access to dental services
3. Help to stop smoking and/or more publicity on who to contact
4. Affordable activities for people to participate in and keep fit
5. Quicker access to mental health support and more information on how to access support

6. Information and support on healthy food options and how to prepare/cook healthy, low cost meals.

## 8 What should happen now?

1. To ensure that all offenders are provided with clear information and support on all relevant healthcare services prior, and on release from prison:
  - Details of how to register and access a GP, dentist, opticians and pharmacist
  - What support is available out of hours (NHS111)?
2. Improve mental health support:
  - To improve signposting to mental health support in primary care
  - Quicker access to mental health support
  - More emphasis on preventing mental ill health and supporting people to deal with any underlying issues.
3. Ensure that the information provided to offenders on release from prison is in an accessible format:
  - Ensure people are able to digest and understand the information provided
  - For professionals to take the time to make sure people have understood what has been said
  - Ensure language used in paperwork/leaflets is understandable to all.
4. Work to improve the health and well-being of ex-offenders:
  - To support people to access work and suitable housing
  - Signpost people to affordable keep fit activities
  - Provide people with information and support on healthy food options and how to prepare/cook healthy, low cost meals.

## 9 Response from service providers and commissioners

The Reducing Reoffending, Offending and Offender Health Group commissioned a Health Needs Assessment to better inform decision-making relating to the health and care provided to offenders residing in Derby City and Derbyshire. A sub-group has been established, chaired by the Assistant Director of Public Health from Derbyshire County Council, and with a membership that includes representatives from commissioners and providers across both criminal justice and health and care. The remit of the group is to implement actions identified within the HNA recommendations.

The group welcomes this report that provides additional insight on how organisations can better meet the health needs of offenders in the community. Additional information relating to the specific recommendations are included in the table below.

What should happen now?	Service provider/commissioner response:
<p><b>1. To ensure that all offenders are provided with clear information and support on all relevant healthcare services prior, and on release from prison:</b></p> <ul style="list-style-type: none"> <li>• Details of how to register and access a GP, dentist, opticians and pharmacist</li> <li>• What support is available out of hours (NHS111)?</li> </ul>	<p>The group agrees that ensuring that offenders released from prison have been provided with information, in an appropriate format, is important to allow them to access healthcare services in the community.</p> <p>The group has considered the information that is provided to all offenders in the community, including those released from prisons, and will continue to work across organisations to further develop information and materials provided to offenders. The group will also consider whether more can be done to ensure probation staff have the relevant skills to support offenders with health needs, for example being able to offer the right support from a place of knowledge and confidence, and to inform healthcare staff of the health needs of offenders in the community.</p>
<p><b>2. Improve mental health support:</b></p> <ul style="list-style-type: none"> <li>• To improve signposting to mental health support in primary care</li> <li>• Quicker access to mental health support</li> <li>• More emphasis on preventing mental ill health and supporting people to deal with any underlying issues.</li> </ul>	<p>There are a number of services that are provided to all Derbyshire residents who need mental health support, to complement healthcare services and to help with promoting healthier lifestyles, accessing community groups, accessing education, volunteering and work opportunities, overcoming barriers in day to day life</p> <p>These include:</p> <ul style="list-style-type: none"> <li>• Adult Social Care Enablement service</li> <li>• The Recovery and Peer Support Service</li> <li>• The Independent Living Service (support to maintain tenancy).</li> </ul> <p>These services can be accessed by referral from professionals or by self-referral. To enable those leaving prison to access these services in a timely way, we need to ensure that Through the Gate workers make appropriate referrals to these services, prior to release, including sharing risk assessments where required. Partnership working/discussion could improve referral arrangements.</p> <p>The NHS Long-term plan includes a new community mental health framework that will improve support for living independently, healthy lifestyles, trauma based interventions</p>

	<p>and addressing co-existing substance misuse issues.</p> <p>Development work is in progress to redesign access to community mental health support for those that fall between primary and secondary care and to develop closer working between primary care services and community-based provision (including peer support and self-help approaches). In Tameside and Glossop this is being taken forward by the Living Life Well approach and there are plans to implement a similar approach across Derbyshire.</p> <p>In addition, Adult Social Care is currently developing a working age accommodation strategy which will encompass housing needs for vulnerable people or those with care/support needs.</p>
<p><b>3. Ensure that the information provided to offenders on release from prison is in an accessible format:</b></p> <ul style="list-style-type: none"> <li>• Ensure people are able to digest and understand the information provided</li> <li>• For professionals to take the time to make sure people have understood what has been said</li> <li>• Ensure language used in paperwork/leaflets is understandable to all.</li> </ul>	<p>Please see response to recommendation 1.</p>
<p><b>4. Work to improve the health and well-being of ex-offenders:</b></p> <ul style="list-style-type: none"> <li>• To support people to access work and suitable housing</li> <li>• Signpost people to affordable keep fit activities</li> </ul> <p>Provide people with information and support on healthy food options and how to prepare/cook healthy, low cost meals.</p>	<p>The group will continue to work to improve the pathways of care for offenders in the community. Three priority areas that have been identified already are ensuring access into substance misuse, mental health and learning disability and autism services. The group will finalise development and monitor implementation of these pathways.</p> <p>Co-location of lifestyle services within probation offices is currently being piloted in Derbyshire, thus providing easier access to specialist advice and support on adopting a healthier lifestyle.</p> <p>There are good links in place between probation colleagues and housing and education and employment providers, both of which can be key determinants of an individual's health.</p>

**Offender Health report**

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	<p>The group will continue to explore options for improving the health and wellbeing of offenders in the community, and are considering models of care that are commissioned specifically for this purpose in other areas.</p>
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**HEALTH AND WELLBEING BOARD****6 FEBRUARY 2020****Report of the Executive Director Adult Social Care and Health****DERBYSHIRE BETTER CARE FUND  
2019-20 PLAN****1. Purpose of the Report**

1. To provide a summary of the 2019-20 Better Care Fund Planning Requirements; and
2. To present the 2019-20 Better Care Fund Plan for Derbyshire to the Derbyshire Health and Wellbeing Board;

**2. Information and Analysis**

On 18 July 2019 the Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England published the Better Care Fund (BCF) 2019-20 Planning Requirements following the publication of the BCF Policy Framework on 10 April 2019. This publication included details of allocations of funding for the BCF 2019-20 and the planning template, for which completed returns were due to NHS England by 27 September 2019.

**Planning requirements**

The BCF planning requirements for 2019-20 have been designed to provide a level of continuity from 2017-19. This is partly due a national review of the BCF currently taking place, and therefore any substantial changes to the overall policy and subsequent planning requirements will not be made until this has been completed – likely during 2020, with changes to take effect 2021-2024.

There are four national conditions set out in the Policy Framework that must be achieved to ensure a BCF plan can be approved and funding accessed:

- i. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.
- ii. A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.

- iii. That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, which may include seven day services and adult social care.
- iv. A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). BCF Plans should set out the current state of implementation for each of the eight changes in the model and the planned level of implementation by March 2020. The plans will include a narrative describing the priorities and actions for 2019-20 to embed the model, including:
  - Details of changes;
  - Anticipated improvements to care and discharge, minimising delays and ensuring that as many people as possible are discharged safely to their normal place of residence.

The four national metrics used in previous years to monitor implementation and success of BCF plans across England will also remain the same.

#### **Confirmation of funding contribution**

NHS England has published individual HWB level allocations of the BCF for 2019-20. This includes an uplift in contributions in line with CCG revenue growth. The minimum contributions required for Derbyshire from partners for 2019-20 are:

<b>CCG</b>	<b>Minimum Contribution 2019-20</b>
NHS Tameside and Glossop CCG	£2,389,013
NHS Derby and Derbyshire CCG	£54,445,848
<b>Total Minimum Contribution</b>	<b>£56,834,861</b>

The iBCF funding made available to Derbyshire during 2019-20 is provided below, along with the Winter Pressures grant for 2019-20 which is now part of the BCF Pooled Budget.

<b>Funding Source</b>	<b>2019-20</b>
iBCF	£31,054,728
Winter Pressures Grant	£3,627,306
<b>Total iBCF Funding available</b>	<b>£34,682,034</b>

***Disabled Facilities Grant***

Following the approach taken in previous years, the Disabled Facilities Grant (DFG) will again be allocated through the BCF. The funding made available for the District & Borough Councils in Derbyshire is £6,960,721

***Former Carers' Break Funding***

The BCF at a national level also includes, as in 2016-17, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). In Derbyshire £2.048m has been allocated for services to support Carers in 2019-20, this is an increase of c£0.086m to include costs associated with carer respite services.

In summary the Derbyshire BCF Pooled Budget for 2019-20 is:

<b>Source of funding</b>	<b>2019-20</b>
CCG Minimum	£56,834,861
CCG Additional (spend on Social Care)	£1,432,572
LA Additional (Community Equipment)	£1,566,063
iBCF	£31,054,728
Winter Pressures Grant	£3,627,306
DFG	£6,960,721
<b>TOTAL</b>	<b>£101,476,251</b>

**National metrics**

The national metrics used to monitor the BCF during 2019-20 will remain as in previous years, in summary these are:

- Non-elective admissions (General and Acute);
- Admissions to residential and care homes;
- Effectiveness of reablement;
- Delayed transfers of care.

Targets for non-elective admissions and delayed transfers of care have been set nationally. Targets for the social care metrics were agreed by the Adult Social Care and Health Senior management Team at its meeting on 6 August 2019. The targets were to maintain performance at existing levels, rather than set stretching targets. The rationale being that the Council is about to undertake a long-term transformation programme which will impact upon the performance of these areas over the coming years.

**Local plan development, sign off and assurance**

The assurance of plans has been streamlined into one stage, with an assessment of whether a plan should be approved, not approved, or approved with support. As in previous years, local areas will be required to submit a planning template (which includes a narrative plan) that demonstrates how all

the national conditions are to be met and what targets are set to be achieved. These documents were submitted to the Better Care Support Team (BCST) on 27 September 2019.

The submission and assurance process will follow the following timetable:

<b>Milestone</b>	<b>Date</b>
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local government). All submissions will need to be sent to the local BCM, and copied to <a href="mailto:england.bettercaresupport@nhs.net">england.bettercaresupport@nhs.net</a>	By 27 September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	By 30 October
Regionally moderated assurance outcomes sent to BCST	By 30 October
Cross regional calibration	By 5 November
Assurance recommendations considered by Departments and NHSE	5 – 15 November
Approval letters issued giving formal permission to spend (CCG minimum)	Winter 2019-20
All Section 75 agreements to be signed and in place	By 31 January 2020

### **The Derbyshire BCF 2019-20 Plan**

The Derbyshire 2019-20 BCF Plan is, in effect, a continuation of the 2017-19 plan. The main changes to the plan from 2017-19 relate to an alignment of the services being funded by NHS Derby and Derbyshire CCG following the merger of four former CCGs. The overarching vision and aims of the plan remain the same as they did in 2015-16.

There is a continued focus on community services being funded through the plan to reflect the work of the Joined Up Care Derbyshire Place workstream. This includes services such as Community Nursing, Therapy, Matrons, Evening Nursing, Clinical Navigation, Intermediate Care Teams (North), Social Care support packages, Reablement, Hospital Social Work Teams etc.

Some preventative services have also been included to promote self-management and to reduce the demand on secondary health and care services. These include: Carers services, Community Equipment service, Disabled Facilities Grants, Local Area Coordinators, Wheelchairs service etc.

The full 2019-20 Plan is attached as an appendix to this report.

The Plan has been developed in conjunction with key partners through the Joint BCF Programme Board and its Monitoring and Finance Group. The final plan was approved by the Joint BCF Programme Board, a delegated sub-group of the Derbyshire Health and Wellbeing Board (HWB), at its meeting on 20 September 2019. A copy of the final plan was sent to the Chair of the Health and Wellbeing Board for information ahead of its submission. However, due to timings of meetings, the 2019-20 BCF Plan has not been presented to the HWB until today. The 2019-20 BCF Plan for Derbyshire was formally approved by NHS England on 8 January 2020.

### **3. Background Papers**

- *Better Care Fund Policy Framework 2017 to 2019*, Department for Communities and Local Government and Department of Health and Social Care, London, 10 April 2019
- *Integration and Better Care Fund planning requirements for 2019-20*, Department for Communities and Local Government, Department of Health and Social Care, and NHS England, London, 20 July 2019

### **4. Officer's Recommendations**

The Derbyshire Health and Wellbeing Board is asked to receive the report and:

1. Note the summary of the 2019-20 Better Care Fund Planning Requirements;
2. Note the 2019-20 Better Care Fund Plan for Derbyshire; and

**Helen Jones**  
**Executive Director, Adult Social Care and Health**  
**Derbyshire County Council**

# Derbyshire Better Care Fund

## 2019-20 Planning Template

### *Print Version*

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## 2. Cover

Better Care Fund 2019/20 Template					
Health and Wellbeing Board:	Derbyshire				
Completed by:	Graham Spencer				
E-mail:	graham.spencer@derbyshire.gov.uk				
Contact number:	01629532072				
Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Carol Hart				
Will the HWB sign-off the plan after the submission date?	Yes				
If yes, please indicate the date when the HWB meeting is scheduled:	6/2/2020				
	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
*Area Assurance Contact Details:	Health and Wellbeing Board Chair	Councillor	Carol	Hart	<a href="mailto:Carol.Hart@derbyshire.gov.uk">Carol.Hart@derbyshire.gov.uk</a>
	Clinical Commissioning Group Accountable Officer (Lead)	Dr	Chris	Clayton	<a href="mailto:Chris.clayton2@nhs.net">Chris.clayton2@nhs.net</a>
	Additional Clinical Commissioning Group(s) Accountable Officers		Steven	Pleasant	<a href="mailto:steven.pleasant@tameside.gov.uk">steven.pleasant@tameside.gov.uk</a>
	Local Authority Chief Executive		N/A	N/A	<a href="mailto:NA@NA.com">NA@NA.com</a>
	Local Authority Director of Adult Social Services (or equivalent)		Helen	Jones	<a href="mailto:Helen.Jones@Derbyshire.gov.uk">Helen.Jones@Derbyshire.gov.uk</a>
	Better Care Fund Lead Official		Graham	Spencer	<a href="mailto:Graham.Spencer@derbyshire.gov.uk">Graham.Spencer@derbyshire.gov.uk</a>
	LA Section 151 Officer		Peter	Handford	<a href="mailto:Peter.Handford@derbyshire.gov.uk">Peter.Handford@derbyshire.gov.uk</a>
<i>Please add further area contacts that you would wish to be included in official correspondence --&gt;</i>	Service Director Commissioning and Performance (Derbyshire County Council)		Julie	Vollor	<a href="mailto:Julie.Vollor@derbyshire.gov.uk">Julie.Vollor@derbyshire.gov.uk</a>
	Director of Joint Commissioning and Community Development (NHS Derby and Derbyshire CCG)		Kate	Brown	<a href="mailto:kate.brown12@nhs.net">kate.brown12@nhs.net</a>
	Head of Delivery and Assurance (NHS Tameside and Glossop CCG)		Elaine	Richardson	<a href="mailto:Elaine.Richardson@nhs.net">Elaine.Richardson@nhs.net</a>



### 3. Summary

#### Income & Expenditure

##### [Income >>](#)

Funding Sources	Income	Expenditure	Difference
DFG	£6,960,721	£6,960,721	£0
Minimum CCG Contribution	£56,834,861	£56,834,861	£0
iBCF	£31,054,728	£31,054,728	£0
Winter Pressures Grant	£3,627,306	£3,627,306	£0
Additional LA Contribution	£1,566,063	£1,566,063	£0
Additional CCG Contribution	£1,432,572	£1,432,572	£0
<b>Total</b>	<b>£101,476,251</b>	<b>£101,476,251</b>	<b>£0</b>

##### [Expenditure >>](#)

#### NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£16,004,896
Planned spend	£22,985,124

#### Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£32,180,173
Planned spend	£33,312,078

**Scheme Types**

Assistive Technologies and Equipment	£7,794,061
Care Act Implementation Related Duties	£2,148,836
Carers Services	£2,048,328
Community Based Schemes	£710,215
DFG Related Schemes	£6,960,721
Enablers for Integration	£6,790,283
HICM for Managing Transfer of Care	£5,325,293
Home Care or Domiciliary Care	£6,568,103
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£27,878,542
Intermediate Care Services	£5,905,908
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£4,099,098
Residential Placements	£0
Other	£25,246,863
<b>Total</b>	<b>£101,476,251</b>

**HICM >>**

		<b>Planned level of maturity for 2019/2020</b>
<b>Chg 1</b>	<b>Early discharge planning</b>	Established
<b>Chg 2</b>	<b>Systems to monitor patient flow</b>	Established
<b>Chg 3</b>	<b>Multi-disciplinary/Multi-agency discharge teams</b>	Established
<b>Chg 4</b>	<b>Home first / discharge to assess</b>	Mature
<b>Chg 5</b>	<b>Seven-day service</b>	Established
<b>Chg 6</b>	<b>Trusted assessors</b>	Established
<b>Chg 7</b>	<b>Focus on choice</b>	Established
<b>Chg 8</b>	<b>Enhancing health in care homes</b>	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	640

### 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 (%)	86.1%

## [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	No

## 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 undertaken from the previous planning 2017-19*

<b>A) Person-centred outcomes</b>	
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:	173
<p><b><u>Introduction</u></b></p> <p>The Derbyshire 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:</p> <ul style="list-style-type: none"> <li>the development and implementation of the Derbyshire Sustainability and Transformation Plan (STP) known locally as Joined Up Care Derbyshire (JUCD);</li> <li>the Tameside &amp; Glossop Corporate Plan and Care Together Programme;</li> <li>the Derbyshire Health and Wellbeing Strategy 2018-2023; and</li> <li>Organisational Plans (e.g. Council Plan 2019-2021, CCG Operational Plans).</li> </ul> <p>The predominant focus of the Derbyshire BCF continues to be on supporting the delivery of place-based population health and care across Derbyshire.</p> <p><b><u>The Vision</u></b></p> <p>The overall vision of the Derbyshire 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.”</p> <p>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. During 2018-19 there were 146 Personal Health Budgets provided to Children and Adults with the number increasing throughout 2019-20, as an example of how people are being supported differently to manage their own health and care needs. Carers are also supported through the BCF in a variety of ways, not least through Carers Personal Budgets ( 1,874 in 2018-19) and provision of Information Advice and Guidance ( 6,998 contact with Carers requesting IAG during 2018-19)</p>	

### **The Approach**

Over the past few years, the BCF has funded the ongoing development of community support teams across Derbyshire. These teams have brought 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 Glossop locality of Derbyshire, a similar approach has been taken with Tameside & Glossop CCG in supporting their development of Neighbourhoods.

Where people do need to be admitted to a hospital, close working between the hospital and community support teams means individuals are increasingly better supported upon discharge, enabling them to return to their own homes sooner. Increased preventative care and community support will, in the long-term, 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.

The continued development of person-centred care remains a funding priority for the Derby and Derbyshire Better Care Fund plans 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 both Derbyshire County (M: 79.1, F: 82.8), and Derby City (M: 78.2, F: 82.7) is below the national average for England (M: 79.5, F: 83.1)
- In the city, 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 the county, the life expectancy gap is 7.9 years for men and 6.8 years for women when comparing the most deprived areas of the county to the least deprived areas
- In the county approximately 15% (19,300) children live in low-income families with 21% (10,700) 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. Excess weight in adults in Derbyshire (63.8%) and Derby City (65.1%) are 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 both the city and the county compared to the England average

It should, however, be noted that the majority of preventative services funded through the Derbyshire BCF relate to provision of equipment, or other aids/adaptations and services to support Carers – in essence preventing admission to hospital or a residential care-setting. Preventative services funded through the BCF account for c19% of overall funding as the priority is to focus on development of community services across place/neighbourhood. 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 Derbyshire.

### **The Workforce**

In order to deliver person-centre care effectively, we need a workforce that is able to provide this. Through the BCF, funding has been used to support the work of Joined Up Careers Derbyshire, formerly known as the Derbyshire Health and Social Care Talent Academy. This 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) Neighbourhood / 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)

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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 – some of which will continue to be funded through the BCF:

- Further development of Community Wellness Hubs; focusing on obesity, smoking, falls, sexual health, alcohol, CVD prevention, Health Protection
- Implement evidenced-based falls pathway, based on Falls Needs Assessment
- 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.
- Implement the agreed Derbyshire frailty pathway for those at risk of becoming frail or living with frailty through adoption of the approaches above.
- 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 – all beds delivered across the County are funded through the BCF along with elements of other discharge to assess pathways.
- 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 (excluding Glossop which continues to be part of Tameside & Glossop CCG) the local approach to Joint Commissioning is currently being reviewed. A Joint Commissioning Group has been formed, comprising Officers from the new Derby and Derbyshire CCG, Derby City Council, 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 Better Care Fund Programme Board which has, and continues, to oversee jointly commissioned services that were introduced via the original Better Care Fund in 2015/16. 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. In doing so it will continue to report to the health and Wellbeing Board and JUCD workstream Boards e.g. Place to ensure that the BCF continues to align with developments within the JUCD delivery of the STP and emerging ICS in Derbyshire.

### **Alignment with Primary Care Networks**

There are sixteen Primary Care Networks covering Derbyshire (including Glossop) and Derby City. These PCNs were confirmed at the end of May 2019 and commenced operation on 1 July 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)**

Derbyshire County Council is currently undertaking a strategic review of the funding provided to the VCS for both its infrastructure, and the services it delivers. The aim of this review is to develop a new offer that moves away from the traditional model of grant funding. In doing so it is envisaged that this will help the VCS to grow and thrive, providing the right support in the right areas and reduce inefficiencies and inequity of services.



**(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)

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As in previous years, the Disabled Facilities Grant (DFG) has been 'passported' directly to the District and Borough Councils across Derbyshire. Each District and Borough Council has developed local assurance plans for 2019-20 which, as with the wider BCF plan, are an extension to assurance plans delivered during 2017-19.

The local assurance plans set out how each District and Borough will utilise their DFG funding, which in most areas includes continued delivery of mandatory Disabled Facilities Grants alongside more innovative pieces of work to improve housing and housing opportunities to help support people to remain independent in their own communities. Some of this work is being supported by work with the NHS on Place. From a policy perspective officers are considering how best to use the DFG's flexibilities in supporting the BCF's aims whilst maintaining statutory obligations. In particular, decisions around how BCF is used to address disrepair of owner occupied homes where the condition of the home has a direct influence on the likelihood of hospital admission or delayed discharge.

This is also supported by a County wide Older Persons Housing Commissioning Strategy for Derbyshire which Districts and Boroughs are adopting which will support continued focus on the improved delivery of meeting the needs of older people and those with reduced mobility.

Examples include:

- Integrated adaptations of new build social housing to better match disabled residents to suitable accommodation (Amber Valley, Erewash, South Derbyshire);
- Support of Place Alliances – District & Borough Council's will continue to work with partners at the Place level to identify ways in which they work together, current examples include Chesterfield Holistic Care Model, Trialling use of new technology, small dementia grants (based on Worcestershire), support moves to adapted or more suitable properties;
- Work is underway to provide stairlifts as equipment rather than DFG to improve waiting times and increase recycling as well as provide a more responsive service for short term needs;
- Hospital Avoidance Scheme (South Derbyshire District Council);
- Support for the Healthy Homes programme operated by Derbyshire County Council;
- Stock Condition Survey being undertaken across Derbyshire and Derby City – purpose of this is to provide intelligence to inform STP and other partners about the condition of the housing stock and inform commissioners and their policy decisions based on the findings of the report;
- Dedicated mental health Worker in South Derbyshire – to support people in crisis and reduce risk of homelessness.

There are continuing challenges facing the delivery of DFGs across Derbyshire which have been identified during 2018-19. The main ones concern processes around efficiently identifying need through assessment and reducing duplication across the system. There are also workforce resourcing issues across both

housing services to administer the DFGs and Occupational Therapy to support the assessment process. Consideration is being given as to how to address these issues and various proposals have already been identified in some areas that could be utilised more consistently across the County. Longer term certainty around DFG funding allocations will be critical to maintain momentum and confidence that investment in more efficient processes will be supported by the funding required to meet that demand.

**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

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**BCF and STP/ICS Alignment**

The Derbyshire Better Care Fund pre-dates the development of STPs and ICSs and also operates across a different footprint to these. This has, therefore, presented challenges in understanding how the different plans fit together considering Derbyshire's BCF crosses two Health and Wellbeing Board areas, two CCGs in different NHS regions, two different STPs (one in Derbyshire and the Greater Manchester Health & Social Care System) and eight District and Borough Councils. In Derbyshire, however, it has become clear over time that the BCF is best-placed to support the delivery of Place-based health and care services.

The 2019/20 BCF Plan for Derbyshire will predominantly fund services that are delivered across the eight Place Alliance areas in Derbyshire, as it has in previous years. These are services that are key to supporting the wider system in shifting the model of care into the community to enable acute services to provide various specialist and urgent and emergency care services.

The 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 across local populations. 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.

**BCF Governance**

The Derbyshire Health and Wellbeing Board established a BCF Programme Board as a delegated sub-group, to oversee the management and monitoring of the Derbyshire Better Care Fund programme back in 2014/15. This Board comprises representatives from the two CCGs covering Derbyshire (DDC and T&G CCGs), and Derbyshire County Council. Over the last 12 months, the Board has expanded to include Derby City Council to prevent duplicating effort of monitoring between the newly merged CCGs and the City Council. Whilst the Board has delegated authority from the County Health and Wellbeing Board, it does not have the same level of power in respect of Derby City. Therefore, for consistency, all BCF national returns (planning and quarterly monitoring) are reported via the Board to both Health and Wellbeing Boards.

## 5. Income

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Derbyshire	£6,960,721
DFG breakdown for two-tier areas only (where applicable)	
Amber Valley	£1,281,883
Bolsover	£999,472
Chesterfield	£1,208,957
Derbyshire Dales	£530,326
Erewash	£936,182
High Peak	£489,109
North East Derbyshire	£722,417
South Derbyshire	£792,375
<b>Total Minimum LA Contribution (exc iBCF)</b>	<b>£6,960,721</b>

iBCF Contribution	Contribution
Derbyshire	£31,054,728
<b>Total iBCF Contribution</b>	<b>£31,054,728</b>

Winter Pressures Grant	Contribution
Derbyshire	£3,627,306
<b>Total Winter Pressures Grant Contribution</b>	<b>£3,627,306</b>

Local Authority Additional Contribution	Contribution
Derbyshire (additional ICES Funding)	£1,566,063
<b>Total Additional Local Authority Contribution</b>	<b>£1,566,063</b>

CCG Minimum Contribution	Contribution
NHS Derby and Derbyshire CCG	£54,445,848
NHS Tameside and Glossop CCG	£2,389,013
<b>Total Minimum CCG Contribution</b>	<b>£56,834,861</b>

Additional CCG Contribution	Contribution
NHS Derby and Derbyshire CCG (Pathway 2 – CSB Additional)	£871,572
NHS Derby and Derbyshire CCG (Pathway 1 – Home Care Additional)	£561,000
<b>Total Addition CCG Contribution</b>	<b>£1,432,572</b>
<b>Total CCG Contribution</b>	<b>£58,267,433</b>

	2019/20
<b>Total BCF Pooled Budget</b>	<b>£101,476,251</b>

## 6. 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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Mental Health Enablement	Preventative & recovery focussed support to people living with a mental health condition	Prevention / Early Intervention	Other	Mental Health / Wellbeing			Medium	Not applicable	Not applicable	Not applicable	Mental Health		LA	Local Authority	Minimum CCG Contribution	£537,660	Existing
1	Integrated care teams	Alignment of Social Care staff to GP Practices to provide early intervention to people at risk of health or social care admission.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	High	Medium	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£1,566,000	Existing
1 Page 63	ICS - Integrated Workforce (social care)	Provision of assessments and support and care for out of hospital clients and others in a residential or home care setting on either a short term or long term basis.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Not applicable	High	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£2,262,676	Existing
1	Care packages to maintain clients in a social care setting	provision of social care packages to help and support clients to remain outside of an acute setting and within their local community	Home Care or Domiciliary Care			Hours of Care	286,566.0	High	High	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£6,568,103	Existing
1	Dementia Reablement Service	Specialist social care reablement service for people living with dementia	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	720.0	Not applicable	High	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£1,284,120	Existing
1	Falls Recovery	24 Hour Service - alternative response to non-urgent fallers	Prevention / Early Intervention	Other	Physical Health / Wellbeing			High	Not applicable	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£253,692	Existing
1	Mental Health Triage	AMHPs to support work of the Mental Health Triage Hub	Prevention / Early Intervention	Other	Mental Health / Wellbeing			High	Not applicable	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£99,180	Existing
1	Mental Health Acute Based Social Worker Support	Social Workers working at inpatient (Acute Mental Health Wards	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams				Not applicable	High	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£99,180	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Seven Day Working	Additional Social Worker and OT capacity to provide core 7 day offer.	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				Medium	High	Medium	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£783,000	Existing
1	Mental Health - Recovery and Peer Support	County wide offer of targeted support through 1:1, group work and drop-in including face to face and telephone; recovery education; low level housing related support.	Other		Mental Health Recovery & Support			High	High	Not applicable	Not applicable	Social Care		LA	Charity / Voluntary Sector	Minimum CCG Contribution	£307,980	Existing
1	ICS Reablement & DSO Reablement	Countywide reablement service	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	1,900.0	Not applicable	Not applicable	Not applicable	High	Social Care		LA	Local Authority	Minimum CCG Contribution	£4,621,788	Existing
1	Community Support Beds	Pathway 2 (D2A) Community Support Beds	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Low	Medium	Social Care		LA	Local Authority	Minimum CCG Contribution	£2,631,942	Existing
1	ICS - Hospital Teams	Dedicated hospital social work teams working across acute providers in and surrounding the County	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams				Medium	High	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£939,600	Existing
1	Dementia Support	Advice and information support service for people living with dementia and their family / carers	Prevention / Early Intervention	Other	Advice & Information			Low	Low	Not applicable	Not applicable	Social Care		LA	Charity / Voluntary Sector	Minimum CCG Contribution	£417,600	Existing
1	Assistive Technology	The Telecare service provides equipment to support people to maintain their independence in the community, to live in their own homes for longer, assist people leaving hospital, prevent avoidable admissions and to underpin care support for vulnerable people of all ages.	Assistive Technologies and Equipment	Telecare				Medium	Medium	Not applicable	Not applicable	Social Care		LA	Private Sector	Minimum CCG Contribution	£709,920	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	ICS - Specialist Teams	Specialist social care services that support people to remain at home.	Prevention / Early Intervention	Other	Care Planning, Assessment and Review			Not applicable	Medium	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£622,224	Existing
1	Supporting the Care Market	Incentivised Payments and other associated schemes to support the wider care market in Derbyshire	Other		Care Market Sustainability			Medium	Medium	Medium	Medium	Social Care		LA	Private Sector	iBCF	£7,937,693	Existing
1	Reduce Budget Savings to Protect Social Care	iBCF funding used to offset budget savings required across Adult Social Care and Health	Other		Adult Social Care Delivery			Medium	Medium	Medium	Medium	Social Care		LA	Local Authority	iBCF	£11,351,652	Existing
1	Support to Improve System Flow	Additional posts across Adult Social Care & Health to support hospital admission avoidance and reduce delayed transfers of care	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium	Social Care		LA	Local Authority	iBCF	£3,473,500	Existing
1	Winter Pressures	Further funding to support the wider care market during winter period to be as responsive as possible to pressures on NHS	Other		Care Market Sustainability			Medium	Medium	Medium	Medium	Social Care		LA	Local Authority	Winter Pressures Grant	£3,627,306	New
1	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				Medium	Medium	Medium	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£10,507,743	Existing
1	Integrated 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	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£439,632	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
		links to the wider Integrated community teams functioning in other levels of care																
1	Evening Nursing Services	The service provides nursing care to adults who require nursing care within their own 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	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£1,126,448	Existing
1 Page 66	Care Co-ordinators	The service aims to improve the co-ordination and provision of packages of care for adults with complex care needs and their families, enabling patients to be cared for in their place of their choice that meets their needs	Other		Care Coordination			High	Medium	Medium	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£687,754	Existing
1	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	Medium	Medium	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£2,140,610	Existing
1	Community Therapy	The Community Therapy Teams (physiotherapy and/or occupational therapy) aim to provide highly skilled assessment and intervention to patients with physical problems affecting	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	High	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£3,456,814	Existing



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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
		their functional abilities																
1	Senior Medical Input	Advanced Care Practitioners - provide senior assessment and intervention to patients within patients own home environment (for the community element), within community support beds and within the acute Trust	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£353,048	Existing
1 Page 67	Voluntary SPA	The aim of the voluntary sector Single Point of Access (vSPA) service is to provide one referral route into health and social care voluntary services to support people to receive services at home or as close to home as is possible	Other		Single Point of Access			Medium	Medium	Not applicable	Low	Other	Voluntary Sector	CCG	Charity / Voluntary Sector	Minimum CCG Contribution	£17,867	Existing
1	Primary Care Hubs	Extension of available primary care access via two GP Hubs in Erewash that will give patients local access and support, reducing the need to attend other services	Prevention / Early Intervention	Other	Access to Primary Care			High	Medium	Medium	Not applicable	Primary Care		CCG	NHS Community Provider	Minimum CCG Contribution	£130,130	Existing
1	Care Home Support Service	Ward Rounds carried out in care homes by a multi- disciplinary team (supported by a GP) to improve care and reduce the number of acute interventions. First point of contact for assessment for acute interventions.	Other		Healthcare Services to Care Homes			Medium	Medium	Medium	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£439,651	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Glossopdale Neighbourhood Team	Multi-Disciplinary Integrated Care Team to deliver Neighbourhood services in Glossop	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£483,171	Existing
1	Intermediate Care Team Chesterfield	The premise of ICTs is the coming together of existing teams, mainly across health and social care in order to provide a seamless service for both patients and professionals at different points of need.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£40,792	Existing
1 Page 68	Intermediate Care Team BSV	The premise of ICTs is the coming together of existing teams, mainly across health and social care in order to provide a seamless service for both patients and professionals at different points of need.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£199,257	Existing
1	Intermediate Care Team NED	The premise of ICTs is the coming together of existing teams, mainly across health and social care in order to provide a seamless service for both patients and professionals at different points of need.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£982,066	Existing
1	Community IV Therapy	Provides services to facilitate the timely discharge from acute and community hospital care. In some instances the service can be used to prevent unnecessary admissions into hospital	Community Based Schemes					Medium	Medium	Not applicable	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£149,215	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Clinical Navigation 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				Not applicable	High	Not applicable	Not applicable	Community Health		CCG	NHS Community Provider	Minimum CCG Contribution	£846,784	Existing
1	Community Support Beds - Additional	Pathway 2 (D2A) Community Support Beds	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Low	Medium	Social Care		CCG	Local Authority	Additional CCG Contribution	£871,572	New
1	Pathway 1 home care	Provision of home care to support Pathway 1 (D2A)	Community Based Schemes					Not applicable	High	Medium	High	Community Health		CCG	Local Authority	Additional CCG Contribution	£561,000	New
2	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				Medium	Medium	Medium	Low	Social Care		LA	Local Authority	Minimum CCG Contribution	£171,612	Existing
2	Carers	Number of services delivered to support Derbyshire Carers Strategy Inc. Derbyshire Carers Service, Emergency Card etc.	Carers Services	Other	Carer Advice, Information and Respite Services			Low	Medium	Low	Not applicable	Social Care		LA	Charity / Voluntary Sector	Minimum CCG Contribution	£2,048,328	Existing
2	Disabled Facilities Grant	Provision of Disabled Facilities Grants across 8 District & Borough Councils	DFG Related Schemes	Other	Adaptations, wider Health & Housing Solutions			Medium	Medium	Medium	Not applicable	Social Care		LA	Local Authority	DFG	£6,960,721	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
2	Integrated Community Equipment Service	The Integrated Community Equipment Services provides a range of equipment from simple aids for daily living to more complex pieces of equipment enabling people to stay in their home environment.	Assistive Technologies and Equipment	Community Based Equipment				Low	High	Not applicable	Low	Social Care		LA	Private Sector	Minimum CCG Contribution	£4,533,937	Existing
2	Integrated Community Equipment Service - additional	The Integrated Community Equipment Services provides a range of equipment from simple aids for daily living to more complex pieces of equipment enabling people to stay in their home environment.	Assistive Technologies and Equipment	Community Based Equipment				Low	High	Not applicable	Low	Social Care		LA	Private Sector	Additional LA Contribution	£1,566,063	Existing
2	Preventative Services (Inc. Public Health and Health and Housing)	Includes development of a Derbyshire Falls Pathway, funding for voluntary and community sector groups to make local communities more resilient and better able to support vulnerable people without statutory agency support; support to Welfare Rights.	Prevention / Early Intervention	Other	Health & Housing			Medium	Medium	Medium	Medium	Social Care		LA	Local Authority	iBCF	£1,867,000	Existing
2	Wheelchairs	The Wheelchair Service provides assessments for people with permanent mobility problems (longer than 6 months), including specialist seating for wheelchairs users	Assistive Technologies and Equipment	Community Based Equipment				Not applicable	Medium	Medium	Not applicable	Community Health		CCG	Private Sector	Minimum CCG Contribution	£984,141	Existing

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	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
		with postural problems.																
3	Autism Support	Implement Improvements in the adult element of the all age pathway for people with autism - specifically: Increase access to peer support/befriending/ short term skill development and coping skill support/support to access and maintain employment.	Other		Pathway Developm ent			Low	Low	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£469,800	Existing
4	Workforce Developme nt	Funding for Joined Up Careers Derbyshire Service	Enablers for Integration	Integrated workforce				Low	Not applicable	Low	Low	Social Care		LA	Local Authority	Minimum CCG Contribution	£261,000	Existing
4	Programme Manageme nt (BCF & TCP)	Programme management and Support for the BCF	Other		Enabler			Low	Low	Low	Low	Social Care		LA	Local Authority	Minimum CCG Contribution	£407,160	Existing
4	Information sharing across health	Supports delivery of former BCF national condition and continued developments in shared data.	Enablers for Integration	Shared records and Interoperability				Medium	Medium	Medium	Medium	Social Care		LA	Local Authority	Minimum CCG Contribution	£104,400	Existing
4	Care Act	This area of expenditure relates to the provision of services to support the continued implementation of the Care Act	Care Act Implementati on Related Duties	Other	Various - Advocacy, Prisoners, Safeguardi ng			Low	Medium	Not applicable	Not applicable	Social Care		LA	Local Authority	Minimum CCG Contribution	£2,148,836	Existing
4	Enablers (System and Service Redesign to increase capacity)	Additional support to improve case management system and direct care transformation (to support D2A)	Enablers for Integration	Implementation & Change Mgt capacity				Medium	Medium	Medium	Medium	Social Care		LA	Local Authority	iBCF	£6,424,883	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 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?
Chg 1	Early discharge planning	Established	Established	
Chg 2	Systems to monitor patient flow	Established	Established	
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established	Established	
Chg 4	Home first / discharge to assess	Mature	Mature	
Chg 5	Seven-day service	Plans in place	Established	
Chg 6	Trusted assessors	Established	Established	
Chg 7	Focus on choice	Established	Established	
Chg 8	Enhancing health in care homes	Established	Established	

## 8. Metrics

### 8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
Total number of specific acute non-elective spells per 100,000 population	<b>Collection of the NEA metric plans via this template is not required</b> as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	<p>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</p> <p><b>Prevention</b> – 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.</p> <p><b>Access</b> – from 1<sup>st</sup> October there will be 100% coverage of extended access (i.e. 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)</p> <p><b>Reducing demand</b> – 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, and 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</p>	<b>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.</b>

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](mailto:ENGLAND.bettercaresupport@nhs.net)



## 8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative	
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	35.0	<p>The ambition in Derbyshire is to maintain DTOC levels at, or below, the daily average rate of 35.0. This will prove challenging as performance during Q1 and into Q2 of 2019-20 is showing higher rates of DTOCs than have been experienced for over two years. There are certain factors that have contributed to this such as refined DTOC guidance, increases in Non-Elective Admissions, and a greater number of people requiring social care packages than previously seen.</p> <p>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 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.</p> <p>The Winter Pressures Grant, provided to Derbyshire County Council for 2019-20, along with the iBCF will continue to fund a number of initiatives, set out in previous years. 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:</p> <ul style="list-style-type: none"> <li>• Provision of additional care packages to help people leave hospital in a timely manner (694 additional care packages were delivered via 2018-19 Winter Pressure Grant, with 149,933 hours of home care delivered);</li> <li>• Funding to increase capacity across the Healthy Homes programme (boiler repair/installation, hoarding clearance etc) including a seasonal incentive payments scheme to improve responsiveness of contractors throughout the winter period. (There were 71 new heating system installed through the programme in 2018-19 via additional Winter Pressures funding).</li> </ul>	<p>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.</p>

		<ul style="list-style-type: none"> <li>• Additional Social Care staffing was provided at the two main acute hospitals within Derbyshire to support decision making on admissions and reduce demand.</li> <li>• Incentive payment to encourage home care providers to prioritise hospital discharge packages over Christmas and New Year.</li> <li>• Additional social workers, occupational therapists and community care worker roles across the county to support assessment and care planning (14.5 fte roles in addition to the safeguarding of 60 existing fte social worker roles).</li> <li>• Roll-out of single-handling principles to support hospital discharge teams in identifying appropriate levels of care packages for discharges.</li> <li>• Home from Hospital Service – provided by British Red Cross to support vulnerable people upon discharge from hospital, e.g. transport, prescription/medication, basic provision in the home &amp; ensuring heating works, ensuring social workers are aware person is home, signposting to other services.</li> </ul>
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### 8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments	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.
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	651	640	The planned numerator figure for 2019-20 is the same as in 2018-19, though the annual rate will be lower. The intention is, at the very least, to maintain performance at this level.	
	Numerator	1,118	1118		
	Denominator	171,683	174,740	Despite the County being an outlier for admissions, a stretch target has not been set because Derbyshire County Council is currently undertaking a procurement process to identify a Strategic Partner to help transform services for Older People and People living with a Disability. This will include work to reduce admissions to residential and nursing care for older people. The design of this work will be undertaken during 2019-20 and a four-year implementation programme will begin in April 2020, aimed at promoting greater independence and supporting cultural change in staff to enable this.	

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.

## 8.4 Reablement

		18/19 Plan	19/20 Plan	Comments	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.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.1%	86.1%	The planned figure for 2019-20 is the same as in 2018-19. The intention is, at the very least, to maintain performance at this level.	
	Numerator	365	365	A stretch target has not been set because Derbyshire County Council is currently undertaking a procurement process to identify a Strategic Partner to help transform services for Older People and People living with a Disability. This will include work to improve both the capacity and efficiency of the reablement service.	
	Denominator	424	424		

## 9. Planning Requirements

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
Page 79: NC1: Jointly agreed plan	PR1	A jointly developed and agreed plan that all parties sign up to	<p><b>Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?</b></p> <p>Has the HWB approved the plan/delegated approval pending its next meeting?</p> <p>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?</p> <p>Do the governance arrangements described support collaboration and integrated care?</p> <p>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?</p>	Yes	None
	PR2	A clear narrative for the integration of health and social care	<p><b>Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:</b></p> <ul style="list-style-type: none"> <li>- Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care?</li> <li>- 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?</li> <li>- A description of how the local BCF plan and other integration plans e.g. STP/ICSs align?</li> <li>- 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.</li> </ul> <p>Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?</p>	Yes	<p>2019-20 Plan is a continuation of the 2017-19 assured plan.</p> <p>More details of the previous BCF Plans and our BCF journey can be found here:  <a href="https://www.derbyshire.gov.uk/social-health/integrated-care/derbyshire-better-care-fund/derbyshire-better-care-fund.aspx">https://www.derbyshire.gov.uk/social-health/integrated-care/derbyshire-better-care-fund/derbyshire-better-care-fund.aspx</a></p>

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
	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	District and Borough Council's have produced Local Assurance Plans outlining the use of the DFG funding. These will be included in the supporting schedules of the Section 75 agreement.
Page 80 NC3: 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

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
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

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
	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
Page 82  Metrics	PR9	Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?	<p>Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric?</p> <p>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?</p> <p>Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements?</p> <p><b>Have stretching metrics been agreed locally for:</b></p> <ul style="list-style-type: none"> <li>- Metric 2: Long term admission to residential and nursing care homes</li> <li>- Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement</li> </ul>	No	<p>Stretch targets for the social care metrics have not been set for 2019-20. This is due to a programme of work that will begin later this year to redesign the Older People and Whole Life Disability pathways provided by Derbyshire County Council. The long-term objective of this work is to reduce the numbers of people going into residential care, and ensuring reablement services are both productive and effective for the people that use them. Additional information about this can be found in the following places:</p> <p><a href="https://democracy.derbyshire.gov.uk/documents/s1677/Older%20People%20and%20Whole%20Life%20Disability%20Path">https://democracy.derbyshire.gov.uk/documents/s1677/Older%20People%20and%20Whole%20Life%20Disability%20Path</a></p>



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
					<a href="#">way%20Assessment%20and%20Provision%20of%20Specialist%20Professional%20S.pdf</a>  And: <a href="https://derbyshireleader.wordpress.com/2019/07/11/plans-to-transform-support-to-older-and-disabled-people-revealed/">https://derbyshireleader.wordpress.com/2019/07/11/plans-to-transform-support-to-older-and-disabled-people-revealed/</a>

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## **DERBYSHIRE HEALTH AND WELLBEING BOARD**

**6 February 2020**

**Report of Ifti Majid, Chief Executive,  
Derbyshire Healthcare NHS Foundation Trust**

### **DERBYSHIRE OPTIONS FOR INTEGRATED CARE PARTNERSHIPS**

#### **1. Purpose of the report**

As part of the journey towards becoming an Integrated Care System (ICS) by April 2021, all STPs across the country will be required to develop more integrated care which will be delivered through Integrated Care Partnerships (ICPs).

ICPs will include Places, Primary Care Networks or neighbourhoods. These terms are used interchangeably and there is a degree of variation nationally, but essentially form the sub-ICP level to ensure integrated care is delivered as close to people and communities as possible.

This paper provides the Board with an update on the process followed to identify the footprint of the ICPs for Derbyshire and share the decision made by the December meeting of the Joined Up Care Derbyshire Board.

#### **2. Information and analysis**

Integrated Care Partnerships (ICPs) will require health and care providers to move increasingly to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place/Primary Care Network levels. Through the ICPs there will be aligned incentives to improve population health outcomes by encouraging integrated provision and preventative approaches, this will require flexible redeployment of resources to best meet needs and encourage a stronger focus on overall wellbeing and health within allocated resources. 'Integrated care partnerships (ICPs) are alliances of providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers' (Making Sense of Integrated Care, Kings Fund, February 2018).

Ifti Majid, Chief Executive of Derbyshire Healthcare NHS Foundation Trust has chaired the Integrated Care Partnership Development and Implementation Group; the initial stage was to consider the options for the local ICP configurations across the Derbyshire footprint. This was done through a series of workshops to consider the key things which must be taken into account in developing our ICPs. These workshops included stakeholders, broader than the ICP Development &

Implementation Group membership, to ensure wider engagement in identifying the preferred option. It is intended that the next phase to define the scope and operating model for the ICPs will again progress through a series of workshops.

Whilst the initial stage worked through some elements of the ICP Development and Implementation Group's remit, it is expected that the detailed implementation will be taken forward more formally through the ICP group from April onwards.

### Options Appraisal

From a long-list of nine options, the Implementation Group considered an initial option appraisal and concentrated further discussion on two possible options, as detailed in the table below:

Option	By this we mean...
<b>1. 3 x Geographical ICPs:</b> i) North - Chesterfield, North East Derbyshire and Bolsover, Derbyshire Dales and High Peak ii) South - South Derbyshire, Amber Valley and Erewash iii) City - Derby City	<ul style="list-style-type: none"> <li>• Derby City Council fully coterminous at a unitary level,</li> <li>• Derbyshire County Council divided North and South to enable population size consistency with national direction whilst maintaining co-terminosity at council borough level</li> <li>• Focus on geography and size rather than pathways</li> </ul>
<b>2. 4 x Geographical ICPs:</b> i) Chesterfield, North East Derbyshire and Bolsover ii) Derby City iii) South Derbyshire, Amber Valley and Erewash iv) Derbyshire Dales and High Peak	<ul style="list-style-type: none"> <li>• Aligned to district/ borough councils whilst maintaining scale and size (i.e. with combined areas)</li> <li>• Builds on existing Place Alliances, but S Derbyshire/Erewash/Amber Valley not an obvious fit</li> <li>• Retains focus on population health need</li> </ul>

Following agreement of the case for change, the working hypothesis of either 3 or 4 ICPs was further considered by a sub-group of the wider workshop attendees. The discussion focused on the identification of the potential benefits/opportunities of either 3 or 4 ICPs (as identified in the previous table) to confirm the preferred option for 4 ICPs which was recommended to the JUCD Board for approval and approved at its meeting on 19 December 2019.

### Recommendation

Based on the assessment process and considerations undertaken, the recommendation made was for four Geographical ICPs (Option 2):

- i) Chesterfield, North East Derbyshire and Bolsover
- ii) Derby City
- iii) South Derbyshire, Amber Valley and Erewash
- iv) Derbyshire Dales and High Peak

This is based on:

- Local Authority boundaries taking primacy, to enable a focus on population health, prevention and relevance to local populations – all of which were identified as key factors throughout the considerations.
- Recognising that the value of existing Place Alliances remains important both in terms of progress, development and alignment with council boundaries; the

mixed economy of existing Place Alliances will need to be considered in the development of the ICP and Place interface.

- Cross boundary working being recognised, for PCNs in particular; some PCNs in South Derbyshire for example are already working in this way across Place boundaries and it is being managed.
- Respective ICPs will need to remain cognisant of this in the developments.
- Patient flows identified as lower in ranking in terms of the considerations; the key factor is the heterogeneous nature of the local communities and how that will be managed to maintain localism (which also links to the ICP and Place interface).
- Recognition that the South Derbyshire issues require mitigations and that the ICPs role would be to manage these.
- A further sense check having been undertaken based on the primacy of certain criteria over and above others which reaffirmed the preferred option for four geographical ICPS.

Next steps for implementation will see a series of workshops taking place to develop the approach to enable ICPs to commence operating in shadow form from April 2020, including:

- Agreeing meaningful descriptors for each ICP
- Confirming the scope and developing the operating model by drawing upon previous work undertaken for the Erewash MCP where appropriate, defining the interface with the workstream/Programme Boards and alignment to approaches being taken to develop a proof of concept approach in relation to specific disease pathways for example. This will be brought back to the JUCD Board in February 2020.
- Continued engagement with stakeholders i.e. PCNs, Place Alliances and District Councils will also continue to inform the operating model and ensure all partner concerns are addressed wherever possible in advance.

### **3. Links to the Health and Wellbeing Strategy**

This report explains how the Derbyshire health and care system is seeking to establish Integrated Care Partnerships across Derbyshire to support delivery of the previously agreed STP Plan.

### **RECOMMENDATIONS**

The Health and Wellbeing Board is asked to:

1. NOTE the process followed by the Joined Up Care Derbyshire Board to appraise options for the implementation for Integrated Care Partnerships in Derbyshire.
2. NOTE the decision of the Joined Up Care Derbyshire Board to move to establish four ICPs for the county, to run in shadow form from 1 April 2020.

**Ifti Majid,  
Chief Executive,  
Derbyshire Healthcare NHS Foundation Trust**

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## **DERBYSHIRE HEALTH AND WELLBEING BOARD**

**6<sup>th</sup> February 2020**

### **Report of PCC Hardyal Dhindsa**

#### **Issues relating to Females in contact with the Criminal Justice System**

##### **1. Purpose of the report**

To raise for discussion issues arising from a 'Females in contact with the Criminal Justice System' event that was held in October 2019 to assess what needs to be done in Derbyshire to move towards a 'whole system approach' for female offenders in line with the national Female Offender Strategy.

##### **2. Information and analysis**

In October 2019 Derbyshire's Police and Crime Commissioner Hardyal Dhindsa funded a 'Females in contact with the Criminal Justice System' event to assess what needs to be done in Derbyshire to move towards a 'whole system approach' for female offenders in line with the national Female Offender Strategy. The Strategy aims are to ensure:

- Fewer women coming into the criminal justice system as a result of less offending, appropriate community-based support, earlier intervention, more liaison and diversion and more support for women in the community.
- Better conditions for those in custody by improving rehabilitation, improving family ties, reducing rates of self-harm and better supporting transition back into the community.
- Local partners will feel empowered to design approaches tailored for the specific needs of women resettling into Derbyshire.

A multi - agency 'Women and Girls in the CJS Strategic Group' is taking forward the recommendations from the day. However, there are a number of issues to raise with you as the Strategic Group is not empowered to resolve these.

##### **A) DIFFICULTIES WITH THE THRESHOLD FOR MENTAL HEALTH/GENERAL HEALTH SERVICES AND WAITING LISTS**

Many female Derbyshire offenders have entrenched difficulties that stem from unresolved trauma that has then developed into some form of depression, anxiety or other developmental/behaviour disorder or other mental ill health. National Probation Service and Community Rehabilitation Service staff are often advised to refer to primary care - the IAPT services initially such as Trent PTS or Talking mental health

– this service offers a 6 to 8 weeks counselling session tailored to an individual's needs. However complex cases, which can often include women, will then be told early on in their sessions that they will need more intensive long-term treatment and they will be referred to the secondary care team.

The process to access the IAPT services can take up to 4 to 6 weeks to begin, then people are told they need secondary care and this process can take up to 6 months for them to be assessed (this appears to be a city and county wide issue). During this time their needs/risk factors are not being met and their behaviour continues and this has often resulted in them being recalled back to prison or committing a further offence as their risk and treatment needs are not being met during this waiting period when they are left in limbo – therefore the risk of harm/reoffending remains. This is a vicious cycle that many offenders find themselves in as these services are not available in prison.

#### B) MENTAL HEALTH TREATMENT ORDERS

The limited use of MHTRs is a national issue that has been discussed locally to try and reach a resolution for at least seven years. National Community Sentence Treatment Order pilot projects that are taking place in courts throughout the country (the nearest being Birmingham). Some appear to have a degree of funding attached to them, which means they are able to benefit from a resource that is distinct to the offender cohort. Sadly, this is not available in Derbyshire. Currently the outcome of these pilots is awaited before any further guidance is forthcoming at a national level. There are meetings taking place locally to try to progress this issue but the lack of any funding for dedicated provision has impeded this. Joint work with NHS England is needed to take this further.

#### C) LACK OF PERSONALITY DISORDER SERVICES

Research shows that nationally 60% of prisoners have a personality disorder and yet there is no commissioned service provision. The newly formed Forensic team has limited capacity and funding to take on PD work and the joint MOJ/NHS scheme is only for screening and case formulation, not treatment.

#### D) CURRENT ISSUES WITH CHILDREN'S MENTAL HEALTH SERVICES (CAMHS) – LONG WAITING TIMES, STRICT PROCESS AND LACK OF FUNDING.

A service is currently out for tender regarding the services for children and young people and in particular the Emotional and Mental Health service for children in care. The new trauma informed service will be in place from April 2020 and will benefit children in the care of both Derbyshire County Council and Derby City Council. It will be a multi-level model, as requested by young people (not over-medicalised). The specification includes support for carers as well as direct support for children. The specification includes the importance of recognising that these are 'children first' who deserve the same entitlement as any other child to support to fulfil their potential. The needs of care leavers are included. Assurance that the new arrangements will provide sufficient improvement in relation to Children's Mental Health issues is desirable.

#### E) LACK OF FEMALE ONLY APPROVED PREMISES HOSTELS WITH SUPPORT IN THE EAST MIDLANDS.



There is only one female Approved Premises hostel with support that can be accessed by female offenders from Derbyshire and this is out of the area. There is national work ongoing to increase the number of AP beds, including for women. If health partners in the East Midlands were to indicate a willingness for a joint approach, it may be possible to secure some additional bed space with mental health support as developed elsewhere in the female estate.

F) LINKS TO THE HEALTH AND WELLBEING STRATEGY

The points raised are linked to three of the priorities in the Health and Wellbeing Strategy these being:

- Enable people in Derbyshire to live healthy lives.
- Build mental health and wellbeing across the life course.
- Support our vulnerable populations to live in well-planned and healthy homes.

## **RECOMMENDATIONS**

The Health and Wellbeing Board is asked to:

- i) Receive the report presented by the Police and Crime Commissioner on behalf of Derbyshire Criminal Justice Board.
- ii) Comment on the issues raised by the report.

**Hardyal Dhindsa, Derbyshire Police and Crime Commissioner and Chair of Derbyshire Criminal Justice Board**

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**DERBYSHIRE HEALTH AND WELLBEING BOARD****6 February 2020****Report of the Executive Director for Adult Social Care and Health Derbyshire  
County Council****HEALTH AND WELLBEING BOARD ROUND-UP REPORT****1. Purpose of the report**

To provide the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

**2. Round-Up****The English local government public health reforms: an independent assessment**

This [report](#), commissioned by the Local Government Association, assesses the success of the 2013 reforms to public health in England, which were part of the coalition government's wider health reform programme. These reforms, which saw the responsibility for many aspects of public health move from the NHS to local government, involved the transition of staff and services and required the formation of new relationships to ensure public health was embedded across local government services.

**Community-centred public health: taking a whole system approach**

Public Health England has published [resources](#) which aim to provide guidance to improve the effectiveness and sustainability of action to build healthy communities and to embed community-centred ways of working within whole systems action to improve population health. They are intended for use by local authority, NHS and voluntary and community sector decision-makers.

**Beyond parity of esteem: achieving parity of resource, access and outcome for mental health in England**

Mental health services remain a long way behind most physical health services in terms of their resourcing, patient ability to access care and overall patient outcomes. This [report](#) published by the BMA outlines findings about the state of mental health in England and recommendations for improvements. Key findings: under a third of children with mental health problems in England are able to access the care they need; those with a severe mental illness in England on average die 15 to 20 years earlier than the general population; and suicide is the leading cause of death among young people in the UK aged 20-34 years, and for men in the UK aged under 50.

**Older people's mental health**

Age UK and NHS England have launched a [campaign](#) to encourage older people to access treatment for mental health conditions. The campaign aims to boost the number of older people getting the help they need by writing to GPs to urge them to look out for the symptoms of mental health problems in older people, along with making them aware of the NHS support services available.

### **Determinants of mental health**

The Commission for Equality in Mental Health is carrying out a two-year investigation and has published its first briefing [paper](#) which focuses on the unequal determinants of mental health. The briefing explores why some groups of people have a much higher risk of mental ill health than others and what can be done to reduce the disparities. The briefing finds that mental health inequalities are closely linked to wider injustices in society. Inequalities in wealth, power and voice are linked to poorer mental health. Exclusion, discrimination, violence and insecurity all increase the risk of poor mental health and explain why some groups of people face markedly higher rates of mental ill health than others. It explores actions that can be taken, from communities and local services to national policies, to reduce mental health inequalities.

### **Delivering the Dementia Moonshot: A plan to find life-changing treatments**

Alzheimer's Research UK has published a [report](#) which calls on the government to invest in six priority research areas, which will help to deliver a life-changing treatment for dementia by doubling research funding and speeding up trials for new treatments. These include to find ways to detect the diseases that cause dementia 10 – 15 years earlier, make the UK the best place to conduct clinical dementia research and further the understanding of dementia risk reduction and prevention and dementia in the context of multi-morbidities.

### **Technology use and the mental health of children and young people**

This [report](#) published by the Royal College of Psychiatrists explores the use of technology among children and young people. It looks at the wider impact of different types of screen use on the mental health of children and young people including issues around screen time, the impact of negative content, and the potential for bullying and addiction. It also explores how vulnerable groups such as those with mental health problems and very young children may be affected and discusses issues around safeguarding.

### **Measuring progress: commitments to support and expand the mental health workforce in England**

This [report](#) published by the King's Fund finds that recent commitments to support and expand the mental health workforce have fallen short of their goals. To assess progress against these commitments and identify where further action is required, the report analyses workforce data and a survey of health care professionals working in the sector.

### **SpeakUp2020: Share your views and help make the NHS better**

Healthwatch has launched a new campaign [SpeakUp2020](#) to encourage people to speak up about what would make health and social care services in their communities better. The results will be shared with decision makers across the NHS, social care sector and

Government to ensure that improvements to services are informed by people's experiences.

### **Pass the parcel: children posted around the care system**

The Children's Commissioner has published a [report](#) which looks at the number of children living 'out of area' and their experiences of the care they receive including what it is like to be uprooted and placed miles away, what it means for friendships and family relationships, and how it affects a child's sense of belonging.

### **Adult social care statistics in England**

This [report](#) sets out the findings from a review of adult social care statistics in England. Adult social care is a large and important area that requires strong evidence to support effective policy development, delivery of care and personal choice. While there is rightly a focus on delivery, a scarcity of funding has led to underinvestment in data and analysis, making it harder for individuals and organisations to make informed decisions. This review highlights three main areas for attention: better leadership and collaboration; gaps in available data for example private household expenditure and private funded care; and improving existing official statistics.

### **Health matters: physical activity - prevention and management of long-term conditions**

One in 3 adults in England live with a long-term health condition and they are twice as likely to be amongst the least physically active. This edition of [Health Matters](#) focuses on the benefit of physical activity for the prevention and management of long-term conditions in adults.

### **Community pharmacies: promoting health and wellbeing**

A new draft quality standard from NICE highlights the important role community pharmacy teams have in health promotion and prevention. The draft quality standard is open for [consultation](#) and comments can be submitted until 5pm on Friday 14 February 2020.

### **Pharmacy Advice campaign**

A new [Pharmacy Advice campaign](#) has launched to encourage the public to visit community pharmacies for advice on minor illnesses. The campaign highlights that minor health concerns, such as coughs, colds and aches and pains, can be treated by pharmacists and runs until 22 March 2020.

### **Notification of Pharmacy Applications**

Under the requirements of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 the NHS Commissioning Board must notify the HWB of all relevant applications to provide pharmaceutical services, including the relocation of existing pharmacies. Notification of the following applications has been received:

Notification of closure: Cease to provide pharmaceutical services from Lloyds Pharmacy 42 Chatsworth Road, Brampton, Chesterfield, S40 2AQ at the close of business on 21 January 2020.

Application approved: Change of ownership Lloyds Pharmacy Ltd T/A Lloydspharmacy at 139 Victoria Park Road, Fairfield, Buxton, SK17 7PE to Ihsan Pharma Ltd.

Application approved: Change of ownership Lloyds Pharmacy 431 Sheffield Road, Chesterfield, S41 8LY to PCT Healthcare Ltd.

One-off change to Supplementary Hours: Weds 8 January, 12 February and 18 March 2020 Amber Pharmacy, Four Lane Ends, Main Street, Horsley Woodhouse, Ilkeston, DE7 6AX. They will operate 8.30am – 1pm, 2pm – 6.30pm as they will be closed for 1 hour for training purposes.

Change of trading name: PCT Healthcare Ltd 21 Ilkeston Road, Heanor, DE75 7DT has changed its trading name from Manor Pharmacy to Peak Pharmacy from 28 November 2019.

Application approved: No significant change relocation of John Dents (Chemists) Ltd from 1 Windermere Road, Newbold, Chesterfield, S41 8DU to Newbold Surgery 3 Windermere Road, Newbold, Chesterfield, S41 8DU.

### **3. BACKGROUND PAPERS**

Pharmaceutical notifications are held electronically on file in the Policy and Research Service.

### **4. RECOMMENDATION**

The Health and Wellbeing Board is asked to:

- Note the information contained in this round-up report.

**Helen Jones**  
**Executive Director for Adult Social Care and Health Derbyshire**  
**County Council**

## **DERBYSHIRE HEALTH AND WELLBEING BOARD**

**6 February 2020**

### **Report of the Director of Public Health**

#### **Approval of Health and Wellbeing Board Air Quality Strategy**

##### **1. Purpose of the report**

To seek approval of the Health and Wellbeing Board Air Quality Strategy, and agree the development of a working group to develop and monitor the associated annual action plan.

##### **2. Information and analysis**

The Health and Wellbeing Board agreed to develop a Health and Wellbeing Board Air Quality Strategy in January 2019, to support the Health and Wellbeing Board Strategies, priority around Air Quality improvement.

The Strategy has been developed following a review of the evidence, and consultation with the Board and stakeholders of the Air Quality working group. The Strategy aims to set out the overarching principles and priorities of the Board to achieve reduction in the health impact of poor air quality for the people of Derbyshire County. The strategy utilises the Outcomes Based Accountability Approach.

The Strategy will be supported by an annual action plan, developed and monitored by the Air Quality Working Group. Partners of the Health and Wellbeing Board will be responsible for providing a Strategic and Operational lead within their respective organisations to be drive forward actions.

##### **3. Recommendations**

That the Health and Wellbeing Board;

1. Approve the Health and Wellbeing Board Air Quality Strategy
2. Provide a Strategic lead (Health and Wellbeing Board member) and Operational lead (Air Quality working group member) for each respective organisation to drive forward actions identified within the Strategy and associated action plan.
3. Agree a minimum of annual reporting to the Health and Wellbeing Board of progress against performance measures in the annual action plan and progress against population outcomes.

**Dean Wallace  
Director of Public Health  
Derbyshire County Council**

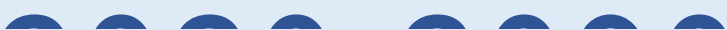




DRAFT

Derbyshire County and Derby City

# AIR QUALITY STRATEGY



# Air pollution in Derbyshire?

**Air pollution is the biggest environmental health risk**, contributing to an estimated 530 deaths and 5400 life years lost in Derbyshire County and City, and an economic cost to the UK of around £20 billion a year<sup>1</sup>.

Studies demonstrate long-term exposure to air pollution (over years) can reduce life expectancy, mainly due to cardiovascular and respiratory diseases and lung cancer. Short-term exposure (over hours or days) to high levels of air pollution can also cause a range of health impacts, including exacerbation of asthma, increases in respiratory and cardiovascular hospital admissions and mortality<sup>2</sup>.

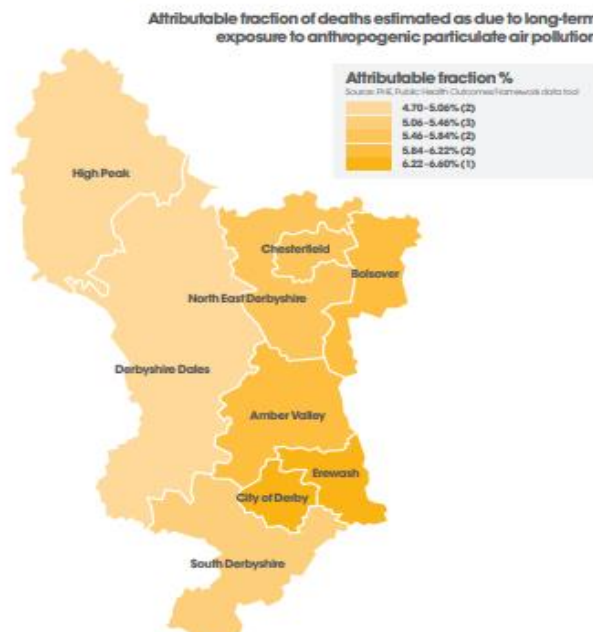
The impact of air pollution often disproportionately affects the young, older people, those with underlying health conditions and the most disadvantaged within our communities.

Reductions in air pollution require both global, national and local action.

Even modest reductions in air pollution levels could have significant direct and indirect benefits<sup>3</sup>, including;



**Sources of air pollution** are predominantly the result of human activity, and include transport sources, combustion from heating, industrial activities and certain farming activities<sup>4</sup>.



**Air pollution levels** vary across the County and City due largely to the proximity to sources of pollution. Information regarding local air quality levels can be found at;

[Derbyshire County mapping portal](#)  
[Derby City mapping portal](#)



The partners of the **Health and Wellbeing Board** alone cannot improve air pollution in Derbyshire. As partners we are however well placed to use our individual and collective influence as employers, providers and commissioners, to reduce our own contribution to local air pollution, facilitate change, influence others and protect health.

# OUR VISION

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Together we will reduce the health impact of poor air quality for the people of Derbyshire County and Derby City.

# How will we make this happen?

Working together as partners of the Health and Wellbeing Board, we will seek to reduce the health impact of poor air quality for the population of Derbyshire.

The cumulative effect of a range of interventions has the greatest potential to reduce local air pollution and improve population health. The board will develop an annual action plan which will utilise the available evidence and best practice.

## Guiding principles;

- Partners of the board will work collaboratively through the Air Quality Working group to improve air quality, sharing best practice, driving change, and supporting and influencing national policy and strategy.
- Partners will reduce the impact services have on local air pollution levels.
- Partners will act as a champion within their own organisation, to ensure organisational practice seeks to reduce the impact on Derbyshire's air quality.

The strategy will utilise three key priorities; Seek to reduce the sources of pollution, prioritise those interventions which offer additional health benefits, and mitigate the impacts on health. Due to the nature of the rapidly changing evidence base and likely change in air quality over the next 10 years, the Air Quality Working Group will review evidence and data to support the Health and Wellbeing Board in reviewing the Strategy as required to ensure this continues to support its guiding principles.



# What will success look like and how will this be monitored?

The Health and Wellbeing Board cannot alone improve air quality, however its partners will use its individual and collective influence to reduce our own impact on local air pollution, facilitate change and influence others. The strategy therefore aims to support reductions in the following population outcomes.



Monitoring of the strategy will be undertaken through the Derbyshire Air Quality Working group, reporting at least annually to the Health and Wellbeing Board. This will include providing oversight of key population outcomes, performance against the strategic priorities and progress on the annual the action plan.



## Population Outcomes;

Outcome	Baseline (2017)
Fraction of mortality attributed to particulate matter air pollution* (source; PHOF 3.01 <sub>7</sub> )	4.5%
Average annual average concentrations of nitrogen dioxide and range (source; local air pollution monitoring data)	28.19µ/m3 City upper limit 61.9µ/m3 County upper limit 49.9µ/m3
Average particulate matter (PM2.5)* (source; PHOF <sub>7</sub> )	9.2µ/m3
Number of air quality monitoring sites. Number of air quality monitoring sites with Particulate matter 2.5 above 10µ/m3 annual average and Nitrogen Dioxide above 40µ/m3 across Derbyshire** (source; local air pollution monitoring data)	272 Data unavailable PM2.5 13 Nitrogen Dioxide

Number of Air Quality Management Areas	8
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Reference; \* <https://fingertips.phe.org.uk> \*\* World Health Organisation Air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide (2005)

# STRATEGIC PRIORITIES

			
<b>Priority</b>	<b>Facilitate travel behaviour change</b>	<b>Reduce sources of air pollution</b>	<b>Mitigate against the health impacts of air pollution</b>
<b>Outcome</b>	Partners will increase the number of people using sustainable and active travel options, amongst the workforce and wider population.	Partners will reduce their own contribution to local air pollution and facilitate change to reduce sources of air pollution locally.	Partners will seek to reduce the impacts of air pollution on health.

<b>Population Outcome measures*</b>	% of adults walking and cycling for travel at least three days per week	Number of public electric charge points	Number of air quality management areas
	% of children travelling sustainably to school	Number of registered ULEVs	Number of schools, care homes and health settings with air pollution levels above WHO thresholds.
		Population living within a smoke control zone	
		Number of ULEV public transport units	

The outlined population outcomes seek to use recognised data collection processes where available. Baseline and trend data in relation to the outlined population outcomes can be found in Appendix 1.

## Facilitate travel behaviour change



### Background

Shifting everyday travel away from private car usage, towards walking and cycling and public transport and provide sustainable solutions to reduce air pollution locally. Promotion of walking and cycling can also provide additional health benefits increasing physical activity, improving mental health and reducing obesity.

Interventions to facilitate travel behaviour change can include awareness campaigns, infrastructure improvements, schemes which incentivise sustainable travel options.

### Strategic Action

- Participate in engagement campaigns
- Facilitate sustainable travel choices for service users and employees
- Utilise policy to promote sustainable travel
- Utilise schemes to support and incentivise sustainable travel

### Baseline

Data is currently unavailable which demonstrates staff and service user sustainable travel activity. Data collection mechanisms will therefore need to be developed by partners and reported annually.

Performance Measure	Baseline 2020
% of staff travelling sustainably to work within health and wellbeing board partner organisations	Unknown
% of service users travelling to provided services sustainably	Unknown

### Turning the curve;

**Objective;** Partners will increase the number of people using sustainable travel options, amongst the workforce and wider population.

Baseline; Current baseline data is unavailable

Monitoring; Data will be collated by partners of the Health and Wellbeing Board through the Air Quality Working Group annually

Impact; Changes in travel behaviour are generally gradual and therefore small incremental changes are expected.

## Reduce sources of air pollution



### Background

The most effective interventions will involve reducing sources of air pollution. Across Derbyshire the main sources of air pollution include transport and heat sources. There are a number of ways partners can support local reductions in air pollution, including increasing the uptake of lower emission vehicles, reducing travel and reducing emissions from heating sources.

### Strategic actions

- Participate in engagement events to promote awareness of the sources of air pollution
- Facilitate the uptake of ULEVs amongst employees and within own fleet
- Utilise policy to reduce sources of pollution including mileage reduction, solid fuel burning and uptake of ULEVs.
- Work collectively to help de-carbonise transport and contribute to a D2 Low Carbon Growth agenda.
- Explore opportunities to promote low-carbon heating options such as district heating schemes or heat exchange pumps



## Baseline

Data is currently unavailable which demonstrates the use of ULEVs across Derbyshire and also the mileage undertaken by partners. Data collection mechanisms will therefore need to be developed by partners and reported annually.

Performance Measure	Baseline 2020
Number of ULEV units within partner fleets	Unknown
Total mileage undertaken annually by health and wellbeing board partners	Unknown

## Turning the curve;

**Objective;** Partners will reduce their own contribution to local air pollution and facilitate change to reduce sources of air pollution.

Baseline; Current baseline data is unavailable

Monitoring; Data will be collated by partners of the Health and Wellbeing Board through the Air Quality Working Group annually

Impact; Changes in fleet require financial investment and for some partners alternative vehicles may not be currently available. Gradual incremental changes are therefore expected.

# Mitigate against the impacts of air pollution



## Background

Improvements in air quality require national and local intervention. Whilst reducing sources of air pollution is the priority to improving air quality locally, there is a need to ensure the mitigation of the health impacts where individuals may be exposed to higher levels of air pollution. Interventions to mitigate the impact of air pollution may include utilising planning policy, providing advice to individuals with long term conditions and utilising mitigation measures.

## Strategic Priorities

- Monitor air pollution levels locally with particular reference to vulnerable sites
- Utilise policy to reduce exposure to air pollution
- Provide advice to individuals with long term conditions around the impacts of air quality
- Utilise schemes to mitigate the impact or air pollution on health

### Baseline

Data is currently unavailable which demonstrates the level of mitigation measures in place locally. Data will therefore be collated through planning authority partners by the Air Quality Working Group annually.

Performance Measure	Baseline 2020
% of planning authorities within mitigations included within planning policy	Unknown

### Turning the curve;

**Objective;** Partners will seek to reduce the impact of air pollution on health.

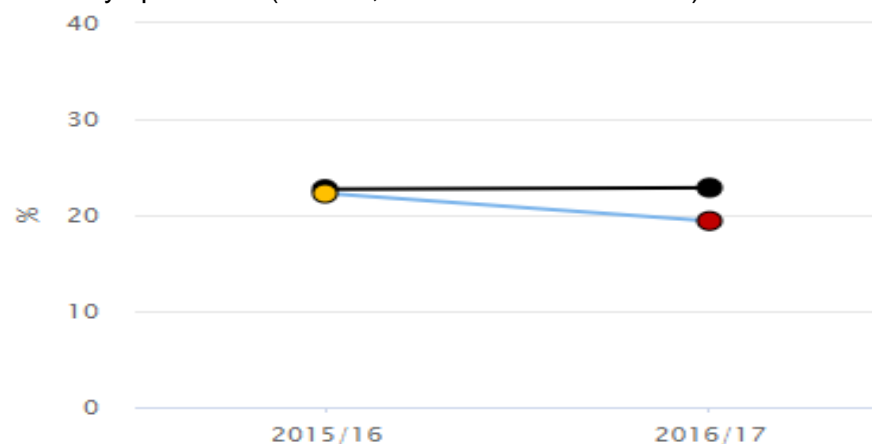
Baseline; Current baseline data is unavailable

Monitoring; Data will be collated through the Air Quality Working Group annually

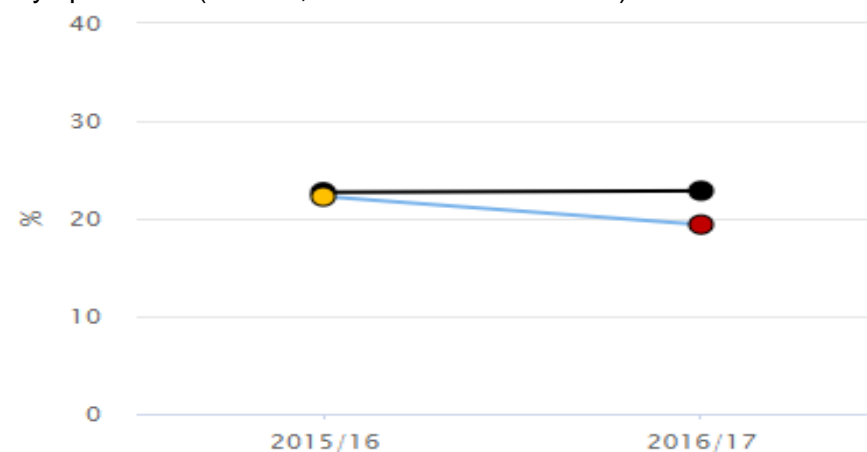
Impact; Changes will be dependent on stages of planning authorities within the planning policy development cycle.

## APPENDIX 1 – County baseline data Facilitating travel behaviour change

**Derbyshire County;** Percentage of adults walking for travel at least three days per week (Source; Public health outcomes)



**Derby City;** Percentage of adults walking for travel at least three days per week (Source; Public health outcomes)



**Turning the curve;** Travel behaviour change requires gradual incremental change. Impact would seek to reverse the current declining trend.

### Percentage of children travelling sustainably to school (Source; School travel survey)

Data is collected annually by Derbyshire County and Derby City Councils as part of the school travel survey process. Data is not complete however provides a standardised process for monitoring travel behaviours in school age children.

## Reduce sources of air pollution

### Number of public electric charge points (Source Goultralow)

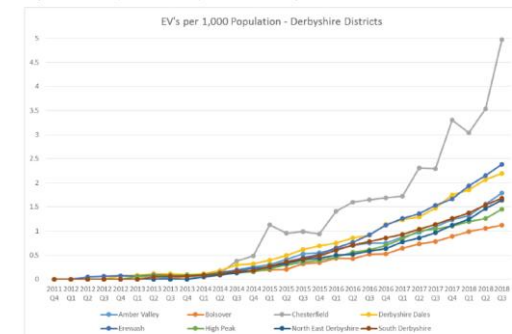
National ULEV mapping portals provide information on the number of public electric charge points. This data has not previously been analysed or monitored.

<https://www.goultralow.com/how-do-you-charge-an-electric-car/charging-point-map/>

**Turning the curve;** We would look to see an increase in the current upward trend

### Number of registered ULEVs (Source DVLA VEH0132)

Figure 1: EV's per 1,000 Population – Derbyshire Districts



Department for Transport VEH0131; Plug in cars and vans and quadracycle's licensed at end of quarter.

**Turning the curve;** We would look to see an increase in the current upward trend

### Population living within a smoke control zone (Source Borough and District Councils)

Data is currently available thorough Borough and Districts regarding

### Number of ULEV public transport units (Source; Derbyshire County and Derby City Council)

Data is currently not available about the number of ULEV public

## Mitigate against the health impacts

### Number of air quality management areas (source DEFRA)

Data regarding air quality management areas is currently available via Borough and District Councils.

2019 - Chesterfield; 1 (Church Street, Brimington)

Erewash 2 (East of M1 in Sandiacre and Long Eaton)

Bolsover 3 (Barlborough next to the M1 and A38 in South  
Normanton)

Derby City 1 (Inner and Outer ring road, sections of the A52  
and properties surrounding QDF foundary)

High Peak 1

**Turning the curve;** The Air quality management processes is overseen by DEFRA. Criteria is required to revoke and evoke AQMA's therefore changes to the current number of AQMA's is unlikely to change substantially year on year. We would however expect to see a

### Estimated number of schools and care settings with air pollution levels greater than the DEFRA / WHO thresholds (Source Derbyshire County Council heat map)

The air quality working group develops a heat map showing estimated air quality across Derbyshire, using overlays for schools and care homes we can estimate the number of these sites exposed to levels potentially greater than the DEFRA and WHO thresholds.

**Turning the curve;** Data is based on modelling data however we would expect a gradual reduction in the number of sites as air pollution levels decline and AQMA's reduce.

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**References;**

1. Public Health England (2014) Estimated local mortality burdens associated with particulate air pollution [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/332854/PHE\\_CRCE\\_010.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf)
2. Public Health England (2019) Health Matter; Air pollution <https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution>
3. DEFRA (2017) A briefing for Directors of Public Health <https://laqm.defra.gov.uk/assets/63091defraairqualityguide9web.pdf>
4. Public Health England (2018). Health Matters <https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution>
5. Public Health Outcomes Framework <https://fingertips.phe.org.uk/search/air%20pollution#page/0/gid/1/pat/6/par/E12000004/ati/102/are/E06000015>

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Derbyshire County and Derby City

# AIR QUALITY STRATEGY;

## Annual action plan 2020-2021

### Overarching actions

Action	Performance measure	Lead	Timescale
Partner organisations of the Health and Wellbeing Board provide an operational representative on the Air Quality Working Group	% of partner organisations represented on the AQWG	ALL	January 2020
Local authorities provide resource to develop combined annual status report to enable monitoring of air pollution levels and trend.	Annual status report	Borough and District Councils	January 2020
Utilise national and regional policy and funding opportunities to support local implementation	Number of available grants Number of grants applied	ALL	Ongoing
Ensure inclusion of air quality improvement and mitigation within strategic policies	Number of strategic policies referencing air quality	ALL	Ongoing
Utilise best practice and available evidence to inform local decision making		Public Health	Ongoing
Partner organisations will utilise awareness days to promote sustainable travel and raise awareness around air quality	% of organisations taking part in promotional events	ALL	Ongoing

### Facilitate travel behaviour change

Action	Performance measure	Lead	Timescale
Derbyshire County Council will implement the Derbyshire	???	Derbyshire	Ongoing



Cycle Plan <a href="https://www.activederbyshire.org.uk/derbyshire-cycling-plan">https://www.activederbyshire.org.uk/derbyshire-cycling-plan</a>		County Council	
Derbyshire County Council will promote active travel to schools as part of the Council's Sustainable Modes of Travel Strategy	???	Derbyshire County Council	Ongoing
Derbyshire County Council will work with schools and workplaces to promote active travel using accreditations schemes such as Modeshift Stars	% of schools engaged in mode shift stars Number of workplaces engage in mode shift stars	Derbyshire County Council	Ongoing
Borough and District Councils promote and encourage the uptake of walking and cycling through Local Cycling & Walking Infrastructure Plan (LCWIP).		Borough and District Councils	Ongoing
Planning policy facilitate travel behaviour change, prioritising pedestrians, cyclists and public transport, and include the use of vehicle restrictions where appropriate.	% of local plans with policies to support sustainable travel	Borough and District Councils	2022
Planning processes utilise Section 106 to support local improvements in sustainable travel, to ensure the sustainability of future developments	% of development applications which utilise section 106 for improvements to sustainable travel infrastructure	Borough and District Councils	2022
Partner organisations develop policies to promote sustainable travel by service users	% of provider organisations with policies to increase sustainable travel by service users.	ALL	2021

	% of service users travelling sustainably		
Explore opportunities to facilitate the use of ebike use.	Number of sites and ebikes available for public hire	ALL	Ongoing
All partner organisations will provide an operational representative at the Sustainable travel group.	% of organisations with representation on the Sustainable travel group	ALL	2020
All partner organisations will provide cycling storage across their estate	% of estate with cycling storage  % of organisations with cycling storage across all estate	ALL	2022

### Reduce sources of air pollution

Action	Performance measure	Lead	Timescale
Derbyshire County and Derby City Council develop and implement a Low Emission Vehicle Strategy to support the uptake of ULEVs	Low Emission Strategy or policy in place.	Derbyshire County and Derby City Council	2021 2022
All partner organisations utilise national campaigns to promote awareness of the sources of air pollution and encourage behaviour change	Number of campaigns organisations engage with.  Number of people reached by campaigns	ALL	Ongoing

Local authorities utilise powers and to seek to reduce the use of solid fuel burning	Number of smoke control areas  Number of people using solid fuel as heating source	Borough and Districts  Derbyshire County and Derby City Council	Ongoing
Local authorities support public transport sector to utilise LEVs particularly within the highest polluted areas.	Number of LEV public transport units  Number of LEV taxis	Borough and Districts	Ongoing
School transport policies and procurement support reduction in air pollution, particularly within the highest polluted communities.	Number of LEV school transport vehicles  % of pupils with access to school transport  Number of pupils travelling sustainably to school	Derbyshire County Council  Derby City Council	Ongoing
Promote and support the use of public car share schemes	Number of people utilising public car share schemes	ALL	Ongoing
Support the private sector to utilise practices to reduce air pollution through conversion of fleets and mileage reduction (proposed 3% annual reduction)	Number or organisations undertaking fleet reviews	District and Borough  Derbyshire County and Derby City Council	Ongoing

Partner organisations utilise procurement opportunities to reduce impact of activity on air pollution, including requirements for all commissioned transport or fleet services to address air pollution.	% of organisations with policy within procurement process to support air pollution improvement.	ALL	2021
Partner organisations undertake a fleet review	% of organisations having undertaken a fleet review	ALL	2021
Partner organisations develop policies or plans to ensure the acceleration of the conversion of their own fleets to low emission vehicles.	% of organisations with targets for conversion of fleets % of organisations with policies to ensure the lowest emission vehicles are utilised.	ALL	2021
All partner organisations will develop policy and practice to facilitate the take up of ULEVs amongst the workforce.	Number of ULEV charge points available within organisations. % of employers using ULEVs	ALL	2022
Acute Trust will sign up to and participate in the “Clean Hospital” framework8.	Number of Acute Trusts signed up to Clean Hospital framework.	Acute Trust	2021
All partner organisations will have workplace travel planning policies which promote and facilitate work from home policies, teleconferencing, promotion of sustainable travel	% of organisations with workplace travel plans % of staff travelling sustainably to work Number of miles travelled annually	ALL	2021

## Mitigate against the impact of air pollution

Action	Performance measure	Lead	Timescale
Guidance and practices facilitate reductions in exposure to air pollution for schools and care homes where feasible	% of local authorities with guidance to reduce exposure to air pollution for vulnerable sites	Derbyshire County Council Derby City Council	2022
Where air pollution exceeds EU limits at vulnerable sites, Local Authorities will explore the feasibility of mitigation measures.	% of vulnerable sites within areas of EU exceedance with mitigation measures in place	Borough and District Derby City Council	Ongoing
Partner organisations develop policies to ensure corporate anti-idling practices	% of organisations with policy incorporating anti-idling practices	ALL	2022
Health professionals will provide advice to those with long term conditions around the impact of air quality and management of long term conditions	% of organisations with pathways for long term conditions including air quality considerations  Number of employees provided with training around air quality	Primary Care Acute Trusts Pharmacy Services	2022
Local authority planning policy supports the mitigation of exposure to air pollution	% of local authorities with mitigations from the East Midlands Air Quality Network	Borough and Districts	2023

	<p>Supplementary Planning Guidance included in planning policy</p> <p>% of major development planning air quality mitigations within conditions (NICE guidance QS181)</p>		
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## DERBYSHIRE HEALTH AND WELLBEING BOARD

6 February 2020

Report of Vikki Taylor, Derbyshire STP Director

### DERBYSHIRE SUSTAINABILITY & TRANSFORMATION PARTNERSHIP: PLAN UPDATE

#### 1. Purpose of the report

Every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) have been asked to develop five-year Long Term Plan implementation plans, covering the period to 2023/24, by autumn 2019. This must form our system's response for implementing the commitments set out in the NHS Long Term Plan and our journey alongside system partners to become ICS by April 2021.

The Health and Wellbeing Board has been updated on the plan 'refresh' at previous meetings during summer 2019. Draft submissions of the plan have been made to NHS regulators on 27 September 2019 and 1 November, ahead of final submission on 15 November 2019. Derbyshire is committed that this is a system plan that reflects our plans for people and not just patients and to incorporate the wider determinants of health.

This paper provides the Board with the final version of the report as it was submitted to NHSD England/Improvement on 27 December 2019 following period of final amendment.

#### 2. Information and analysis

Joined Up Care Derbyshire is the name of the Derbyshire STP. All 44 STPs in England are required to review their exiting plans to outline the steps to be taken to implement the NHS Long Term Plan, published in January 2019. The process in Derbyshire has been a 'refresh' rather than a rewrite to reflect the continued support for overarching models of care and headline business cases as submitted in the original STP in 2016.

Key considerations in refreshing our plan have meant that:

- Our plan is outcomes driven so that the citizens of Derbyshire *'have the best start in life, stay well, age well and die well'*.
- The Derbyshire ambition to deliver the Quadruple aim - Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience and resilience, Reducing the per capita cost of healthcare-remains at the forefront.
- We have learned from the 2016 STP Plan.

- We have built on that which we believe still holds true.
- We have focused on making improvement in wider determinants of health, such as housing, education and air pollution management leading to improved outcomes for people in Derbyshire, including the partnerships needed to progress this work.
- We have ensured there is a stronger focus on addressing inequalities and population health management.
- The refresh has been informed and developed through strong engagement with people, patients, staff and wider stakeholders and this will continue to drive our approach.
- We recognised that the 5 year plan is a requirement to demonstrate how we will implement the NHS Long Term plan – we will take a whole population approach ensuring this is done with our Local Authority partners.

We have focussed on people not patients.

The five strategic priorities identified within the plan are:

- Place-based care:** We will accelerate the pace and scale of the work we have started through the previous transformation programmes in the North and South of the County to 'join up' primary care, mental health, community services, social care and the third sector. So they operate as a single team to wrap care around a person and their family, tailoring services to different community requirements.
- Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand.
- Population Outcomes:** We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach
- System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers are a key component of ensuring we address the Derbyshire financial challenge.
- System Development:** Manage the Derbyshire system through an aligned leadership and governance approach, supported by aligned incentives and a single view of system performance.

### 3. Links to the Health and Wellbeing Strategy

This report explains how the Derbyshire health and care system is refreshing plans to deliver improved outcomes for people across Derbyshire.

### RECOMMENDATIONS



The Health and Wellbeing Board is asked to:

1. REVIEW and provide ongoing support of the content and progress being made with the plan.
2. NOTE that the plan was submitted to regulators within the national deadline of 15 November, with a final window of amendments available with a final submission of 27 December 2019. The Derbyshire Health and Care system awaits regulator feedback prior to determining the implementation approach.

**Vikki Taylor**  
**Derbyshire STP Director**  
**Joined Up Care Derbyshire**

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# **Joined Up Care Derbyshire**

## **5 Year Strategy Delivery Plan:**

### **2019/20 to 2023/24**

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**FINAL**

**15 November 2019**



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# Executive Summary

This plan sets out our response to the NHS Long Term Plan published in January 2019. To better enable delivery of the ambitions set out the Derbyshire system has agreed to ensure a broader population health and wellbeing approach in our plan. Fundamentally, this five year plan sets out:

- Our response to implementing the commitments set out in the to the NHS Long Term Plan to 2023/24, with 2019/20 as the transitional year
- Our plan to become an Integrated Care System (ICS); including how we will bring together local organisations to redesign care and improve population health, creating shared leadership and action
- An outcomes driven approach so that the people of Derbyshire **‘have the best start in life, stay well, age well and die well’**. These are the three population level outcomes which the Derbyshire system has agreed and are consistent with the NHS LTP ambition to ensure that we give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people to age well
- Our approach to growing and transforming our workforce in line with the NHS Interim People Plan
- Our approach to developing stronger links and improvements in the wider determinants of health, leading to improved outcomes for people in Derbyshire which include housing, education and air pollution management, which is considered particularly important given the link between health and each of these areas
- Our approach to using our resources wisely and living within our financial allocation as a system
- A stronger focus on addressing inequalities through population health management, embedding the personalised care model as an enabler to improve outcomes through segmentation approaches
- Our engagement and involvement approach to ensure strong collaboration and coproduction with our public and stakeholders

Importantly, we recognise the cultural shift required to enable wellbeing rather than solely fixing ill health, throughout our plan and our approach going forward will focus on people not just patients.

*“The longstanding aim has been to prevent as much illness as possible. Then illness which cannot be prevented should where possible be treated in community and primary care. If care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home”. NHS Long Term Plan, January 2019.*

The health and care case for change is strong; we know that:

- By 2033 it is forecast that a quarter of the population will be over 65 years old

- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving
- People die earlier than they should in some parts of Derby and Derbyshire from respiratory, mental health, falls, CVD and MSK related conditions compared to national averages

Demand on services has been increasing, but much of that extra demand is for treatment of conditions which are preventable. At its heart, the NHS remains a treatment service for people when they become ill. Our ambition is to develop a system in Derbyshire which shifts the focus from treating ill-health to enabling wellness; to improve the health of local people, reduce health inequalities and stem the rising demand for health and care services. If we are serious about improving population health, health inequalities and stem the demand for services, we need to take action across the four domains:

Vision	A Vision for Population Health in Derbyshire – that people in Derbyshire have the best start, stay well, age well and die well			
	Delivered through improving population health and reducing inequalities			
Outcomes (what)	1. Have the best start in life		2. Stay well	
4 pillars (how)	Wider determinants of health	Health Behaviours & lifestyles	Integrated health and care system	Our Communities
	e.g. Income, housing, environment, transport, education, work	e.g. Diet, smoking, physical activity, alcohol and drug use	e.g. Integrate care around need, ability to manage multi-morbidity, services effective and efficient	e.g. Planning, licensing, relationships, community networks, asset-focussed.

The Derbyshire ambition to deliver the **Quadruple Aim - Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience and resilience, Reducing the per capita cost of healthcare**; will remain at the forefront in our approach and will be underpinned by our five strategic priorities: **Place based care, prevention and self management, population outcomes, system efficiency and system development**. In addressing the quadruple aim and delivering the ambitions set out in our plan, Derbyshire will be a great place to grow up in, work and live.

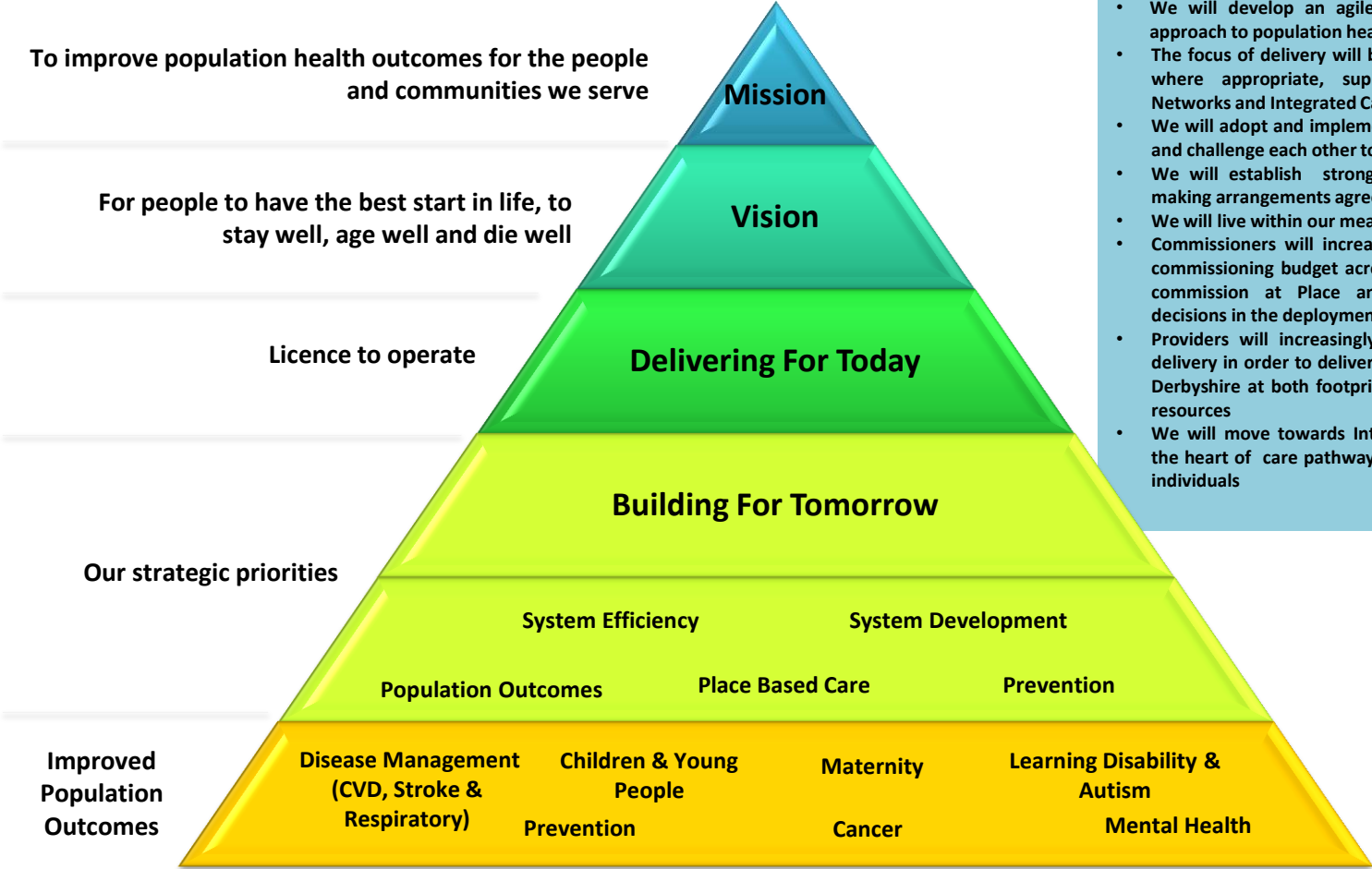
Our plan will continue to evolve and there will be opportunities for Derbyshire people to share their views to help make services the best they can be. For more information, and to find out in coming months about how to get involved please visit <https://www.joineducarederbyshire.co.uk/>

Any changes proposed to current services would involve local engagement and, if appropriate, consultation. Any consultation would follow legal guidance, and involve as many local people as possible.

What is Joined Up Care Derbyshire?

Our partnership is made up of providers (NHS, Local Authority and Voluntary Sector) and commissioners; Joined up Care Derbyshire (JUCD) is the identity by which we work together in this partnership.

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- What Will Be Different
- Our system will jointly plan for the health and social care needs of the population; moving from fixing illness to enabling wellness
  - We will develop an agile workforce to meet the changing approach to population health and system working
  - The focus of delivery will be PLACES rather than organisations where appropriate, supported by strong Primary Care Networks and Integrated Care providers
  - We will adopt and implement core principles for how we work and challenge each other to upholding them
  - We will establish strong system governance with decision making arrangements agreed
  - We will live within our means
  - Commissioners will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at Place and make strategic commissioning decisions in the deployment of that budget
  - Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place levels within allocated resources
  - We will move towards Integrated Care Partnerships being at the heart of care pathway delivery to meet the local needs of individuals

Be driven by the interests of the people and communities we serve

Support each other to address barriers to system transformation

Ensure services are provided as close as possible to the places people live

Design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them

# Joined Up Care Derbyshire – ‘plan on a page’

The summary below provides a high level overview of the five year Joined Up Care Derbyshire Strategy Delivery Plan

## (1) The Quadruple Aim: Challenges

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; there are areas of significant rurality which create access challenges
- We have made significant progress with beginning to ‘join up care’; however, there remain many opportunities to integrate care more effectively and consistently
- 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 if we do nothing for the Derbyshire health system is anticipated to be £332m by 2023/24
- In addition the anticipated cost pressures for Derbyshire County Council is circa £113m. We are working with Derby City Council to determine the cost pressures from that perspective. Both Local Authority and General Practice elements will be considered as part of the system view as we develop a better understanding
- 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.**

## (3) Impact & Implications

Delivering our plan will help us to:

- 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 2023/24

We will significantly change the ‘shape’ of the system:

- With more care delivered through Place based care, we will work to reduce care delivered in specialist settings where appropriate
- Major changes to the workforce – more staff delivering place-based care
- Changes to the physical configuration of place-based services
- Greater integration and streamlined commissioning across health and local authority driven by a population health management approach
- Increased integrated provision of services wrapped around people and their communities

## (2) Our priorities

Five priorities form the core of our 5 Year Joined Up Care Derbyshire Strategy Delivery Plan:

- **Place-based care:** We will accelerate the pace and scale of the work we have started to ‘join up’ care to transform out of hospital care and fully integrate community place based care by operating as a single team to wrap care around a person and their family; tailoring services to different community requirements across our 8 Places, underpinned by Primary Care Networks
- **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
- **Population Outcomes:** We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes
- **System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers
- **System Development:** We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Partnerships (ICPs) and our Strategic Commissioning function through aligned leadership and governance

## (4) Next steps

Delivering the STP:

- The work over the next five years to deliver our plan is part of and consistent with our ongoing journey to deliver our model of care which will transform ‘out of hospital care’ through fully integrated place based care ; reducing reliance on institutional care
- We will accelerate the pace and scale of these changes to have the necessary transformational impact. We will build upon progress made to date to establish our Place Alliances and develop these further in light of new models which include Primary Care Networks (PCNs) and Integrated Care Partnerships (ICPs)
- Our approach will be facilitated by the development of our Integrated Care System by April 2021, to now begin the transition from planning into delivery
- During the next 6 months we will:
  - Align system capacity and capability to enable even greater focus on delivery
  - Progress delivery of a number of high impact transformation schemes to support future sustainability
  - Continue our localised engagement programme focussing on staff, stakeholders and our local population



## What (Outcomes) & How (Workstreams and Provision)

### Best Start in Life:

A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support

- Fewer women smoking at time of delivery (6% or less by the end of 2022)
- Reduce stillbirths, neonatal deaths, maternal death and brain injury by 20% by 2020/21 and serious neonatal brain injuries by 50% by 2025
- Increase in women on continuity of carer pathway
- Community Wellness approach developed where individuals and families can receive the improved support for their physical and emotional health and wellbeing
- Provision of 24/7 services for Children and Young People with mental/emotional behavioural needs, requiring urgent care response; accessible via NHS111 by 2023/24
- Reduction in child excess weight; Derbyshire Childhood Obesity Strategy with improved coordination of treatment across health, local authority, public health

### Stay Healthy:

Helped to live a healthy life, make healthy choices and protected from threat. Able to maintain quality of life and recover from ill health or injury

- 30% of non-elective attendances treated as same day emergency care, including same day urgent care services in primary care and treating people within community-based Urgent Treatment Centres (UTCs)
- At least 75% of people with a learning disability and/or autism aged >14yrs will receive an annual health check
- Reduced reliance on inpatient care so no more than 28 people with LD require inpatient care (secure and acute) by 2020/21
- Reduce the length of time people spend in hospital and end the need for all out of area adult acute mental health placements by 2020/21; for those requiring Psychiatric Intensive Care we plan to develop a local PICU unit by 2023/24
- Implementation of a service for High Intensity Users (HIU) with chaotic lifestyles which enables targeted proactive care management
- Better cancer screening uptake for Breast (80%), Cervical and Bowel (75%) leading to 62% of all cancers to be diagnosed at an earlier stage by 2020
- Transform the way outpatient services are delivered, reducing the need for face to face outpatient appointments by a third by 2023/24; using digital technology to support prevention and self-management

### Age Well, Die Well:

Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable and supported end of life

- More people with dementia and delirium being supported in their own home or in a place they call home
- Older people will receive proactive, person centred and integrated care. We will embed the frailty model of care for Derbyshire to manage frailty as a long term condition in its own right, rather than as a label
- People living in care homes will receive more support, ensuring that their needs are assessed and met; reducing the need for unnecessary and avoidable hospital admissions
- Embed the ageing well programme so that integrated care teams enable more effective care closer to home; contributing a 4.5% reduction in non-elective admissions
- People approaching the end of their life will have fair access to personalised end of life care and support and to die in their preferred place of care. We will promote honest and open conversations about death across communities; with those caring for the dying person are involved and supported

### Provision

Integrated Care Partnerships

Places/ Primary Care Networks

NHS Providers

Primary Care

Local Authorities

Voluntary and Independent Sectors

### Work Streams: CYP

Maternity

Urgent & Emergency Care  
EoL Disease Management

Planned Care

Mental Health

Learning Disabilities & Autism  
Improving Flow Place/ PCNs

Cancer

### Enabler Workstreams: Comms. & Engagement

Workforce

Digital

Estates

Prevention

Population Health Management



**Partners involved in Joined Up Care Derbyshire**

**Primary Care Networks Place Alliances**

**Derbyshire Health United**

**Derbyshire Healthcare Foundation Trust EMAS**

**Chesterfield Royal Hospital General Practice**

**Derbyshire Community Health Services**

**Derby and Derbyshire CCG GP Provider Alliance**

**Derbyshire District and Borough Councils**

**Derby City Council Derbyshire County Council**

**University Hospitals of Derby and Burton LMC**

**Voluntary Sector NHS England Direct Commissioning**

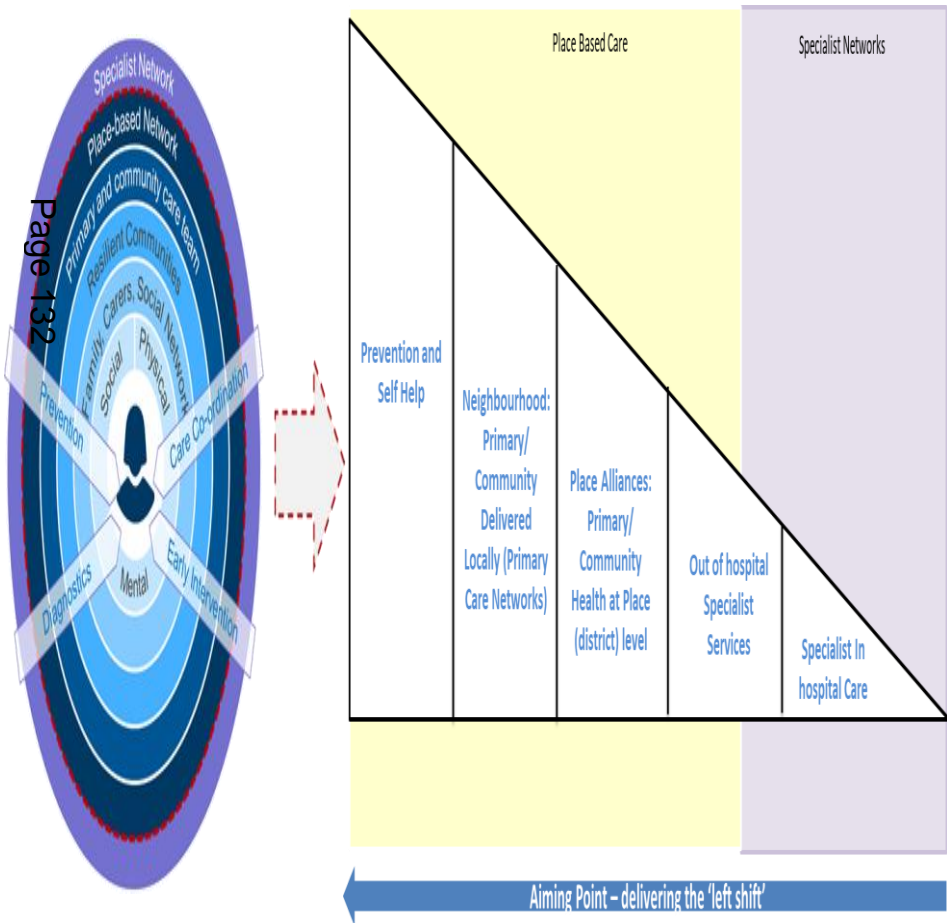
**We are in this together.....**

# Journey So Far (1)

Health and social care organisations across England have been working together more closely than ever as Sustainability and Transformation Partnerships (STPs), to look at improving care and services for people, making them as effective and efficient as possible. In Derbyshire, organisations came together in 2016, as the Derbyshire STP and developed **Joined Up Care Derbyshire (JUCD)** as our identity. Since this time we have been working hard to break down traditional organisational boundaries to develop greater integrated care for the population we serve. Together, we have made some progress but there is significantly more to be done.

Within our partnership, JUCD is committed to corporate citizenship to ensure that we meet our legal, ethical and economic responsibilities in our environmental, social and governance practices.

## The Derbyshire Model of Care



The 2016 plan provided the foundations for the next iteration and development of our five year Strategy Delivery Plan in response to the NHS Long Term Plan (LTP) published in January 2019. **The agreed Derbyshire model of care remains valid; providing the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes, as set out in this refreshed five year plan.** We are therefore refreshing rather than re-writing our plan.

Our model of care defines a placed based system which is effectively joined up with specialist services and managed as a whole. So that, fundamentally, the Derbyshire system would aim to keep people:

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

**... founded on building strong, vibrant communities.**

### Working together to deliver our model of care

Our plan is underpinned by a system wide Clinical Care Strategy developed through our Clinical and Professional Reference Group (CPRG). This is based on a set of agreed care principles and standards, which fully support the model of care. The role of CPRG is to provide clinical and professional leadership to support development and implementation of service changes required to deliver the system objectives.

Both Local Authorities are members of the JUCD Board and have been fully engaged in the STP to date, in addition have leadership roles at Place level and are SROs for specific workstreams. We expect these relationships to mature further as we continue on our journey towards an Integrated Care System.

We are actively engaging with broader representatives in relation to our plan. We intend to develop our approach in relation to the wider determinants of health and have progressed collaborative working with partners in areas such as housing, air pollution, fire services etc. We will also continue to discuss the plan with both Health and Wellbeing Boards and Health Scrutiny.

Our eight Places and Primary Care Networks will increasingly take a leadership role and will be integral in delivering our model of care.

Healthcare research is a core part of the NHS; JUCD recognises that in order to achieve the highest standards of excellence and professionalism, it is essential to promote, conduct and use research findings to improve health for both the current and future populations. We are actively involved in promoting research and innovation within our individuals organisations and will continue to spread the approach across boundaries as we move forward.

In addition we are working closely with partners beyond our footprint, including Public Health, Health & Justice, and Specialised commissioning and tertiary services to consider population health improvements at a local level for example Nottinghamshire ICS in relation to the development of the National Rehabilitation Centre.

## Journey So Far (2)

*Whilst we recognise there is a lot more to be done; since the publication of our STP Plan in October 2016 we have made significant progress which provides a solid foundation going forward...*

We set out some bold ambitions in our 2016 plan including that we would:

- Achieve a financially sustainable system
- Significantly change the ‘shape’ of the system:
  - 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
  - And, changes to the physical configuration of place-based services

### In response we have:

- Remodelled our bed requirements and recognised that our position has now changed, confirming that a reduction of 535 beds is no longer feasible
- Delivered a major transformation programme; Better Care Closer to Home in the North which has resulted in a reduction in Pathway 3 beds and resources converted into providing additional Pathway 1 and Pathway 2 capacity and additional staff for both Pathways 3 and 2 to provide equitable staffing across the pathways
- Established “Joined Up Careers” a collaborative system approach to recruitment, retention and development
- Established a specialist inpatient OPMH Centre of Excellence (Walton Hospital)
- Established Community Dementia Rapid Response Teams to work across each of the eight communities; supporting Place based care for older people with mental ill health rather than traditional inpatient bedded care
- Long cancer diagnostics (molecular testing) have reduced from a 22 day test result turnaround down to 6 days
- Derbyshire wide Faecal Immunochemical Testing (FIT) for colorectal cancer to speed up early diagnosis implemented
- Place based integrated care teams including general practice, community, fire and voluntary services, housing and social care established to support people in their own communities
- Intensive Home Support service for children and young people in mental health crisis has led to a reduction in use of in-patient beds
- More efficient use of our emergency departments with GP streaming, and an enhanced emergency department ‘pit stop’ at Chesterfield Royal Hospital
- More than 3,700 online holistic wellbeing assessments have been completed in Derbyshire, helping to prevent ill-health
- 100% coverage across Derbyshire for extended access to GP practices, leading to 108,264 additional GP appointments available a year
- A reduction in the stillbirth rate, exceeding the local target of 4.79 stillbirths per 1,000 birth set for 2019
- Access and recovery rates for Improving Access to Psychological Therapies (IAPT) are above national average
- 1,422 members of the health, social care and voluntary sector have completed online delirium awareness training
- We have established a Derbyshire-wide aging well programme which was previously referred to as our Frailty Model. Implementation of this model of care has been recognised nationally as an example of best practice
- A Clinical Assessment Triage Service for MSK has been implemented across Derbyshire
- 6 sites have been sold c£20m disposal value

By working more closely together over the past 3 years, we have developed a better understanding of the services offered already, where gaps might be, and what changes should be considered to offer everyone the best care, now and in future; using all available resources to maximum effect. This understanding balanced alongside the LTP commitments have enabled us to challenge our assumptions and recognise that some of our original ambitions need to change as we move forward. Joined Up Care Derbyshire is therefore in a strong position to accelerate plans and implementation to achieve the desired outcomes for our population.

### Challenges and lessons learnt

Whilst we have delivered real change, there have been challenges along the way and it is important that as a system we learn from these challenges as it will affect the way in which we succeed in delivery of our plan going forward. The following table demonstrates some of the key lessons learnt. This is based on feedback received directly from within the system, from individuals implementing transformational change and also recognising the change in the environment in which we are now operating.

Lessons Learnt
<b>Capacity and Resourcing:</b> <ul style="list-style-type: none"><li>• Delivering the scale and pace required for transformation programmes requires capacity to deliver</li><li>• Dedicated Clinical Leadership is required to ensure clinical credibility in our plans</li></ul>
<b>Communication and Wider Relationships:</b> <ul style="list-style-type: none"><li>• Stronger system wide communication and engagement, so everyone is moving in the same direction</li><li>• Effective system working - needs to be based on solid, open communication across all levels.</li></ul>
<b>Finance and Contracting:</b> <ul style="list-style-type: none"><li>• There is a need to establish a single system control total.</li><li>• We must continue to move away from a focus on short-term, organisational level transactional savings plans and adopt behaviours which enable larger/ longer term transformation and system savings</li><li>• We need to consider alternative contracting mechanisms which better support the model of care which we are trying to achieve</li></ul>
<b>Workforce:</b> <ul style="list-style-type: none"><li>• We need radical change to our workforce; to build resilience and to enable greater flexible working practices</li></ul>

These lessons learned have informed our approach to the refresh of our plan and more importantly the way we organise ourselves as we move towards becoming an Integrated Care System (ICS).

# Case for Change: Overview of the Joined Up Care Derbyshire Footprint

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

## Demography and Diversity

- As at April 2019, our registered population was 1.05 million people
- By 2033, a quarter of the population will be 65+ years (275,000 people)
- Over the next 5 years, the number of people aged 75+ years is expected to increase by around 23% to more than 116,000
- High deprivation in Derby and the North East contrasts with affluence in the Dales and South West
- Dense urban communities in Derby and North East; rural comparatively isolated communities in the North and West; smaller urban centres a mix of more affluent market towns and more deprived ex-mining areas
- Rich cultural mix across Derby City; 97.5% White British in the County

**Our plan must be flexible to meet diverse needs – in relation to both geography and population. To achieve consistent quality we must not take a 'one size fits all' approach.**

Derbyshire STP with Places, showing Acute and Community Hospitals and DCC P2 Establishments



## A wide range of health and care commissioners & providers

The statutory organisations within Derbyshire are:

- NHS Derby and Derbyshire Clinical Commissioning Group (CCG), two local authorities (Derby City, Derbyshire County, Borough and District Councils), Regional NHS England and Improvement
- Two acute Foundation Trusts in Derby (University Hospitals Derby and Burton) and in Chesterfield (Chesterfield Royal Hospital)
- One community Foundation Trust (Derbyshire Community Health)
- One mental health and wellbeing Foundation Trust (Derbyshire Healthcare)
- 115 GP practices (reg. pop. ranges (2-25k) forming 15 Primary Care Networks, plus one Out of Hours provider
- Residential and care home providers
- Ambulance Trust – East Midlands-wide
- Multiple voluntary and independent sector organisations

**Our plan must provide a common framework – and, importantly, aligned incentives - for us to work together.**

## Health of our population

- Life expectancy in Derby and Derbyshire is significantly lower than the national average for both men and women and is no longer improving. The national average is 79.5 years and 83.1 years for men and women; in Derbyshire this is 79 years and 82.8 years respectively.
- The gap in healthy life expectancy between the most and least deprived areas is approximately 19 years and 14 years in City and County respectively
- The rate of infant mortality is gradually worsening; in Derby it is significantly higher than the national average. Premature mortality rates, for example, from cardiovascular disease, liver disease and respiratory disease in Derby and parts of Derbyshire are significantly worse than the national average
- Around two thirds of our adult population are estimated to be overweight or obese, significantly higher than the national average (Derbyshire County: 63.8%, Derby City: 65.1%, England: 61.3%)
- 15.7% of mothers are recorded as smoking at time of delivery, significantly higher than the national average of 10.8% and more than double the national ambition of 6% or less
- Around 40% of people diagnosed with Type 2 diabetes did not receive all 8 care treatment processes in 2017/18

**Our plan must be both realistic about the challenges we face, and ambitious in tackling them – particularly in addressing the causes of ill health to slow future increases in demand.**

## 'Out of county' healthcare provision

- Significant patient flows to acute hospitals in Sheffield, Nottingham, Mansfield, Burton and Stockport
- Specialist/tertiary care is provided from Sheffield and Nottingham

**Our plan must be sensitive to reflect the current flows between Derbyshire and neighbouring footprints.**

## Health and care spending

We have used agreed growth rates for all services across the system to provide estimates of the costs of NHS treatment and care for 2020/21 to 2023/24.

These estimates generate a need for NHS savings of £127m, £81m, £68m and £55m between 2020/21 to 2023/24. This assumes delivery of the 2019/20 Derbyshire system control total and does not model any potential shortfall in social care provision and commensurate need for savings.

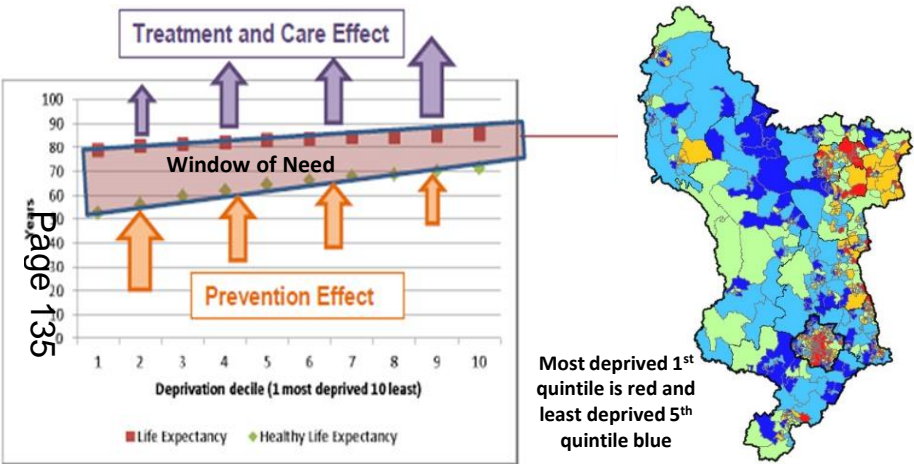
We will further develop the mitigations within this plan and their impact inside and outside of our footprint, where those providers cross a number of STP/ ICS boundaries.

**Our plan must tackle and address the forecast growth in health and care service demand.**

# Case for Change: Improving the health of the population

Fundamentally we know that across Derbyshire people are living longer in ill health and significant inequalities exist...

More people in Derbyshire are living longer in poor health due to a combination of increasing life expectancy and decreasing healthy life expectancy and persisting inequalities. The period in people’s lives when they require health and social care support, the ‘Window of Need’, is steadily rising. We also know there are marked inequalities in healthy life expectancy. People who live in the more deprived communities in the footprint or are part of certain groups such as those with severe and enduring mental health or learning disabilities spend more of their lives in ill health.



We are in the worst quartile of STP areas for key indicators of preventing disease (e.g. the number of mothers smoking at time of delivery) and reducing the impact of established disease (e.g. the number of diabetes patients to achieve all three NICE recommended treatment targets). Lifestyle risk factors such as smoking, physical inactivity and poor diet is more prevalent in our deprived communities. There are currently 49,500 unidentified cases of hypertension across the Derbyshire footprint.

26% and 45% cases of hypertension are due to obesity in men and women respectively

There is increasing evidence of the importance of emotional health and wellbeing in early years. Having the best start in life has a major impact on health and life chances, as children and adults, so early intervention and prevention can significantly improve population health and reduce inequalities. Deprived communities have greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. These wider determinants of health underpin lifestyle risk factors such as smoking, physical inactivity and poor diet, which are most prevalent in these communities.

The table below shows the variation in lifestyle and behaviour between our most and least deprived areas. Almost all are notably higher in the deprived communities.

Averages of MSOA rates	10% most deprived	STP average	10% least deprived	England average
Binge drinking adults (%)	18.9	20.8	19.6	20.0
Healthy eating adults (%)	23.2	28.2	36.0	28.7
Obese adults (%)	26.5	24.9	20.7	24.1
Obese Children (Reception) (%)	10.4	8.4	5.8	9.3
Obese Children (Year 6) (%)	23.9	18.0	13.6	19.3
Regular smoker (Age 15) (%)	10.0	9.5	7.3	8.9
Deliveries to teenage mothers (%)*	2.2	1.0	0.0	1.1
Teenage Conceptions (rate per 1,000)*	41.7	24.4	15.4	20.0

\*affected by suppressed values

It is known that a small proportion of the population accounts for a high proportion of use of health and social care resources as people are living longer with ongoing needs and increased risk of developing one or more chronic conditions. Lifestyle factors are also contributing to a rise in long-term conditions among younger people.

Men and women living in deprived areas are 4.5 and 3.9 times more likely to die from an avoidable cause compared with those living in the least deprived areas respectively



# Case for Change: Improving the health of the population: Derbyshire Places

## Bolsover and North East Derbyshire

**Bolsover:** Population ↑ 2.3% next 5 years, 75+ years ↑ to 8.5K. High deprivation, significantly lower average weekly earnings, significantly higher premature mortality and significantly lower overall life expectancy. However, the self-rated happiness score is highest in the county.

**NE Derbyshire:** Population ↑ 1.4% next 5 years, 75+ years ↑ to 14K. Largely rural and prosperous area but pockets of deprivation in and around Clay Cross and Grassmoor. 6.6% ESA claimants. Highest adult excess weight in county. Significantly higher rates of hospital admissions for self harm and alcohol.

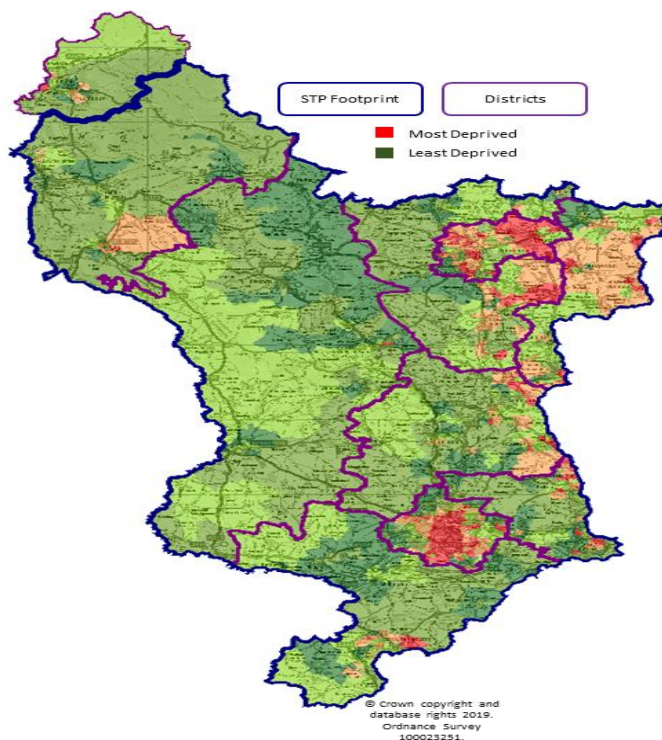
**High Peak** Population ↑ 0.9% next 5 years, 75+ years ↑ to 10.5K. Sparsely populated areas reflected in above average travel times to key services. Generally better than or similar to England, but alcohol specific hospital admissions remain significantly higher than average. The gap in employment for people with a long-term condition is in the highest 20% in England.

A more detailed breakdown across each of our areas can be found at Appendix 1

**South Derbyshire** Population ↑ 4.3% next 5 years, Two thirds of the population are working age, but the number 65+ will increase by 12% to 21.6K. Relative job density is low and it is the only county district with a significantly higher rate of homelessness. Female life expectancy is significantly below average.

'Double jeopardy'; we know that far shorter lives are spent in far poorer health in the most deprived areas. Much of the increasing demand for health and care services is for treatment of preventable conditions.

*Men and women living in deprived areas are 4.5 and 3.9 times more likely to die from an avoidable cause compared with those living in the least deprived areas respectively*



The life expectancy of someone living in Derbyshire Dales is three to four years longer than someone living in Bolsover.

There is up to a 10-year gap in life expectancy in different parts of Derby (between Allestree and Arboretum).

**Chesterfield** Population ↑ 0.9% next 5 years, 75+ years ↑ to 12K. Clear areas of high deprivation throughout the district. 8% of people claiming employment support benefits and 20% of children in low income families. Average life expectancy significantly lower for men and women. Premature mortality from CVD highest in the county.

**Derbyshire Dales** Population ↑ 0.6% in 5 years, 75+ increase to 11K, around 15% of total population. Though a largely prosperous area, the older population, rurality, inaccessibility to key services and hidden pockets of deprivation present their own challenges.

**Amber Valley** Population ↑ 1.9% next 5 years, 75+ years ↑ to 15.5K. Deprivation in and around Alfreton, Somercotes, Ripley and Heanor reflected in stark inequalities in average life expectancy. Gap in life expectancy for females is in the highest 20% nationally. Smoking significantly higher in both R&M occupations and pregnant women.

**Derby City** Population 26% 16-34 years. Population ↑ 2% next 5 years, 75+ years ↑ to 23K. Around a quarter of the population from BME groups. Significant areas of deprivation in and around the city centre and higher proportions of children in lower income families and ESA claimants. Significantly lower life expectancy and higher premature mortality from CVD and respiratory disease. Smoking prevalence, alcohol and self-harm admissions all worse than average.

**Erewash** Population ↑ 2.4% next 5 years, 75+ years ↑ to 13K. Deprivation exists around the 2 towns of Ilkeston and Long Eaton. Job density is relatively low for an area with a younger population. 18% of women are smoking at time of delivery, and a quarter of 4-5 year olds are overweight/obese. Self harm admissions are significantly higher.

## Case for Change: Improving experience of care (quality & satisfaction)

80% of a person's good health is influenced by social, behavioural and environmental factors as set out previously; 20% of health outcomes are determined by level of access and quality of care received. We have made significant progress in 'joining up care'; however, many opportunities remain to integrate care more effectively and consistently...

### Why do we need to change?

#### The lack of joined up care results in...

##### Services which are not integrated effectively:

- Fundamentally, our health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care). These services are often characterised by organisation and role boundaries, not a system that is centred on people and communities.
- Individuals and teams do not yet work in a fully integrated way and are often conflicted and constrained by organisational priorities.
- Our services are struggling to meet the increasing demand for ongoing complex care (social, physical and mental) the way they are currently delivered.
- People with such needs often experience care that:
  - (i) does not support their independence and control;
  - (ii) is fragmented and difficult to navigate;
  - (iii) results in a poor quality of life for both the patients and their carers.

##### Care is not proactive:

- We do not routinely and systematically identify and support people with complex ongoing needs.
- Mechanisms for information sharing, care planning and care coordination are generally ineffective.
- There are occasions where harm could be prevented for vulnerable people (e.g. pressure ulcer and falls)

##### Frail elderly patients decompensate:

- Elderly patients sometimes spend too long in bed-based care (acute and community) causing physical, psychological, cognitive and social deconditioning resulting in lost independence.

#### Our system being overly reliant on bed-based care...

##### Patients are not supported to be independent:

- Derbyshire is an outlier for numbers of people admitted to care homes, key drivers are long-term stays and overprescribing of care home use on discharge from hospital.
- We have made improvements with Better Care Closer to Home in North Derbyshire but too many people with dementia continue to be hospitalised particularly in the south of the county which can have negative impacts on both physical and mental health, making a return home difficult.
- Reported 'Delayed Transfers of Care' performance is in line with the standard and the Derbyshire System remains in the top quartile nationally. However, local experience highlights flow and discharge issues.

#### We don't always provide care in the right settings or give people alternative ways to access information about care...

- Patients being admitted to hospital when they could be cared for in alternative, more appropriate ways if the necessary services were available. This includes care for our frail elderly patients but also ambulatory care for acute conditions (in particular UTIs and pneumonia) and chronic conditions (in particular CVD and Respiratory).
- Poor access to services which would prevent crisis and exacerbation
- Within Derbyshire, 45% of all deaths occurred in hospital (PHE, Fingertips 2017 data) a significant proportion of these will be individuals on our palliative/supportive care registers
- There is no single record of an individual's health and care that is accessible to the person and care professionals in the system.
- Use of telehealth and telecare to support people, particularly those with long-term conditions, is still embryonic.
- Individuals are often provided prescriptions and interventions with limited health education and implementation support. Lack of follow-through on provider recommendations is a key contributor to negative health outcomes

### What does this mean for our services and our people?

#### We are not consistently providing the right services, in the right place at the right time...

##### Urgent & Emergency Care

- An inconsistent integrated urgent care offer 7 days a week In Derbyshire's most rural areas MIUs are not fully utilised; there are uncoordinated points of delivery, inequitable access and limited integration which results in confusion with A&E departments remaining the default.
- System 4 hour wait A&E performance as at July 2019 is 84.1% , with A&E attendances at CRH increasing by 9% and UHDB 7% year on year
- Reliance on acute and community (health and social care) beds placing patient safety at risk as alternatives are not clear, easy to access or responsive and integrated.

##### Cancer

- Inconsistent delivery of Cancer waiting times standards
- Around 79% of deaths from lung cancer and COPD can be attributed to smoking; estimated that 43% of people with a mental illness smoke

##### Mental Health

- Overreliance on bed based care; the Length of Stay in Derbyshire acute beds is around 45 days compared to a national average of 32, which is above the 85% threshold
- There is a high reliance on admission for older adults due to lack of crisis intervention services.
- Adults requiring acute, Psychiatric Intensive Care Units (PICU) and rehabilitation services continue to be treated out of Derbyshire
- Mental health hospital admission rates per 100,000 are higher than the England average; as are emergency hospital admission for self-harm.
- Disjointed community pathways for individuals with severe functional presentations often outside of 'Place' still exist and there is inequity in provision across the county.

##### Planned Care

- Meeting RTTs in some specialties for example urology, lung and Gynae
- Contacts with secondary care are not always valuable.
- Elective services largely delivered within acute hospital.
- Over 25% of surgical interventions are considered unnecessary due to a lack of end-to-end integration.

##### Learning Disabilities & Autism

- People with a learning disability and/or autism in Derbyshire are more likely than the national average to be receiving care in inpatient settings.
- More likely to also suffer with physical health problems such as epilepsy, hypothyroidism, diabetes, heart failure, chronic kidney disease or stroke.
- Less likely to receive cancer screening.
- Are more likely to be obese between the age of 18-35 and more likely to be underweight once they are over 64.

##### Children & Young People

- Services focus heavily on provision rather than on enabling children, young people and families to respond to their own needs.
- High-cost placements for vulnerable groups create pressure on provision.
- Inconsistent support for children with SEND

##### Condition Specific:

- Lack of preventative interventions which avoid late diagnosis and sub-optimal management

##### Primary Care:

- Variation in screening, early diagnosis and chronic disease management , means impact on quality of life, independence and life expectancy.
- Quick access to see GPs varies

##### Workforce

- We have an aging general practice workforce
- Our workforce is not as adaptable and resilient as needed to cope with increasing demand, expectations and increasing clinical needs

## Case for Change: Reducing the per capita cost of healthcare

*The Derbyshire system is collectively spending greater resources compared to our allocations year on year. We recognise there are significant material financial challenges which will continue into future years. If we are to meet the increasing demand identified in our case for change we will need to continue working together collectively to address these challenges...*

### System Efficiency Target

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
NHS Derby and Derbyshire CCG	69,500	55,855	63,319	48,105	34,936	25,380
Chesterfield Royal Hospital NHS FT	9,831	9,831	2,937	2,977	3,507	3,540
Derbyshire Community Healthcare Trust	6,082	6,130	5,565	2,880	3,986	3,925
Derbyshire Healthcare NHS FT	4,599	4,595	6,770	1,614	1,847	1,893
East Midlands Ambulance Service	4,647	4,647	5,560	5,020	5,410	4,610
University Hospitals of Derby and Burton NHS FT	56,300	31,000	43,230	20,614	18,385	16,117
	<b>150,959</b>	<b>112,058</b>	<b>127,381</b>	<b>81,211</b>	<b>68,071</b>	<b>55,465</b>

### Capital Expenditure Plans

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
NHS Derby and Derbyshire CCG	2,158	2,158	1,873	1,880	2,179	1,894
Chesterfield Royal Hospital NHS FT	14,608	14,608	23,673	12,586	8,338	5,000
Derbyshire Community Healthcare Trust	9,312	8,393	14,365	19,234	12,537	5,669
Derbyshire Healthcare NHS FT	5,564	5,564	18,500	5,800	4,500	4,500
East Midlands Ambulance Service	8,331	8,331	9,739	10,694	11,690	11,188
University Hospitals of Derby and Burton NHS FT	61,566	48,590	83,818	125,527	83,090	50,493
	<b>101,539</b>	<b>87,644</b>	<b>151,968</b>	<b>175,721</b>	<b>122,334</b>	<b>78,744</b>

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
CCG Recurrent Allocation	1,622,446	1,621,048	1,678,594	1,722,139	1,785,079	1,846,908

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Recurrent	132,193	96,076	68,226	49,526	49,555	46,505
Non Recurrent	18,766	15,982	59,155	31,685	18,516	8,960
<b>Total Efficiency Target</b>	<b>150,959</b>	<b>112,058</b>	<b>127,381</b>	<b>81,211</b>	<b>68,071</b>	<b>55,465</b>
% of CCG Allocation	<b>9.3%</b>	<b>6.9%</b>	<b>7.6%</b>	<b>4.7%</b>	<b>3.8%</b>	<b>3.0%</b>

The financial modelling for the long term plan, starts with an assumption around the delivery of the 2019/20 Derbyshire system control total. This is a key risk and sensitivity to the model. If we are unable to deliver £151m in 2019/20, 2020/21 and beyond will be more challenging by the shortfall.

Activity growth rates have been modelled and agreed with all the NHS statutory bodies, including mental health, community services and ambulance services; these create the unmitigated overall savings challenge for 2020/21 to 2023/24 - £127m, £81m, £68m and £55m . We have used commissioner spend as a proxy for system marginal costs which looks broadly reasonable on review. This has generated a broadly triangulated, activity, workforce and financial model, pre the required transformational changes.

We have made significant progress in modelling the impact of the transformation deliverables described in this plan, to generate a mitigated, agreed and triangulated position; the greatest impact of which has been identified in relation to changes to planned care, urgent & emergency care and Place. We have assumed that the growth rates in the unmitigated model can be fully addressed through the transformation associated with plan deliverables, which is also a key sensitivity and risk in our model.

The agreed position includes demonstration of our commitment to allocating the additional LTP investment funding in relation to specified key deliverables. We are continuing to work towards developing a firmer view on the 2019/20 savings sensitivity. These savings are modelled in the table above and in the strategic planning workbook. In terms of the status of the mitigation the system believes it can consume the provider CIP requirement listed above, via the delivery of reduced unit costs for the existing models of care, but this is again challenging and a key risk.



# Case for Change: Improving staff experience and resilience

To genuinely deliver 21st century integrated care, will require growth in our workforce, transformation in the roles and ways of working. We need to make the health and care system a better place to work to be able to recruit and retain the staff we need...

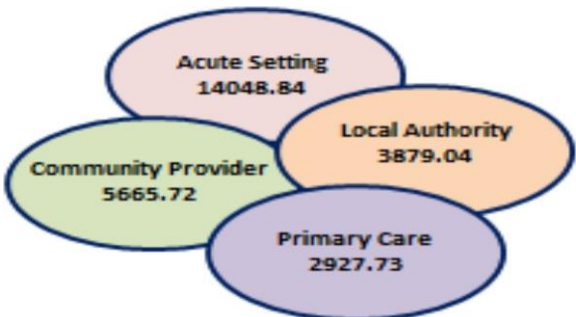
## Recruitment and attraction

In health and care, we operate in multiple labour markets for different types of staff. In Derbyshire, employment is at 79%, compared to 76% nationally with the number of vacancies steadily increasing across all sectors, so we have to rethink how we can attract people into health and care, to develop and support our people and make the health and care system a great place to work. For those roles where we operate in regional and national labour markets, we need to develop a strong brand awareness to present Derbyshire as a great place to live and work to keep students who train here and attract from elsewhere. There are particular national shortages in doctors in psychiatry and learning disabilities which impact on our area.

The Long term Plan envisages 20,000 more staff working in Primary Care Networks, 6,500 more staff in children and young peoples mental health services, 25,000 more staff in mental health services, 4000 more staff to support faster diagnosis and treatment and 10,000 more community staff to support the ageing population. We need to identify what our contribution towards these targets is and to ensure we can recruit and retain those staff.

## Transforming the way in which staff work

Out of a current total health and care workforce of 19,625 (contracted available FTE), 14,048 work in an acute setting. As the expected growth in workforce is predominantly expected to be in community and non bedded care settings, this presents a big challenge in terms of shifting staff into different settings, and working alongside a more diverse team from health, care and the voluntary sector. We can also expect significant developments in technology which will mean many tasks become automated, significantly changing the content of established jobs.



*‘There is a shortage of key clinical roles and increasing demand for NHS services. Care is increasingly delivered in the community, and our staff are treating a wider range of clinical conditions and in ever more complex environments.’*  
DCHS Clinical Strategy 2019

## Changing the skill mix and introducing new roles

Many of our services are run on a traditional medical model, particularly in General Practice and Mental Health and LD and some acute specialties. Shortages in GP’s and consultants due to changes in training numbers mean that we need to develop new roles to operate in holistic, multi disciplinary teams. Roles such as Advanced Practitioners take a number of years to train, and require similar levels of supervision and assessment to medics which is currently not funded. Other roles such as Physicians Associates are not currently trained in Derby, so we do not have a supply pipeline, and they also require significant post qualification training which is not currently funded.

We need to maintain our supply of nurses through a number of routes, a key one will be Trainee Nursing Associates, but we are constrained by the number of clinical placements in the system, particularly in the Private, Voluntary and Independent (PVI) sector and General Practice

*Even in the best-performing health care organisations, staff burnout has a direct negative effect on the experience of care for the patient. There’s also a correlation between high levels of staff engagement and high level of patient engagement. Staff are much more likely to be enthusiastic and positive about securing the best outcomes for patients when they feel supported, empowered, and respected.’* Institute for Healthcare Improvement.

## Making the NHS a great place to work

Our levels of employee satisfaction and indicators such as absence and turnover are similar in comparison with other health and care employers e.g.

	Range in Derbyshire NHS Trusts	Comparator
Sickness absence	4.27% - 5.9%	NHS East Midlands 4.40%
Turnover	9.42% - 10.52%	NHS Midlands & East 13%

There is more we can do to improve the staff experience by supporting and developing our staff. In particular we need to focus on the health and wellbeing of our staff and make it easier for staff to progress their careers by reaching their full potential along less linear professional and organisational boundaries, we need to modernise our offer for the future workforce including more flexible working patterns to appeal to generation X and Y , and we need to promote greater diversity and inclusion by ensuring all our organisations have a positive, person centred leadership culture. We are developing a system workforce dashboard to enable us to identify risks and opportunities across the whole health and care workforce and measure the impact of changes we introduce.

## Our Strategic Priorities

To deliver our vision for people to have **the best start in life, to stay well, age well and die well**, and address the challenges identified in our case for change (quadruple aim), requires major changes to the way care is provided and the way in which we are organised...

As set out earlier in this document the agreed Derbyshire model of care remains valid and will provide the basis by which we will continue to transform the health and wellbeing of our population and improve outcomes. Enabling the 'left shift', to deliver a new service model for the 21<sup>st</sup> century, will be underpinned by five interdependent strategic priorities:

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance

We will ensure ongoing efficiency improvements across commissioners and providers are a key component of ensuring we address the Derbyshire financial challenge

We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach, embedding the personalised care model as an enabler to improve outcomes

By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand

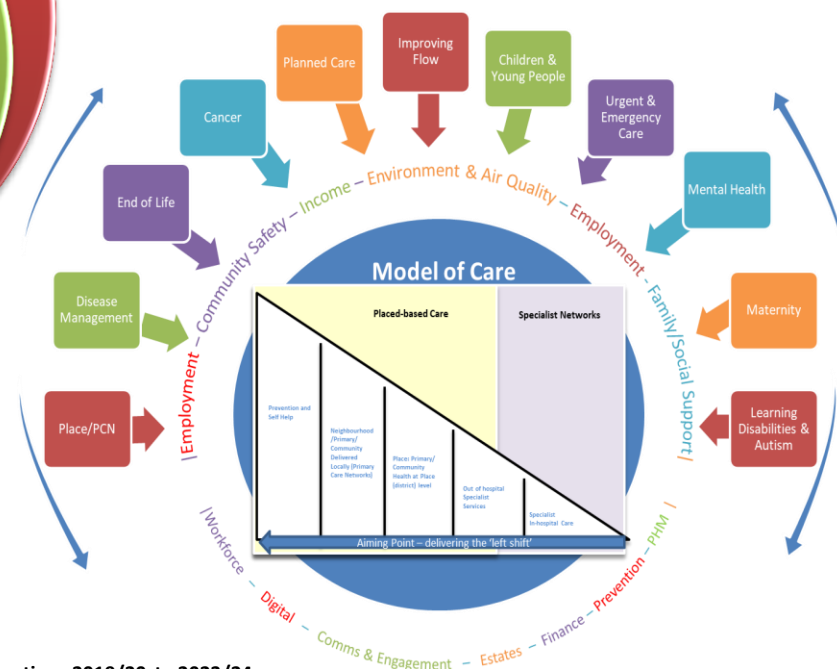
We will accelerate the pace and scale of the work we have started to 'join up' care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. So that services operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 places and 15 Primary Care Networks

Our strategic priorities enable delivery of the commitments set out in the NHS LTP. For the purpose of this five year Strategy Delivery Plan, some of the core elements, set out as 'foundational commitments' in the NHS LTP are described within our strategic priorities; namely our approach to place based care, prevention and self-management and system development. Whilst these are delivered as a whole they are also embedded within more

specific programmes of work, described later in this document. Furthermore, our model of care is based on delivering more personalised care which is also embedded within our programmes of work.

We are organised into key programme areas alongside enabler programmes designed to deliver our priorities, as set out in the diagram below. The workstreams are fully aligned to the LTP commitments and framed around delivering the agreed model of care for Derbyshire. This five year plan therefore describes our approach based on these key programme areas and is structured to demonstrate the commitments in the LTP and interdependencies between programmes of work.

### Joined Up Care Derbyshire Programme Areas



## Strategic Priority: Delivering transformed out of hospital care through fully integrated place based care

We will accelerate the pace and scale of the work we have started to ‘join up’ care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 Places and 15 Primary Care Networks...

To meet the changing needs of our population (growing demand for ongoing complex care – social, physical and mental) and make our system sustainable, we will continue with our approach to make a transformational shift from fragmented care based around institutions and beds, to coordinated community based care wrapped around people and communities; ensuring our hospitals and specialist providers deliver the specialist care only they can.

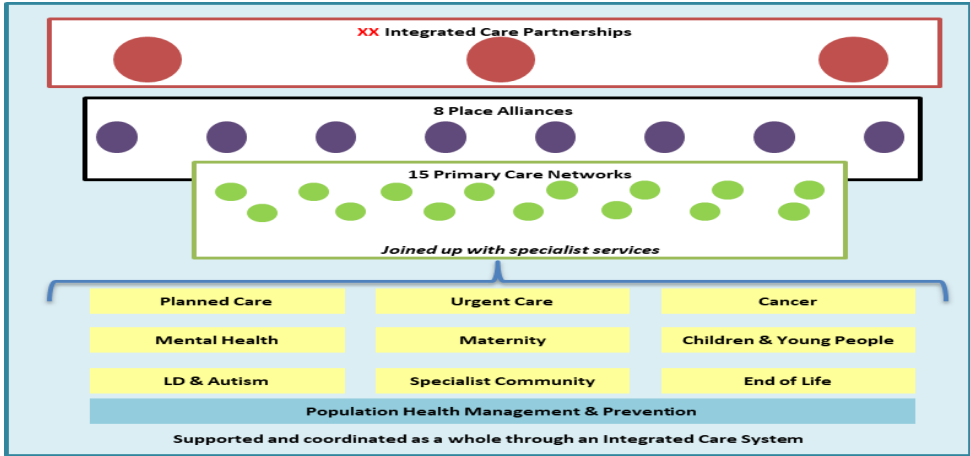
The Derbyshire Model of Care is essentially designed to deliver more localised place based care, whereby we will keep people:

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

...which will be founded on building strong, vibrant communities.

We have already established 8 Places across Derbyshire which have been focused on developing care closer to home and integrating services in the community, through multidisciplinary teams/ approaches to anticipatory care, which include housing and the fire service for example.

This is a journey which will evolve as our system architecture develops. Fundamentally our model of care will underpin our approach across each of our strategic priorities and enable delivery of the commitments for each of our programmes of work, as described below.



### Personalised Care

To achieve the ‘step change’ in preventing ill health and supporting people to live healthier lives; delivery of our model of care will enable a cultural shift for health and care professionals, to promote ‘wellness’ in the public and patients in developing the confidence to self-manage and take a lead role in decisions about their health. This will be at the heart of delivery within our Places/ Primary Care Networks, with personalised care in the broader sense embedded throughout. Our approach is described further in the prevention strategic priority section which follows.

By 2023/24 we are committed to the implementation of The NHS Comprehensive Model for Personalised Care’s 6 principles; namely shared decision making, personalised care and support planning, enabling choice, social prescribing, supported self-management, personal health budgets and integrated personal budgets across the NHS and the wider health and care system. Specifically:

Principle	Commitment
Personal Health Budgets	<ul style="list-style-type: none"><li>• Derbyshire has a commitment to achieve 3,240 PHB’s by 2023/24.</li><li>• PHB as default in Continuing Healthcare (Domiciliary), continuing care (children) and Wheelchair budgets are already implemented in Derbyshire.</li><li>• There will be an NHSE accelerated roll out of ‘legal right to have’ e.g. for people with entitlement to Section 117 aftercare (mental health).</li></ul>
Social Prescribing (SP)	<ul style="list-style-type: none"><li>• Derbyshire has a commitment to achieve 16,419 referrals to SP by 2023/24 and provide SP link workers to meet this need via PCNs</li><li>• SPs will be embedded within Derbyshire PCNs through the Network Contract Direct Enhanced Service (DES)</li></ul>
Personalised Care and Support Planning (PCSP)	<ul style="list-style-type: none"><li>• Derbyshire has a commitment to achieve 18,086 PCSP by 2023/24</li><li>• PCSP and its 5 essential criteria will be embedded in 100% of service specifications and care pathways, especially where people have long term conditions or complexity of care. A local CQUIN could support changes in healthcare culture required to meet commitment.</li></ul>
Shared decision making (SDM)	<ul style="list-style-type: none"><li>• To become business as usual for healthcare and therefore will be embedded in 30 of Derbyshire’s clinical situation service specifications and care pathways.</li></ul>
Enabling choice	<ul style="list-style-type: none"><li>• Expansion of choice will include Maternity and End of Life Services therefore this will be embedded in Derbyshire’s Maternity Transformation Programme and the End of Life Services Strategic Vision.</li></ul>
Supported self-management	<ul style="list-style-type: none"><li>• Derbyshire have a target of 15,393 usage of the NHSE provided Patient Activation Measure (PAM) to identify improved knowledge and skills in people with long term conditions (LTC) via PCN’s and LTC care pathways.</li></ul>

We believe that to deliver personalised care effectively will require a universal whole system approach. We will build our approach based on a review undertaken of the key components of personalised care which feature strongly within our programmes of work including examples such as health coaching, peer support and education programmes that support personalised support planning. A summary of how these approaches are embedded within our programmes of work can be found at Appendix 2.

## Strategic Priority: Delivering transformed out of hospital care through fully integrated place based care

We will accelerate the pace and scale of the work we have started to ‘join up’ care; transforming out of hospital care which fully integrates community place based primary care, mental health, community services, social care and the third sector. Services will operate as a single team, wrapping care around a person and their family, tailoring services to different community requirements across our 8 places and 15 Primary Care Networks..

### Primary Care Networks (PCNs)

Central to achieving transformed out of hospital care is primary care. The establishment of our 15 PCNs will be key enablers in delivering our model of place based care. The role of our PCNs is described in our system development strategic priority later in this document; underpinned by the Derbyshire Primary Care strategy (July 2019).

Our PCNs were established in July 2019; each have appointed Clinical Directors to take forward the PCNs and will be equal partners in the ICS development going forward. We will continue to support our PCNs to grow from an embryonic state to mature integrated community care providers and funding has been committed to enable this. PCNs will benefit from the Additional Roles Reimbursement Scheme, which was announced in the 2019 GP Contract Framework. Under this scheme, additional funding will be made available to PCNs for the following five roles:

- 2019/20 Clinical Pharmacist and Social Prescriber
- 2020/21 Physician Associates and First Contact Physiotherapists
- 2021/22 First Contact Community Paramedics

This builds on our positive progress towards our GP Forward View (GPFV) workforce trajectories. Currently, Derbyshire is above target in achieving its GP workforce trajectories, as follows:

	Actual	Actual	Actual	Actual	Forecast	Plan	Plan	Plan	Plan
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff Working in General Practice									
GPs and GP registrars - Total	587	616	581	675	661	661	661	661	661
Registered nursing staff - Total	338	353	353	357	361	361	361	361	361
Direct Patient Care - Total	188	212	206	211	206	206	206	206	206
Admin & Clerical	1287	1279	1282	1312	1,337	1,337	1,337	1,337	1,337

PCNs as part of the Derbyshire Place are now receiving data packs to assist in assessment of local populations at risk and are working with community services to develop approaches for targeted support.

Against the minimum requirements for ‘out of hospital care’ JUCC is committed to:

### Meet the new funding guarantees for primary medical and community health services

- Committed to the continuation of funding currently available non-recurrently to support Extended Access and GP Forward View funding streams, (e.g. practice resilience programme). Additional funding is also included to support the development of Primary Care Networks
- Identified Rapid Diagnostic Centres funding in 2019/20; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams

### Support the development of PCNs

- Fully meet the requirements for PCNs and their development

### Improve the responsiveness of community health crisis response services to deliver the services within two hours of referral, and reablement care within two days of referral

- Within the Derbyshire STP there are interdependencies with the Urgent Care and Mental Health workstreams. The PCNs have identified key personnel who work directly with these areas to ensure effective development of rapid response teams

### Create a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking account of the national phasing of the new five-year GP contract.

- Plans in-place for roll-out of digital services to increase patient access and improve productivity. We are progressing the implementation of online consultations by April 2021, which is a key deliverable in our digital strategy
- In addition to the service requirements, changes in 2020/21 will include the introduction of the Network Dashboard and the Impact and Investment Fund which will complement service requirements. The service specifications will set minimum requirements within the Direct Enhanced Service (DES). The dashboard will include measures of success to allow PCNs to benchmark their performance and monitor their delivery of the five service specifications
- We are committed to investing the Impact and Investment Fund (IIF) to provide additional funding to PCNs and deliver the national service specifications once developed; incentivising PCNs to reduce unwarranted demand on NHS services, including overprescribing and inappropriate A&E attendances. The IIF is expected to commence in April 2020, and will develop over the subsequent four years. Once access measures are confirmed these will be implemented to ensure target is met
- Development of new service models to improve rapid response and greater community offering

Our Places/ PCNs will be central to the delivery of our comprehensive frailty pathway focusing on the Ageing Well programme to support an efficient, high quality, multi-disciplinary response to people who have an urgent need that is best provided in their own home (even if that’s a care home).

### Enhanced Health in Care Homes (EHCH)

Work is underway to develop the approach in 2019/20 which will be aligned to the national Ageing Well programme and the publication of a maturity matrix for full delivery of the EHCH model. We will commission PCNs to work together to develop, at scale, models of pro-active, integrated care to support care homes residents by:

- Developing models which are integrated into community services
- Ensuring that care is based on a CGA style of care planning that is MDT based, holistic and includes residents wishes / preferences
- Developing and monitoring a set of outcomes consistently across Derbyshire Ensuring that PCNs are well prepared to adopt the new NHS England specification from April 2020



## Strategic Priority: Prevention and Self-management

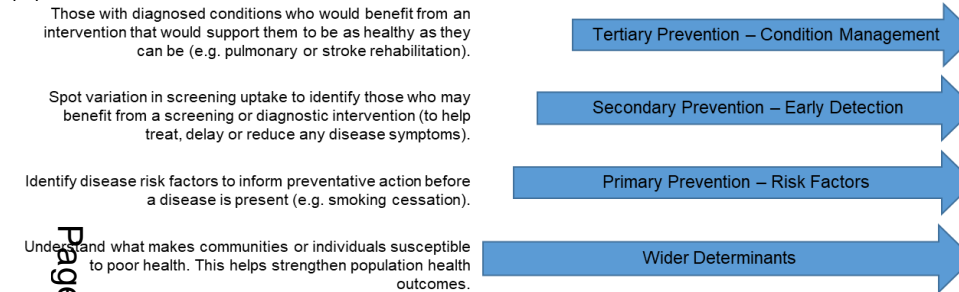
*By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand...*

### Why is this a priority for Joined Up Care Derbyshire?

Our public health challenges are significant, and the widening 'window of need' described in our case for change, means that many people across the county are living longer in ill health, with significant inequalities in life expectancy and Healthy Life Expectancy (HLE) within and between areas in Derby and Derbyshire. We must act now to address these inequalities and move from a system which is focused on solely fixing ill health to a proactive one which enables wellness and reduced dependency.

### Our Approach

To address the challenges, our ambition is to embed prevention across all programmes of work and for all organisations to champion the priority by working together to create healthy, resilient communities and populations.



We will continue with our collective commitment (Health and LAs) to develop a systematic approach to prevention at pace and scale by enacting our agreed system wide prevention strategy and delivering the four priority areas:

- Enable people in Derbyshire to live healthy lives
- Build mental health, wellbeing and resilience across the life course
- Empower the Derbyshire population to make healthy lifestyle choices
- Building strong and resilient communities where people are supported to maintain & improve their own wellbeing

In doing so we will:

- Further embed prevention across all workstreams and organisations within JUCD; led by the Prevention Board.
- Ensure additional investment specifically directed for prevention initiatives will be provided to achieve the step-change required, recognising that many benefits (including financial benefits) may take time to realise. These commitments are necessary to ensure a sustainable health and care system into the future.
- Work together to enable a 'whole-pathway' approach to prevention, particularly recognising the role and impact of wider determinants on morbidity, premature mortality, health inequalities and service utilisation. We will embed a comprehensive approach to prevention (primary, secondary, tertiary where appropriate) across all areas of care deliver; for example through promotion of physical exercise and access to green spaces
- Support primary, community and secondary care in the development of pathways that include referral to healthy lifestyle services and community initiatives; so they are applied systematically and delivered at scale to have a level of impact that will reduce the gaps in life expectancy and healthy life expectancy and reduce the demand for health and care services. We will also develop place-based initiatives where appropriate and feasible.

Final: 15 November 2019

- Work as a system and in conjunction with Public Health England to maximise the opportunities of national and local campaigns aimed to improve health and wellbeing and promote healthy lifestyles through a range of media on a national scale.

Specific interventions include (note many of our approaches are also aligned to our programmes of work):

- Access to wellness services: creation of a network of community venues where local residents can receive information and advice to 'wellness services'
- Falls prevention: (i) Systematic promotion of and signposting to physical activity opportunities across JUCD partners to increase the number of people being active as they approach older age, (ii) referral & signposting to falls prevention services and (iii) implementation of the Derbyshire falls pathway
- Cardiovascular Disease (CVD) Prevention: Determine current prevalence and associated mortality of a range of CVD conditions, and evidence for effective and efficient services
  - Primary care to maximise CVD prevention opportunities across the CVD prevention pathway e.g. AF detection
- Suicide Prevention & Mental health awareness : Embed self-harm and suicide awareness as an organisational priority by recognising key campaigns, sharing information and messages, training all staff and supporting people in more vulnerable groups e.g. people diagnosed with a long-term condition, those with substance misuse issues. Help to build the mental health literacy of the wider workforce and the public challenging stigma and discrimination and promoting positive mental wellbeing
- Healthy Workplaces: Support to employers to develop a positive proactive and responsive approach to mental health and wellbeing in the workplace

### Prevention and Place based care

We have a history of delivering preventative activities, however our efforts to prevent ill health have been small scale; we are now in a position to develop a more systematic approach to preventative services. This will be supported by better coordination of preventive efforts through full alignment and integration in our approach to Place based care; described earlier.

Public Health, within Local Authorities, ensure services are in place to support healthy lifestyles. These include a wide range of locality-based services and activities run by the public sector, voluntary and grant aided organisations – all of which have a role in primary and secondary prevention of ill health and support either physical or mental wellbeing. We will build on this through the application of an effective Population Health Management, approach as set out later in this document; so that primary prevention and early intervention is fully embedded in place based care delivery to ensure targeted efforts are developed within our 'wellness system'.

All professionals that come into contact with patients and the wider public will play a critical role in the promotion of healthy choices, healthy environments and resilient communities. We will support staff to feel confident and have the skills and knowledge to have 'quality conversations' with individuals and communities about their opportunities to improve their health and wellbeing.

Furthermore, prevention and proactive identification of patients, combined with risk stratification, and effective care planning will continue to provide the best approach to supporting patients and carers with the most complex needs; enabling them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services.

## Strategic Priority: Prevention and Self-management

*Derbyshire's public health challenges are significant, and the widening 'window of need' means that many people across the county are living longer in ill health – with the greatest impact in our most deprived communities...*

**Delivering national priorities** - The NHS Long Term Plan provides a renewed focus on prevention, highlighting the need to reduce inequalities and enabling people to stay healthier for longer; setting out the following risk factors as priorities for the prevention agenda; screening and immunisation, smoking, obesity, alcohol, air pollution, anti-microbial resistance (resistance to some anti-biotics). There are also national NHS initiatives that support prevention including Cancer Screening, National Diabetes Prevention programme and NHS Health Checks.

Our strategic approach to the key deliverables set out in the LTP are described below, with more specific prevention deliverables described later and embedded within our respective programmes of work. Our Prevention Strategy (2018) sets out the vision for 'Derbyshire that champions prevention across all organisations and works together to create healthy, resilient communities and populations'. We aim to eliminate unwarranted variation by working with our partners to identify any health inequalities in our patient population. Together we will develop a detailed and measurable delivery plan with milestones and trajectories for how we will contribute to narrowing the health inequalities gap over the next 5 to 10 years.

Embedding preventative approaches in everything we do, has the potential to make the greatest impact to the overall health and wellbeing of our population, reduce inequalities (geographical and for high risk/use groups) and wider determinants which affect use of our systems finite resources. Staff training will include an awareness of the importance of personalised care and self-management.

Key indicators which will demonstrate our progress can be found in **our Population Outcomes**, which include life expectancy, healthy life expectancy, Emergency admissions due to falls, smoking at time of delivery, population vaccination and screening.

### Smoking

We will enable staff, patients and visitors to become smoke-free through:

- Implementing smoke free sites policies, normalising smoke-free
- Provision of pharmacotherapy for inpatients
- Systematic promotion, signposting and referral to stop smoking services will continue and will be built upon to deliver more targeted smoking cessation services in selected sites and smoking cessation services for all inpatients who smoke, pregnant women and users of high risk outpatient services from 2020/21. These will be confirmed in our final submission.

### Obesity

We will develop a greater focus on obesity by 'upscaling' support to people who are overweight or obese within a 'whole systems' approach, for example, planning, licencing, access to green space, active travel and policy. JUCD system organisations will be a leader in enabling staff, patients and visitors to be active and eat healthy through:

- Ensuring organisational policies and infrastructure create an environment that enables healthy eating and active travel
- Ensuring weight management services are promoted and signposting/referring into services is systematic, including links to other programme area deliverables such as the diabetes weight management which includes a targeted plan, delivered by a 'Prevention Facilitator' and agreed referral trajectories which contribute to the national Diabetes Prevention Programme to support 525 people through the programme by 2019/20.
- Utilising nationally developed resources such as fitter, better sooner/stop before any surgical interventions.
- Develop a Derbyshire wide Childhood Obesity Strategy, to include treatment service pathways which is

coordinated through public health, local authority and health

### Alcohol

Alcohol admissions are significant issue for the City and to some degree the County; we have prioritised this in our prevention strategy to enable healthier choices which result in:

- Increased numbers of adults in Derbyshire drinking within the recommended limits
- Decreased rates of alcohol related admissions
- Increased rates of dependent drinkers accessing services

The targeted investment for Alcohol Care Teams (ACTs) from 2020/21 to 2023/24 will also be explored as an option for further development; subject to further national information and requirements to access the funding. We will work closely with the Mental Health Programme to ensure an integrated approach.

Substance Misuse Services across the City and County are currently provided by a partnership led by DHcFT and there are potential opportunities for greater integration into the new models of Adult Community SMI services after April 2021.

### Air Pollution

Air pollution is the biggest environmental health risk, contributing to an estimated 530 deaths and 5400 life years lost in Derbyshire County and City. Our vision is to reduce the health impact of poor air quality for the people of Derbyshire. As partners we will use our individual and collective influence as employers, providers and commissioners, to reduce our own contribution to local air pollution, facilitate change, influence others and protect health. We plan to engage through our Air Quality Working Group, to focus on protection from pollution and prevention, specifically for people with long term conditions to raise awareness of triggers. Our key areas of focus being taken forward by the Health and Wellbeing Board include:

- Travel behaviours with partners facilitating sustainable and healthy travel options through healthy eating and active travel policies
- Reducing sources of air pollution
- Proportion of people living in a smoke control zone
- Mitigating the health impacts of air pollution

The Derbyshire Air Quality Working group will be responsible for implementation of the Derbyshire County and Derby City Air Quality Strategy (2020-2030).

### Antimicrobial resistance (AMR)

We recognise the threat that AMR has on the effective prevention and treatment of an ever-increasing range of infections. We will establish a system wide AMR steering group, and determine a baseline position from each provider to build upon work undertaken to tackle AMR and related Gram Negative Blood Stream Infection (GNBSI). We will use this forum to fully implement the Governments national action plan 'Tackling Antimicrobial Resistance' to reduce overall antibiotic use, health care associated GNBSI and drug resistant infections.

We will target approaches for high risk populations and areas of high variation, key priorities include:

- Further reducing antimicrobial use in the community, tackling unwarranted clinical variation and outlier prescribers
- Enhancing the role of pharmacists in primary care to review antimicrobial prescriptions working with prescribers to review those that are inappropriate through evidence-based, system-wide interventions.
- Raising public awareness to encourage self-care

## Strategic Priority: Population Outcomes

*We will focus on improving the outcomes for the people of Derbyshire by applying an effective Population Health Management approach...*

### Effective Population Health Management (PHM) to improve population outcomes

We recognise that a focus solely on healthcare provision will not solve the significant challenges we face given the relative contribution of other factors to our health. We will therefore further develop our PHM approach to maximise data and intelligence to strengthen our communities so that we:

- Better co-ordinate system wide action to create healthy places
- Improve population health and wellbeing and tackle health inequalities.
- Effectively allocate resources and support service redesign
- Evaluate the impact of interventions and identify system savings
- Understand the population and sub-population need
- Understand the use of, and demand for, services across the health and care system; including where there is variation (warranted and unwarranted)
- Identify best practice, effective interventions and promote innovation

### Our Approach

Whilst we have many important elements of a PHM approach already in place, we recognise that we are early in the journey to develop a comprehensive local cross-system PHM function to deliver the appropriate intelligence which effectively supports local planning and decision-making. To achieve this we will prioritise development of the following:

#### *Culture and leadership*

- Engaging and supporting change in the system to embed effective PHM.
- Better use of clinical leadership to drive transformation.
- An approach rooted in an understanding of equality and inclusion

#### *Workforce*

- Understand and building on, the capacity and capability of the knowledge and intelligence workforce.
- Understand and develop the capability of the wider workforce to effectively engage with and use intelligence and data tools.

#### *Technical & infrastructure*

- Relevant data sources and flows and system requirements are required (understanding what we have now and how to get to where we need to).
- Understand the 'products'/ end user(s) needs to enable accessible and meaningful knowledge and intelligence to support effective decisions.

By applying an effective PHM approach, we will develop a broad set of indicators that measure local conditions for wellbeing and whether those conditions are being delivered fairly and sustainably and build on our outcomes based accountability approach described below.

### Outcomes Based Accountability (Whole System Outcomes)

The Derbyshire system has agreed to apply an outcomes based accountability approach to ensure everything we do is outcomes led, with multiple accountability across partners as appropriate.

We will continue to develop this approach to ensure shared accountability for delivery of the LTP commitments and our broader approach to improving the health of our population. This approach which will be further enhanced through the development of PHM in Derbyshire to ensure our approach is fully aligned and agreed across all parts of the system, including our local Health & Wellbeing Boards and Local Authority (for instance in relation to Housing, Education, Air Quality).

We have agreed a set out outcome indicators across our existing programmes which are aligned to improvements in our three overarching population outcomes for people to have the best start in life, stay healthy, age well and die well. These indicators are also consistent with the LTP metrics. Our framework is set out on the following pages. By delivering the collective transformation programmes as set out in our plan, we will make real improvements in the health outcomes for the people of Derbyshire.

### Derbyshire Wide Quality impact Assessment (QIA) tool

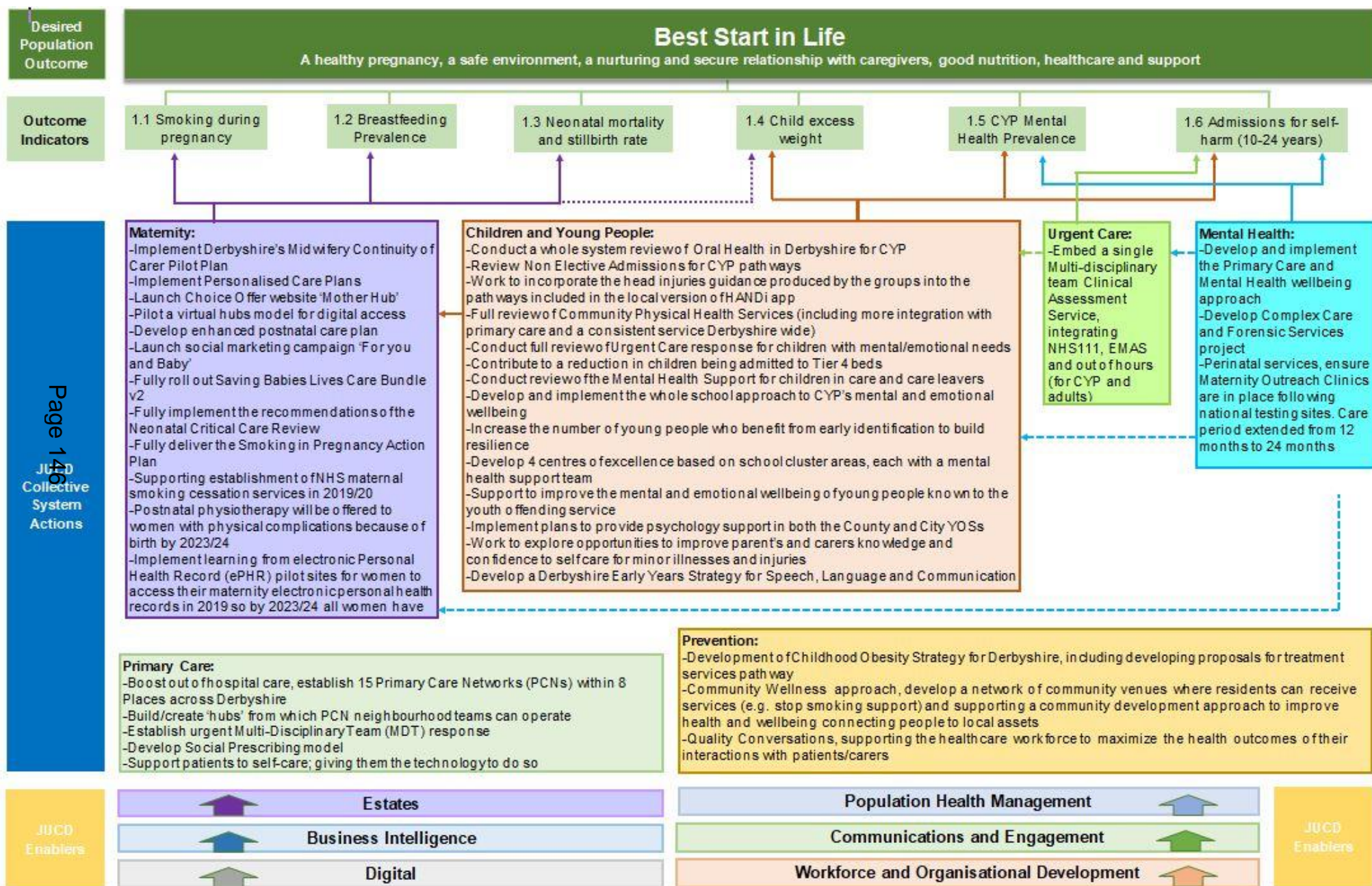
We have developed a system wide QIA approach which sets out how interdependencies and impacts across all component parts of our plan will be managed. This process enables quality and equality implications to be considered more effectively; where potentially negative quality impacts are identified either at organisational or cross system level, robust mitigations will be developed collaboratively across system partners.

We have identified three quality components which underpin the QIA process:

- Patient Safety – there will be no avoidable harm to patients from the healthcare they receive. This means ensuring that the environment is clean and safe at all time and the harmful events never happen.
- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit.
- Patient Experience – the patient's experience will be at the centre of the organisation's approach to quality.

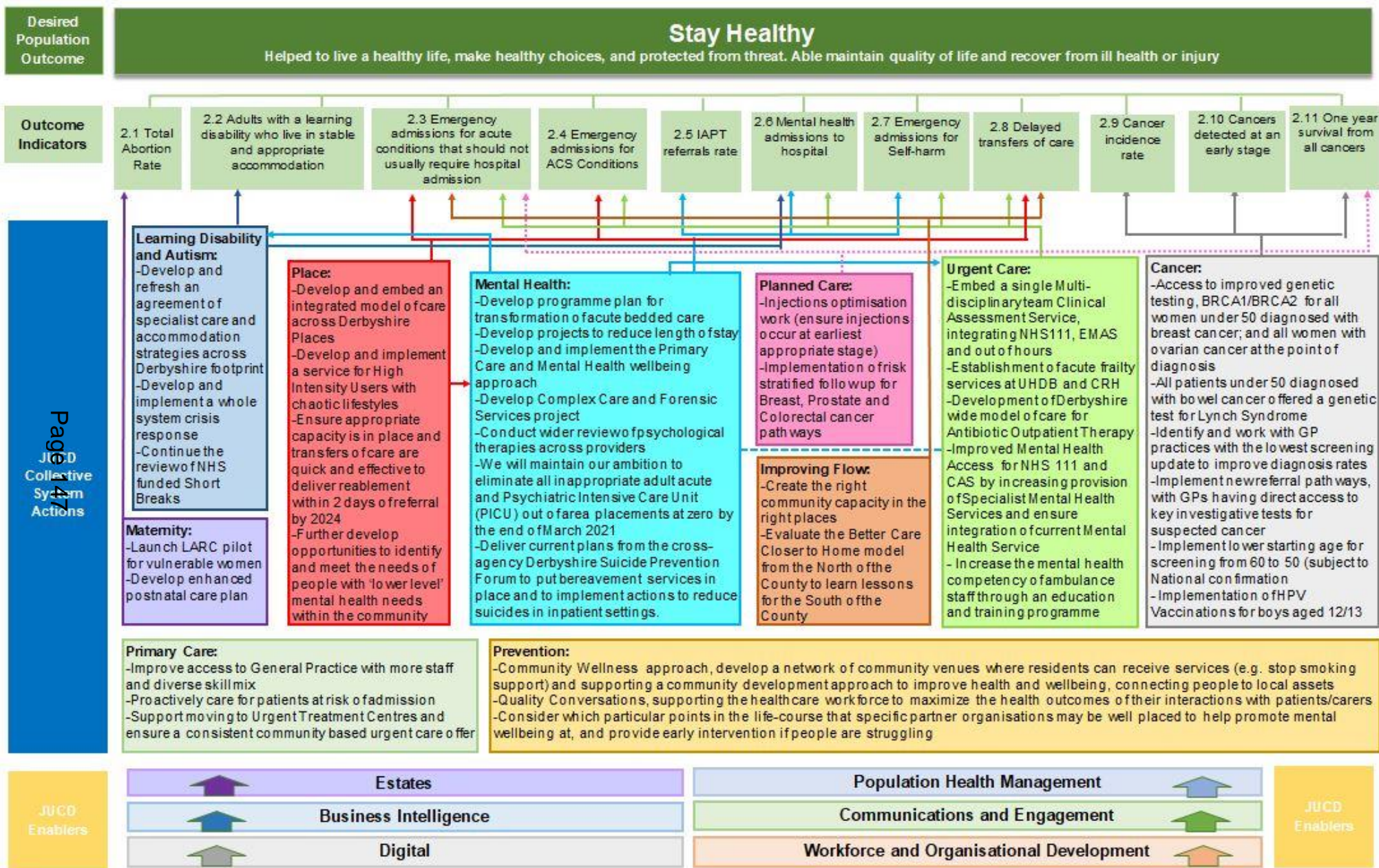


# Improving Population Outcomes: Outcomes Based Accountability – Best Start in Life



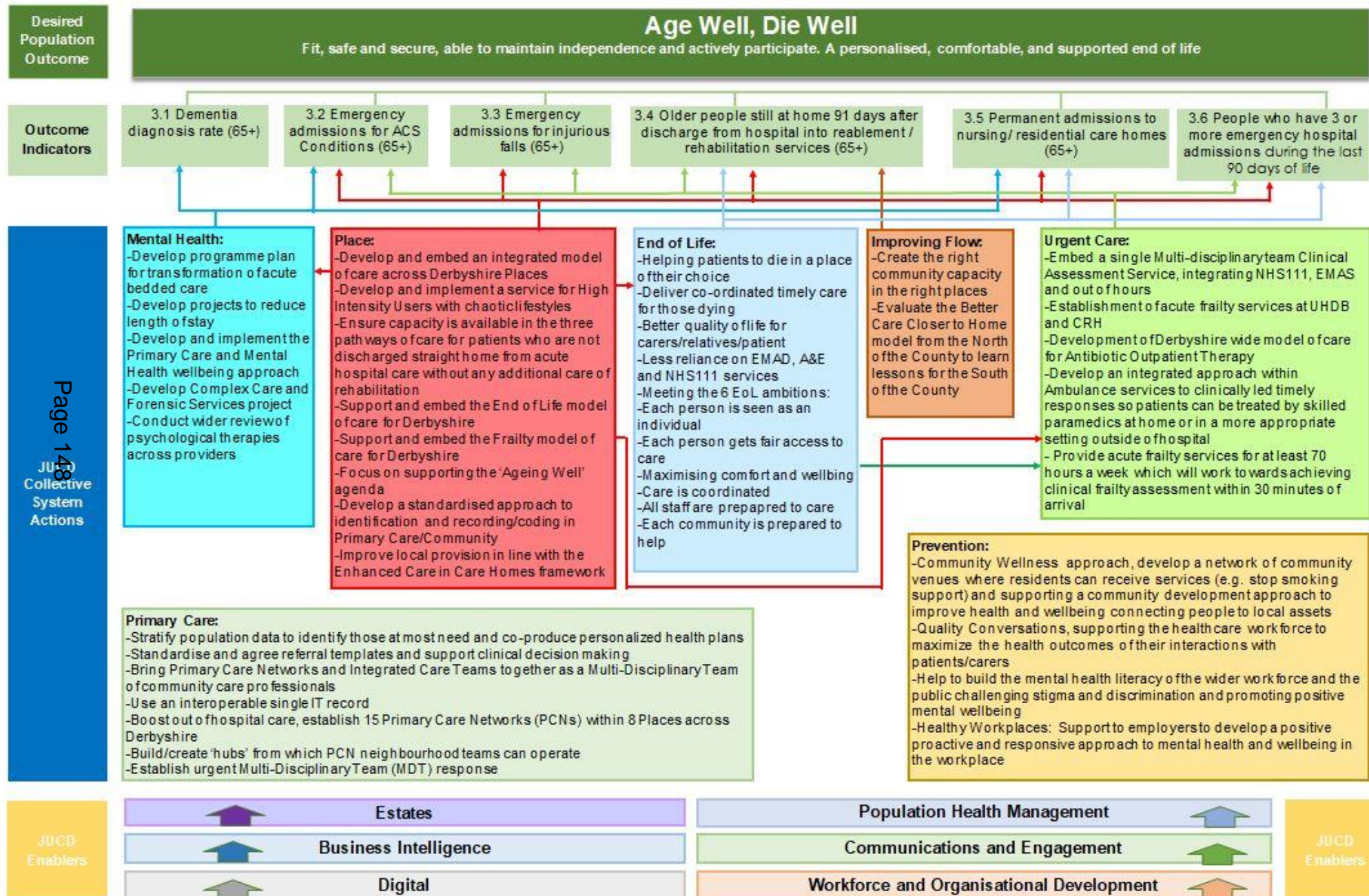


# Improving Population Outcomes: Outcomes Based Accountability – Stay Healthy





# Improving Population Outcomes: Outcomes Based Accountability - -- Age Well and Die Well



## Strategic Priority: System Efficiency

*We know our health system is inefficient in a number of ways, and therefore improved efficiency must be a key part of our plan...*

The financial gap if we do nothing across the Derbyshire healthcare system is forecast to be £332m by 2023/24. We know our health system is inefficient in a number of ways, and therefore system efficiency is embedded throughout our plan and can be evidenced in the specific sections, for example we will:

- Streamline care pathways to reduce duplication and hand-offs; with aligned clinical governance processes
- Align and optimise 'back-office' services (HR, PMO, Business Intelligence) to enable a coordinated approach and single version of the truth
- Optimise integrated care provision including the alignment of clinical support services with a specific focus on diagnostics
- Further optimise the use of medicines: Cost effective choices, reducing waste and harms, transfer of care, disease prevention and symptom control, systems efficiency and procurement. Further information in relation to our overarching approach to Pharmacy & Medicines Optimisation can be found at Appendix 3.
- Streamline organisational governance process and shared decision making
- Develop our place based/PCN networks to improve anticipatory care
- Reduce reliance on agency/locum staffing
- Reduce in waste across the system to which will improve our carbon footprint
- Rationalise and optimise estate
- Make better use of digital technology

Furthermore as a system we have agreed to develop our approaches to improve ways of working to ensure we are more sustainable and affordable, including:

- A commitment to improving operational ways of working, underpinned by the People Plan
- Aligned organisational HR process which will include 'staff passports' to facilitate moving between jobs more easily
- Developing a single system PMO function
- Streamlined organisational contracting, performance management and planning to enable a single system approach

As well as being demonstrated throughout our plan the table below identifies key efficiency opportunities.

Efficiency Initiatives	Supporting Deliverables
Care Pathways	<ul style="list-style-type: none"> <li>• Integrated Care across County and interface with Urgent Care Clinical Pathways including ambulatory care</li> <li>• Same Day Emergency Care</li> <li>• Theatre efficiencies</li> <li>• Efficiency and cost reduction through digitalisation and modernisation of outpatient appointments</li> <li>• Reduction in Length of Stay for Occupied Bed Days</li> </ul>
Optimised use of clinical workforce	<ul style="list-style-type: none"> <li>• Workforce &amp; team efficiency</li> <li>• Align to demand (rotas, job plans)</li> <li>• Skill mix / working to top of license</li> <li>• Sickness levels and turnover</li> </ul>
Estates and facilities management	<ul style="list-style-type: none"> <li>• Community hospital/facility rationalisation</li> <li>• Acute hospital (incl. PFI) optimisation</li> <li>• Technology to support agile working</li> </ul>
Agency Costs	<ul style="list-style-type: none"> <li>• Better control of staffing through e-rostering systems</li> <li>• Improved workforce planning to ensure substantive staff are recruited and trained</li> <li>• Cost control through agency caps</li> </ul>
Digital Technology	<ul style="list-style-type: none"> <li>• Reduction in wasteful duplication by integrating clinical systems and making clinical time more effective</li> </ul>
Reduction in local health inequalities and unwarranted variation	<ul style="list-style-type: none"> <li>• Applying Rightcare data to make improvements including MSK, Respiratory and CVD pathways</li> <li>• Improved cancer wellbeing with Derby County Community Trust working on the 'Wellbeing for All' project targeting seldom heard groups</li> <li>• Moving towards greater place based care</li> </ul>



Strategic Priority: System Development

We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance...

Why is this a priority for Derbyshire?

Many of the initiatives within the NHS LTP are not new to Derbyshire as we have been working on these since developing our last STP plan. However, so far they have not yet been fully implemented to deliver the necessary transformational impact – in either care quality or financial improvement terms. And, we believe that this is significantly due to our existing system infrastructure, which drive competing organisational priorities and an inability to divert funding and investment from historical patterns of provision that do not meet the changing needs of the population.

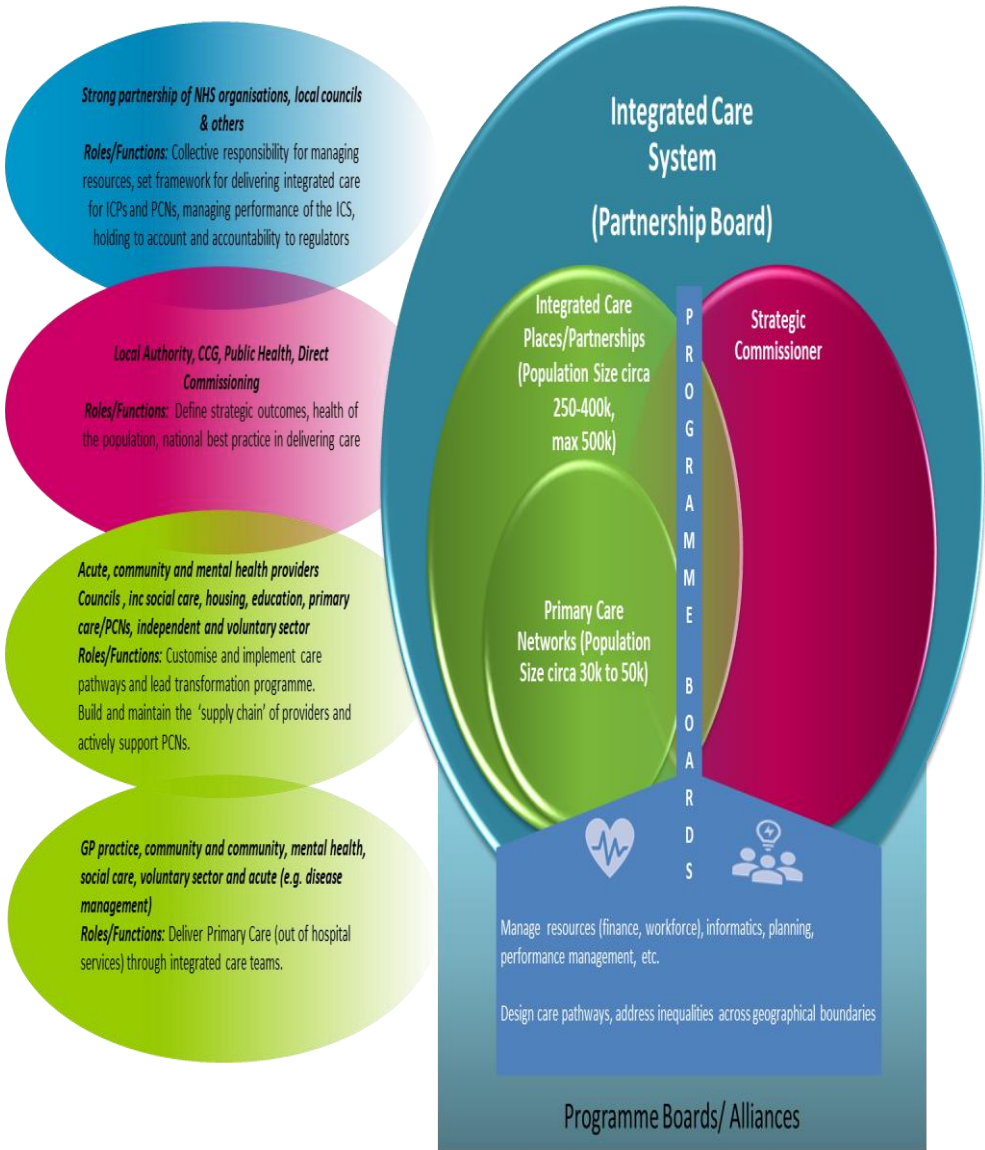
So, we need to ensure that this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and patient-centred perspectives.

Transforming how we work together across organisations to manage the system is therefore a priority for our STP. We must make system-level working the default option - ‘business as usual’ - as an approach for managing all of the care we commission and provide. We will do this by developing as an Integrated Care System by April 2021.

The NHS LTP provides us with the catalyst required for this system change to create a strong underpinning infrastructure which supports transformation and improvements for our population without the historic barriers we have faced.

To facilitate our transition towards an ICS, we have agreed the Derbyshire ICS framework and constituent job cards.

Integrated Care System (ICS): Job Cards



## Strategic Priority: System Development

*We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance...*

### Our Approach

Place based care will remain at the heart of our approach to meet the local needs of individuals; developing our Neighbourhoods through Primary Care Networks (PCNs) within our Integrated Care Partnerships (ICPs) and the wider Integrated Care System (ICS).

### Our ICS Development Plan: Headlines

- We have successfully completed the ICS Development Programme and Commissioning Capability Programme
- General Practice leadership are increasingly engaged in system decision making
- Our ICP configuration is being progressed through the ICP Development Group, and is described further on the following page
- We have launched a System OD programme, including transformation workstreams, Executives, and NEDs/Lay members events

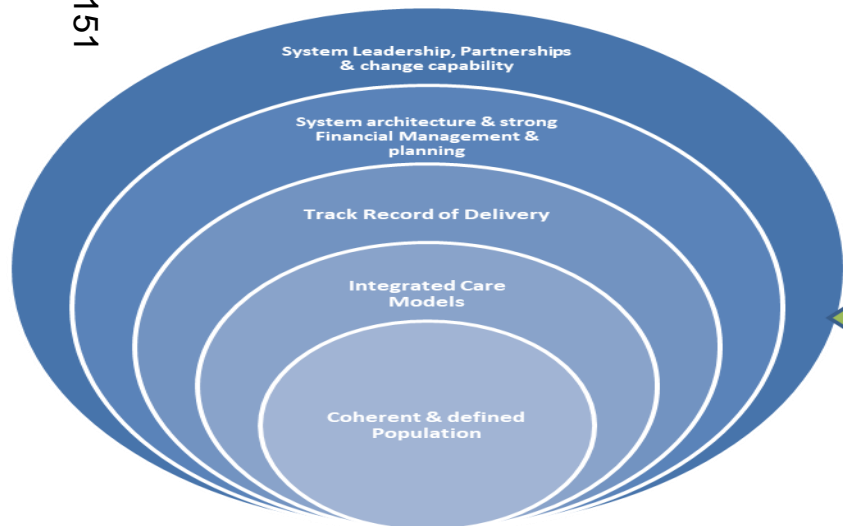
- We have strengthened our governance which now includes a finance sub-committee, Quality and Performance Group and Chairs group
- We intend to be operating as a shadow ICS from 1 April 2020

Furthermore, we have identified the following key milestones in the next quarter:

- Agree our system clinical strategy (December 2019 STP Board)
- Continue to build resilience and services provided at Place level
- Approve STP OD strategy and roll out system wide OD programme to help partners increasingly work in the system space (November 2019 LWAB/STP Board)
- Develop a single system financial savings plan for 2020/21
- Review of STP Board governance and ways of working
- Streamlining of ways of working: HR processes, procurement

Our aim is to be an Integrated Care System which is built around care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

### Characteristics of an Integrated Care System



### Key Deliverables to enable Derbyshire to become an ICS

#### Transformation Workstreams

- Planned Care
- Improving Flow
- Urgent & Emergency Care
- Place/ Primary Care Networks
- Children & Young People
- Maternity
- Mental Health
- Learning Disabilities & Autism
- Cancer
- End of Life
- Disease Management

#### Enablers

- Prevention & Population Health Management
- Workforce
- Digital
- Communications & Engagement
- Estates
- Finance

### Enabling development programmes

- ICS Development Programme ✓
- Commissioning Capability Programme ✓
- Population Health Management Programme
- System wide OD Programme

### Enabling work

- System Savings Approach ✓
- Outcomes Based Accountability ✓
- Business Intelligence/PHM
- Development of Place Alliances and Primary Care Networks ✓
- Derbyshire Clinical Care Strategy
- Shared finance plan and risk share agreement ✓
- Integrated Care Partnership development
- Profiling system wide demand, capacity and workforce

## Strategic Priority: System Development

*We will come together to manage the Derbyshire system through an Integrated Care System (ICS), develop Integrated Care Providers (ICPs) and our Strategic Commissioning function through aligned leadership and governance...*

We will develop our partnership to become an ICS by April 2021 which is central to the delivery of the LTP; our future arrangements will include the following components.

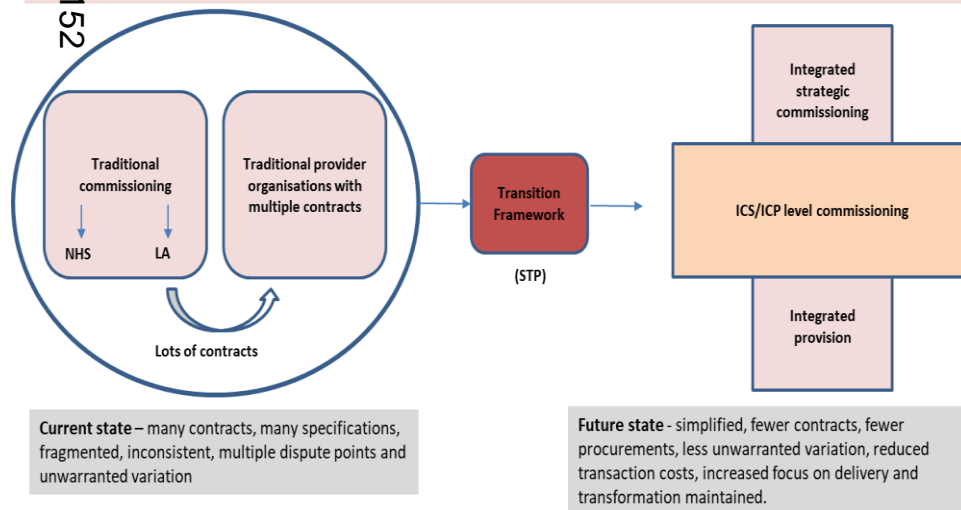
### Streamlined Strategic Commissioning

- We have already streamlined our commissioning arrangements with the merger of four Clinical Commissioning Groups (CCG) into one. Derby and Derbyshire CCG formally came into existence on 1 April 2019. These arrangements enable a single set of commissioning decisions at system level.
- Commissioners will make shared decisions with providers on how to use resources, design services and improve population health. We will increasingly move towards an integrated commissioning budget across health and social care to jointly commission at place and make strategic commissioning decisions in the deployment of that budget.
- We will further develop our joint commissioning arrangements with Local Authorities.

### Strategic commissioning architecture in Derbyshire

#### How strategic commissioning will look for Derbyshire

Strategic commissioning will be a departure from the current state for both the NHS and LA. There will no longer be a focus on **detailed contract specification, negotiation and monitoring** or the **routine use of tendering**. Rather, the emphasis will shift to **defining and measuring outcomes, putting in place capitated budgets, assigning appropriate incentives for providers and using longer term contracts** extending over five to ten year timelines.



### Streamlined Provision: Integrated Care Providers (ICPs)

Providers will increasingly move to integrate provision and delivery in order to deliver the outcomes for the population of Derbyshire at both footprint and Place/PCN levels within allocated resources – known as Integrated Care Partnerships (ICPs). All PCNs will be integral to ICPs; which will be designed to deliver localised place based care.

Our ICPs will provide a fundamental shift in the way care provision is designed and organised with all partners playing an equal role. This inclusive approach will not only drive our approach to longer term care redesign but has also provided the basis by which we have agreed our ICP configuration.

Through this inclusive approach, we agreed the case for change and confirmed 4 geographical ICPs for Derbyshire; these are:

- Chesterfield, North East Derbyshire and Bolsover
- Derby City
- South Derbyshire, Amber Valley and Erewash
- Derbyshire Dales and High Peak

Key factors which influenced this decision are:

- Local Authority boundaries taking primacy, to enable a focus on population health, prevention and relevance to local people and communities to maintain localism
- The value of existing Place Alliances remaining important both in terms of progress and development and alignment with council boundaries
- Cognisance of cross boundary working which will need to be managed; some PCNs are already working in this way across Place boundaries and it is being managed, the ICP role will be to ensure this continues. It is recognised that the South Derbyshire in particular would require mitigations and close monitoring as the ICPs evolve

During quarter 4 of 2019/20 we will develop the ICP Operating Model ready for shadow running from 1 April 2020. This approach is underway and will build upon the key things we want our ICPs to address/deliver for our population:

- Understand our population and their health and social care needs (link to Population Health Management)
- Use place alliance intelligence
- Focus on care models not clinical pathways in isolation
- Recognise that there needs to be a service redesign
- Shared workforce, planning and assets
- Need to consider what is done at different levels within/across the system
- Don't lose gains developed over the years
- Need staff and public engagement
- Engage professional and clinical leadership
- Develop the Place/ PCN and ICP interface

We will continue to engage with partners including primary care in developing our approach. We also recognise the importance of District and Borough Council involvement in this development and the approach is being aligned to ensure factors which may impact from that perspective are also reflected in our developments.

## Delivering further progress on fully integrated Place Based Care

*As described in our strategic priorities, we will deliver transformed out of hospital care; through place based care, underpinned by our model of care with a focus on supporting the national 'Ageing Well' programme...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Urgent Community Response - Assess and improve capacity and quality of key community crisis response and reablement services, developing our integrated community rapid response provision to support the 2 hour response standards where clinically appropriate by 2024					✓
Ensure appropriate capacity is in place and transfers of care are timely and effective in order to implement the urgent community response standards for reablement within 2 days of referral by 2024					✓
Progress towards the ambition of an integrated service model available 24/7 as appropriate					✓
Co-design our urgent community response with all of our stakeholders. The aim being to develop a set of standards, outcomes and a governance framework which will allow our system to commission a community urgent care response from Primary Care Networks in a way that allows local delivery to an STP framework, with a target to implement across Derbyshire by April 2021.	✓	✓			
Work with PCNs to develop multi-disciplinary, cross sector teams of community care professionals and review options for greater integration within the emerging ICP structure		✓			
Consistent proactive identification and management of people at risk of unwarranted health outcomes through risk stratification, assessment and care planning in line with the anticipatory care element of 'Ageing Well'	✓	✓			
Improve local provision in line with the Enhanced Care in Care Homes framework and publication of a maturity matrix for full delivery of the EHCH model as part of the national Ageing Well Programme		✓			
Expression of Interest submission to the Community Health and the Ageing Well programme Urgent Community Response Accelerator Site Proposal for 2020/21. Key elements include: A single number within the system for patients and professionals to access a same day response, a GP led clinical assessment/triage, locally based integrated rapid response teams that, where clinically appropriate, will provide care in people's homes.	✓	✓			
Implement and review targeted case management approach to the most severe 'high intensity users'. Expand if successful	✓	✓			
Ensure community assets are understood and widen the support available for social prescribing link workers to access in each Place.					
Utilise Population Health Management embedding the personalised care model as an enabler to improve outcomes through segmentation approaches to understand the use of, and demand for services across the health and care system to inform planning and prioritisation / development of provision for out of hospital care.	✓	✓			
Further develop opportunities to identify and meet the needs of people with 'lower level' mental health needs within the community			✓		
Maximise the benefits of access to the single health care record by integrated community teams and ambulance staff				✓	
Consider the opportunities, and maximise the benefits, of digitally enabled care in the community promoting early adoption		✓			
Contribute to continued reductions in the number / proportion of delayed transfers of care to achieve Derbyshire share of the national target through ensuring appropriate range and capacity of provision to support people leaving hospital	✓	✓			
Leaders will feel equipped to deliver in a collaborative and transformative way agnostic of organisation, with a focus on people and communities	✓	✓			
Ensure continuation of the well-developed wider partnership role in place based working that has been built in Derbyshire to ensure we draw on the widest range of community assets in developing and delivering improvements in care and outcomes adopting the Ageing Well best practice tools and supporting service guidance for urgent community response, reablement care and community multidisciplinary teams	✓	✓			
Support and manage Places in the transition to a new governance structure in the emerging system architecture, ensuring that the structures and frameworks of ICS/ICP enable true integration of planning and delivery of local services.	✓	✓			
Identify where increased resource in community could deliver impact on system; costs, outcomes and experience and agree mechanisms to plan and manage that shift, incentivising preventative and proactive care.	✓	✓			

## Reducing pressure on emergency hospital services

*Delivering our vision for urgent & emergency care through the combined deliverables below will improve care and create a more coordinated response for our citizens...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
<ul style="list-style-type: none"> <li>A Clinical Assessment Service (CAS), accessible via 111 for Derbyshire is in place with people able to speak directly to a clinician; supporting navigation to the optimal service 'channel' so that only those with more serious or life threatening physical or mental health needs present at A&amp;E with the majority of people accessing suitable alternatives within the community and self-care options.</li> <li>The CAS clinician will seek to complete the call there and then without the need to transfer the patient elsewhere, ensuring 50% plus of calls receive a clinical assessment of this nature and more than 40% of appointments booked direct (extension of Direct booking in GP in-hours primary care and extended access).</li> <li>Where face to face contact is deemed necessary the CAS will advise on the most appropriate services including UCTCs, GP both in and out of hours, community care, pharmacy, emergency dental and will directly book more than 40% of those requiring urgent appointments in services alternative to A&amp;E. NHS111/CAS will also be able to directly book into the acute SDEC assessment function where appropriate.</li> <li>By 2023, our CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care. This will include all adults, children and young people experiencing mental health crisis, with access to mental health triage and crisis care available 24 hours a day, seven days a week by calling 111.</li> </ul>	✓	✓	✓	✓	
<ul style="list-style-type: none"> <li>A 24/7 Clinical Assessment, Advice and Treatment Hub (including dental, pharmacy, paramedics) that supports 111, 999 and out-of-hours calls from the public and all healthcare professionals will be in place; including support for people with known and/or long-term conditions or additional vulnerabilities (such as learning disability and mental health) will be offered enhanced planning and support to avoid acute presentations.</li> <li>Increasing capacity to deliver hear and treat and increase see and treat services with the support of the clinical advice hub.</li> </ul>					✓
<ul style="list-style-type: none"> <li>Delivering the optimal level of on day urgent primary care appointments and home visits to patients (at local/PCN level) to meet the anticipated demand, including the provision of extended access at weekends and evenings.</li> <li>Strengthen our Primary and Community offer so that a broader range of integrated services (GP Access Hubs/UCTCs, mental health crisis clinics etc.) are all in one location for patients within their communities, supporting both physical and mental health urgent needs by when.</li> <li>All Derbyshire localities will have a consistent offer for out-of-hospital same day urgent care.</li> </ul> <p><b>NB this deliverable is linked to developments in place based care</b></p>					✓
<ul style="list-style-type: none"> <li>Delayed Transfers Of Care (DTOC) are further reduced, in partnership with local authorities by: <ul style="list-style-type: none"> <li>Reducing hospital care and resourcing integrated community services capacity within each Place, to meet demand closer to home and support patients to be discharged to a new long term place of care with minimal transfers; improving patient and carer experience, and increasing capacity and flow out of acute hospital settings. The focus will be on the south of the county, building on the Better Care Closer to Home transformation in the north.</li> <li>Mapping resources and capacity across community and intermediate care to better identify and access capacity as part of the Improving Flow work to therefore effectively utilise services better in the community by March 2020</li> </ul> </li> </ul>	✓				
<ul style="list-style-type: none"> <li>We will further develop a comprehensive model of Same Day Emergency Care (SDEC) for medical and surgical pathways, in both our acute hospitals so that there is 100% provision of SDEC services least 12 hours a day, 7 days a week and work towards agreed trajectories for the percentage of non-elective activity treated as SDEC which is subject to technical guidance being released.</li> <li>This will ensure effective flow through the system from acute bedded facilities and integrated discharge pathways into the community. The SDEC model will provide people who access acute services with new diagnostic and treatment practices, allowing patients to spend just hours in hospital rather than being admitted to a ward; increasing the proportion of acute admissions discharged on the day of attendance from a fifth to a third so that there is a 40% reduction in the long length of stays compared to those our patients experienced in 2018, by March 2020.</li> <li>Complete the expansion and redesign of our Emergency Departments and acute front door services which will facilitate the delivery of comprehensive patient assessments and on-going quality urgent health care. This will include on-going development of a co-located Primary Care Streaming Service, improved frailty assessment, pharmacy and mental health, plus greater integration between the Emergency Department and wider emergency provision in the hospital, specifically ambulatory care services, Acute Frailty Service providing assessment within 30 minutes of arrival and Paediatrics.</li> <li>The redesign of our front door services will support us to ensure that patients who arrive at A&amp;E via ambulance have their care transferred from paramedics to A&amp;E staff within 15 minutes of arrival.</li> <li>This comprehensive model for medical and surgical pathways will relieve pressure elsewhere in our hospitals and free up beds for patients who need quick admission either for emergency care, or for a planned operation.</li> </ul>	✓	✓			
<ul style="list-style-type: none"> <li>Fully implementing Urgent Treatment Centres (UTC), operating to the national specification by autumn 2020 as part of our integrated community urgent care offer; designation based on comprehensive urgent care review.</li> </ul>	✓	✓			
<ul style="list-style-type: none"> <li>Efficient A&amp;E departments which are appropriately resourced and are fully meeting the emergency and urgent care standards arising from the national Clinical Standards Review</li> </ul>	✓				
<ul style="list-style-type: none"> <li>Introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls, and increase the mental health competency of ambulance staff through an education and training programme. As a result people with a mental health crisis, will be able to consistently access alternative services to A&amp;E, reducing the need for conveyance to A&amp;E.</li> </ul>					✓
<ul style="list-style-type: none"> <li>Introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&amp;E.</li> </ul>					✓



## Better Care for Major Health Conditions: Improving Cancer Outcomes

Working across multi-professional partners, we will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer & Beyond. We will work in partnership with the East Midlands Cancer Alliance to deliver the National Ten Year Cancer Plan; utilising the additional LTP investment to ensure trajectories for one year survivorship and Early Diagnosis at stages 1 and 2 are achieved...

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
HPV will be a primary screen in the cervical screening programme with the implementation of HPV screening as a more sensitive and reliable test for Cervical Cancer, HPV Vaccinations for girls (complete and in place) and for boys aged 12/13 (Sept 19)	✓				
We will improve bowel, breast and cervical screening uptake by working with GP practices with the lowest cancer screening uptake from national programmes to optimise the uptake of cancer screening programmes to increase the number of cancers diagnosed at an early stage so that 62% of cancers are diagnosed at Stages 1 and 2 by 2020, increasing to 75% by 2028; enabled by increase uptake so that by 2021 there will be 80% uptake of Breast and Cervical Screening and 75% Bowel Screening uptake. This will include continuation of a programme of support to GP practices, particularly within hard to reach communities, facilitated by CRUK and Public Health (City & County)	✓	✓			
Identify opportunities within screening and two week wait pathways to support staff to provide lifestyle advice so by March 2021 all staff are routinely providing lifestyle advice	✓	✓			
Gather data and develop population characteristics for Breast Cancer screening to develop information for professionals to engage key target groups so by March 2022 more tailored information will be in place to enable targeted interventions for key groups			✓		
Hard to reach communities, specifically BAME will have access to the 'Wellbeing for All' programme facilitated by Derbyshire Community Trust so that by March 2022 seldom heard communities will be encouraged to lead healthy lifestyles and early presentation to health services			✓		
We will work to improve GP referral practice and GP direct access to key investigative tests for suspected cancer					
Continue to develop and deliver GP cancer education / learning programmes with dedicated sessions across the footprint	✓	✓	✓	✓	✓
Work with the Digital Workstream to support the implementation of two week wait forms in the GP Referral Support System in Primary Care	✓				
We will roll out implementation of Faecal Immuno-chemical Testing (FIT) testing for symptomatic and non-symptomatic populations in line with national policy so patients have access to non-invasive, hygienic test, with only one sample required. Starting with all patients with bowel cancer symptoms and (complete and in place) extended to Bowel Cancer Screening	✓				
Implement lower starting age for screening from 60 to 50 and increase sensitivity level (Timescales subject to national confirmation)					
We will implement optimal and best practice pathways to facilitate early diagnosis and better outcomes, with patients surviving longer after diagnosis by implementing pathways to enable faster investigation, diagnosis and treatment.	✓	✓			
Direct access MRI Brain Pathway	✓				
Implementation of RAPID Prostate Pathway; implemented at UHDB (Derby) and work has commenced to implement consistently in Burton; straight to Test at CRH implemented	✓	✓			
National Optimal Lung Pathway: Year 1 of two year programme completed. Work progressing to deliver Year 2, embedding efficient and effective lung cancer pathway	✓				
Upper GI Pathway: Pathways to be reviewed and refined		✓			
Direct access to Vague Symptoms Pathway, supporting regional development. Programmes in place; to be clinically evaluated (Sept/ Oct 19)	✓				
Improve access to Genetic Testing (BRCA1/BRCA2) for all women diagnosed with breast cancer who meet the Mainstreaming Criteria and all women with ovarian cancer. Work through ECAG (Expert Clinical Advisory Group) to establish protocol and commission services so that By April 2020 any familial risk of cancer in this group of patients will be identified through this improved Genetic Testing		✓			
Work with Cancer Alliances to provide Lynch Syndrome testing for all patients under 50 diagnosed with bowel cancer		✓			
We will work with the EMCA so that by 2020 one RDC will be implemented in each Cancer Alliance with further rollout by 2023/24. Development of clinical and delivery models for Rapid Diagnostic Centres (RDC); pilot sites will be agreed within the EMCA region to deliver national implementation plans across the footprint, together with any additional cohorts based on local need, capability and capacity; Pilot sites within the East Midlands Cancer Alliance region to be agreed, with at least one RDC to start accepting patients by January 2020 and National evaluation of pilot sites to support further rollout thereafter	✓	✓	✓	✓	✓
We will improve access to high quality treatments, including through rollout of Radiotherapy Networks, strengthening of Children and Young People's Cancer Networks, and reform of Multi Disciplinary Team meetings. Continue to work with Specialised Commissioning to ensure patients have access to high quality personalised treatment/therapies for radiotherapy, chemotherapy and immunotherapy.	✓	✓	✓	✓	✓
Support develop and effective functioning of EMCA Radiotherapy networks	✓	✓	✓	✓	✓
We will implement the National Specification for Early Diagnosis from the GP Contract Reform in line with NICE guidance, for children, young people and adults at risk of cancer by working with Primary Care Networks (PCNs) to review and implement DES and seek a cancer champion in each PCN group to encourage and support implementation at a local level.	✓	✓			
We will deliver the updated Service Specification for children and young people's cancer services subject to national specification timescales					
We will work through the Cancer Workforce Action Group, facilitated by the EMCA to address unwarranted variation, improve patient experience which is supported by an appropriate workforce and will support implementation of National Cancer Workforce Plan and changes as they evolve.	✓	✓	✓	✓	✓

## Better Care for Major Health Conditions: Improving Cancer Outcomes

Working across multi-professional partners, we will deliver the foundational commitment in relation to Cancer across the system, by continuing to prioritise improvements across the footprint (including East Staffordshire) through Prevention, Early Diagnosis & Treatment and Living With Cancer & Beyond. We will work in partnership with the East Midlands Cancer Alliance to deliver the National Ten Year Cancer Plan; utilising the additional LTP investment to ensure trajectories for one year survivorship and Early Diagnosis at stages 1 and 2 are achieved...

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Maintain, deliver and improve the position against National Cancer Patient Experience Survey and develop ongoing programmes to incorporate focus groups, questionnaires and engagement events; to demonstrate a year on year improvement (national average currently 8.8).					
Build on stakeholder events such as focus groups, patient involvement events and react to national and local surveys. There are currently four Health & Wellbeing events planned which will involve patients, carers, clinical stakeholders and third party providers (by Dec 19). Feedback obtained from these events will inform where gaps exist, with focus groups implemented to progress work to fill these gaps. Active Recovery and 'Wellbeing for All' programmes will also support improvements in patient experience and satisfaction.	✓	✓	✓	✓	✓
Ensure all those diagnosed with cancer have the opportunity to undertake a Holistic Needs Assessment (HNA) and Care Plan throughout their diagnosis, treatment and follow up; with 75% of all new cases being offered a HNA.		✓			
Ensure all patients are given the opportunity to join a Physical Activity Programme facilitated by Community Trusts; all patients provided with information on this service. Work towards developing a service for the north of the county		✓			
Ensure all cancer patients are offered access to health and wellbeing support appropriate to their needs at the time. Events publicised through the hospital and primary care. Four events to be held throughout the year (2 Burton/2 Derby) with programme expanded across the footprint	✓	✓			
Develop and implement a pathway to ensure all patients receive a Treatment and End of Treatment (EoT) Summary (EoT only at CRH)		✓			
GP practices to undertake Cancer Care Reviews for all patients within six months of a Cancer Diagnosis. Improved support for patients in the community through joined up care between secondary and primary care	✓				
Improve engagement with Carers and develop plans for ongoing support so that by September 2020 focus groups for carers of children, young people and adults with cancer to support further development	✓	✓			
Undertake Bowel Health Equity Audit; identify recommendations and implement action plan so that by March 2022 actions have been fully implemented	✓	✓	✓		
Ensure patients have access to enhanced supportive care with links to End of Life (subject to links with newly established EoL workstream)					✓
We commit to delivery of the cancer performance standards including 14, 31 and 62 day standards and, from 2020/21, compliance with the 28 day Faster Diagnosis Standard. Ongoing - To achieve required national targets of 93% (2ww), 96% (31 day), 85% (62 day target - recovery action plan in place).	✓	✓	✓	✓	
Ensure actions are taken to meet current constitutional targets for Cancer Waiting Times (CWT) and implement any revised CWT targets in 2020/21.	✓	✓			
Implement recording of the 28 day Faster Diagnosis Standard with shadow monitoring of data in 2019/20 and full implementation from 2020/21.	✓	✓			
Work with stakeholders to produce a Derbyshire-wide report looking at predictive modelling for cancer referrals for next 5-10 years, in order to support commissioning of activity and workforce development	✓				
We will ensure that from April 2020 two thirds of patients who finish treatment for breast cancer will be on a supported self-management follow-up pathway. Also, all trusts will have in place protocols for personalising/stratifying the follow-up of prostate and colorectal patients and systems for remote monitoring for patients on supported self-management. Develop and implement personalised follow-up pathways of care for people with cancer so that by April 2020, 75% Breast patients will be on a personalised self-management follow-up pathway tailored to their needs and by April 2021 Prostate and Colorectal patients will be on a personalised self-management follow-up pathway tailored to their needs. By April 2024, all those diagnosed with cancer will be on a personalised self management follow-up pathway tailored to their needs		✓	✓	✓	
Implementation of Supported Self-Management with Remote Monitoring across remaining tumour sites starting with Breast and Urology and all remaining tumour sites implemented by 2021/22		✓			
New Quality of Life (QoL) Metric in use locally for all Providers to submit QoL data from April 2020		✓			
Working with the EMCA to deliver the National programme (national guidance is awaited) to ensure Genome Sequencing will be offered to all children diagnosed with cancer from April 2020		✓	✓	✓	
By 2023 the first phase of the Targeted Lung Health Checks Programme will be completed, with plan for wider rollout (depending on evaluation)					✓
EMCA will implement one of the ten projects involved in the first phase of delivering targeted lung health checks. Extended lung health check model in place (subject to EMCA plans). Interim evaluation of first phase of projects, Implementation plan/approach for further rollout 22/23 and final evaluation of first phase 23/24			✓	✓	✓
Fully Integrated Cancer Care supported by our Integrated Care Partnerships will be delivered across the system					✓

## Better Care for Major Health Conditions: Improving Mental Health Services

*Delivery of our plan will be supported by our continued commitment to the Mental Health Investment Standard (MHIS); Information in relation to how this will be allocated can be found at Appendix 4. We will deliver the foundational commitment in relation to Mental Health across the system; achieving access standards as defined nationally. We will continue development of the Derbyshire Mental Health Alliance to include all statutory and voluntary sector providers and commissioners of mental health services across health and care will participate in the emerging regional collaborative around Forensic, CAMHS, Eating Disorder services and future waves, to include Perinatal and Learning Disabilities services...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
<b>Perinatal Mental Health:</b> Derbyshire will be lead provider across the region for Tier 4 services once phase 2 of NCMs opens. We will increase access to specialist community perinatal mental health services with performance meeting 5% target of birth rate coverage and Psychological therapy input into the team by the end of 2019/20. Community Perinatal coverage already across the County and performance close to national ambition. Maternity Outreach Clinics will be in place following national testing sites with the care period extended from 12 months to 24 months by the end of 2023/24.	✓				✓
<b>Adult SMI Community Care:</b> We will bolster adult Severe Mental Illnesses (SMI) integrated models of primary and community mental health care with investment in specialist Personality Disorder (PD) support teams in place in Community Mental Health Teams (CMHTs) from 2019/20 onwards. We will link closely with Lincolnshire and other pilot sites to be ready to start implementation of the new models from April 2021 and fully established by the end of 23/24.  We will maintain national performance standards and sustain fidelity of the model for the Early Intervention Psychosis (EIP) service and Individual Placement and Support (IPS). An IPS wave 2 service is being established in line with national model in 19/20. Pilots in digital contacts testing model will take place in 2019/20, enabling EIP Level 3 compliance, with roll out of digital contacts subject to evaluation by 2020/21.	✓	✓			✓
<b>Mental Health Primary Care and Physical Healthcare:</b> IAPT services continuing to meet all national targets, with IAPT therapists into integrated PCN teams, Long Term Conditions (LTC) service in place and IAPT accessed by more older people and people in care homes. National access ambitions met in full by end of 23/24. SMI Physical Health checks at 60% from April 20/21 onwards. Wellbeing approaches (Tower Hamlets and GM models) prototyped in two PCN areas 2019/20 and rolled out across the County in 2020/21, engaging fully with communities and the voluntary sector. This will provide individualised opportunities for people to live full and well lives in their communities without recourse to statutory services. Link CMHT staff with GP practices to provide advice and guidance. Close relationship and interaction between this work and the work to implement new models of Adult SMI Community Care.	✓	✓			✓
<b>OPMH, Dementia and Delirium:</b> Integrated Care Homes training package in place, including Frailty, EoL and OPMH. Training package in place across all providers by 2020/21 to support care staff in identification of delirium and dementia.  Consistent and equitable crisis response services (Dementia Rapid Response Teams and Functional Rapid Response Teams) for Older People using CRHTT Transformational monies in 19/20 and 20/21 (see below). Implementation of Day Services changes to deliver single countywide model across the County in 2019/20. Furthermore, we will agree system wide Derbyshire Well Pathway for Dementia as a whole systems approach to Frailty, OPMH and End of Life and sustain transformation of MAS service and continue to meet diagnosis targets.	✓	✓			
<b>Mental Health Urgent Care:</b> By March 2021 we will have eliminated the placement of Derbyshire patients in out of county adults acute mental health beds. There is currently no PICU facility within the Derbyshire footprint, as such we will continue to need to utilise 1,825 occupied bed days (approximately 5 patients at any one time) out of the county until a local facility can be developed as part of the medium to longer term approach. The DHcFT Estates strategy due for sign off in December, will propose the development of a PICU as part of a redesigned acute inpatient facility to eliminate dormitories. Due to the small number of patients any unit will be considered as part of the wider improvements to ensure viability. There is system agreement to ensure inclusion of the Derbyshire Healthcare plans in to the next refresh of the Derbyshire STP Local Estates Strategy.  Crisis Teams across the county in fidelity with the model across all age groups and alternatives to A&E attendances in place, with 1 alternative to A&E in 2019/20 increasing to two by 2020/21. 100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams (CRHTTs) operating in line with best practice by 2020/21 and maintaining coverage to 2023/24. These will be accessed via a single point of entry for crisis response via 111 by 2023 and supported by Core 24 Mental Health Liaison Services at CRH and DRH sites and PD specialist resource in place in CMHTs from 2019/20. For people with Personality Disorder, only those with exceptional circumstances will require admission to hospital settings.  We will also develop innovative digital alternatives to physical observations (Oxehealth) across all seclusion rooms.	✓	✓			✓
<b>Suicide Reduction and Bereavement Support:</b> We will deliver current plans from the cross-agency Derbyshire Suicide Prevention Forum to put bereavement services in place and to implement actions to reduce suicides in inpatient settings. Trailblazer funding used to establish RTS service with Derbyshire Police and BPT resulting in bereavement support provided within 72 hours in 2019/20 with new services sustained and learning shared with NHSE/1 in 2020/21.	✓	✓			
<b>Problem Gambling and Rough Sleeping:</b> Should Derbyshire be identified as one of the 15 problem gambling sites or one of the 20 areas for increased rough sleeping provision, then the JUCD MH Programme will be ready to respond with proposals to address either or both areas, building on our existing links and strong relationships with the voluntary sector in both areas of work.					✓

## Better Care for Major Health Conditions: Shorter Waits for Planned Care

*Our Planned Care Programme of work is designed to enable significant transformation in end to end pathways so that we fundamentally modernise outpatient care (including through digital options) and ensure shorter waits for planned care when required. Through delivery of our Planned Care programme of work, we will ensure that no patient waits more than 52 weeks from referral to treatment and offer choice where patients reach a 26 week wait...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
<p>We will redesign and transform 'end to end' MSK clinical pathways to reduce variation, improve self-management and shared decision making, and reduce avoidable clinical interventions by:</p> <p>2019/20: Further developing our Clinical Assessment and Triage Services(CATS), maintaining First Contact Practitioner (FCP) Pilot, reviewing and enhancing adherence with clinical policies and optimising use of injections</p> <p>2020/21: Implementing 'end to end' MSK pathways by working with PCNs and review current physiotherapy to deliver FCP ambitions, aligned to CATS</p> <p>2021/22: Implementing a hub delivery model incorporating MSK Triage, Assessment and Treatment utilising FCP, CATs and Physiotherapy models to complement PCN and Place Based Care; including implementation and monitoring of injections policy within primary care</p> <p>2022/23: Monitoring effectiveness of the hub delivery model and refine / enhance with additional services to include podiatry, orthotics and paediatric MSK and incorporate International Consortium for Health Outcomes Measurement models for delivery within MSK pathways</p> <p>2023/24: Monitoring progress and developing the contracting model to support outcomes based pathways, further developing services for alignment with outcomes based pathways and monitor progress of hub model at PCN/Place to review and inform future delivery</p>		✓	✓	✓	✓
<p>Design and deliver sustainable solutions to close the gap in capacity vs demand for ophthalmology services by annually reviewing the plan to address the imbalance in capacity vs demand by 2025 and:</p> <p>2019/20: Completing a capacity and demand review and establish strategic and responsive plan to address the gap, reviewing and redesign ophthalmology pathways, launching a pilot for Minor Eye Conditions service, extending tele ophthalmology pilot (evaluating and establish sustainable service solution) and developing digital solutions to support virtual management of patients</p> <p>2020/21: Standardising and optimising pathways across the system, evaluating Minor Eye Conditions pilot and establish plan to sustain, implementing virtual appointments for agreed pathways and evaluating digital pilots and establish JUCD specification and strategy for digital solutions</p> <p>2021/22: Scale up and optimise use of virtual appointments, modernise workforce models in line with pathway redesign, work with optometrists and primary care to support 'left shift' of services and procedures, implement JUCD strategy to standardise and optimise digital solutions</p> <p>2022 – 2024 : Scale up and optimise use of virtual appointments, modernise workforce models in line with pathway redesign, work with optometrists and primary care to support 'left shift' of services and procedures, explore opportunities to further maximise effective utilisation of resources across the system</p>	✓	✓	✓	✓	✓
<p>Subject to confirmation of specific national metrics; we will modernise, digitally enable and redesign services to deliver the NHS Long Term Plan ambition of avoiding a third of face to face outpatient visits in a secondary care setting by 2025 by:</p> <p>2019/20: Review and redesign four 'end to end' clinical pathways, Pilot digital solutions to support modernisation and redesign of secondary care, Pilot NHS Attend Anywhere to support alternative virtual model for secondary care attendances, Design and implement a digital solution to support referral management in primary care, Develop and implement enhanced advice and guidance services, Scope opportunities to design new co-morbidity clinics</p> <p>2020/21: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan, Implement virtual appointments for agreed pathways, Implement risk stratified and patient initiated follow up for agreed pathways, evaluate digital pilots and establish JUCD specification and strategy for digital solutions, establish plan to develop co-morbidity clinics</p> <p>2021/22: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan ambition, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Implement JUCD strategy to standardise and optimise digital solutions, modernise workforce models in line with pathway redesign, pilot new co-morbidity clinics</p> <p>2022/23: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan ambition, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Modernise workforce models in line with pathway redesign, Work with primary care and place to support 'left shift' of services and procedures, Extend co-morbidity clinics</p> <p>2023/24: Agree and deliver annual plan to review and redesign 'end to end' clinical pathways, prioritised by opportunity to deliver long term plan, Scale up and optimise use of virtual appointments, Scale up and optimise use of risk stratified and patient initiated follow up pathways, Modernise workforce models in line with pathway redesign, Work with primary care and place to support 'left shift' of services and procedures, Scale up and optimise use of co-morbidity clinics</p>	✓	✓	✓	✓	✓
<p>Maximise effective and efficient use of theatre capacity across the system so as to deliver the NHS Long Term Plan ambition for improved patient access to Planned Care by:</p> <p>2019/20: Agree and enact Derbyshire Theatres Strategy, Optimise utilisation of theatre resources at each provider</p> <p>Deliver strategic shift of services from DCHS to UHDB, Agree strategy on fit for surgery and shared decision making, Review and agree strategic approach on national policy for faster treatment offer</p> <p>2020/21: Agree and deliver annual plan to scale up pooling of theatre resources across the system, Review and standardise pre operative assessment processes across the system, Implement national policy on faster treatment offer, develop and implement best practice principles across Derbyshire</p> <p>2021/22: Agree and deliver annual plan to scale up pooling of theatre resources across the system, Explore opportunities for redesign and modernisation of theatre workforce across the system, Optimise use of virtual pre assessment processes across the system</p> <p>2022 – 2024: Agree and deliver annual plan to optimise utilisation of theatre resources across the system, Work with primary care and place to support 'left shift' of services and procedures, Explore opportunities to further optimise theatre efficiency via digital or workforce solutions</p>	✓	✓	✓	✓	✓

## Delivering Further Progress on Care Quality and Outcomes: Maternity and Neonatal Services

The Derbyshire Local Maternity and Neonatal System (LMNS) is responding to the recommendations of Better Births (2016), the Planning Guidance key deliverables and the new LTP commitments 2020-2024. Work is delivered through 21 individual workstreams coordinated by a structure of groups which are held to account by Programme Board which reports into STP governance structures, with parallel alignment to commissioning quality governance...

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
<b>Safety and the 'Halve it' ambition:</b> A single SI process is now in place across the footprint and an established Maternity Quality Review group provides a forum for system wide learning and sharing. The implementation of PROMPT (PRactical Obstetric Multi Professional Training) enables those who work together to learn together and implementation of the Saving Babies Lives Care Bundle v1 is complete. Stillbirths at our two maternity providers have reduced to 2.5 per 1,000 births (2018/19), and neonatal deaths; however, SATOD figures remain static (14% Q2 19/20). We will implement the Saving Babies Lives Care Bundle v2 (March 2020), expand the offer of NHS maternal smoking cessation services (2019/20 )/implement an improved local smoking in pregnancy pathway and play a role in the development of Maternal Medicine Networks (fully operational by 2023/24) to maintain our commitment to a reduction in stillbirth, neonatal death, maternal death and brain injury during birth by 20% by the end of 2020/21, and a 50% reduction by 2025; a 50% reduction in serious neonatal brain injuries by 2025.	✓	✓			✓
<b>Neonates:</b> We will work with Operational Delivery Networks to implement fully the recommendations of the Neonatal Critical Care Review in 2019/20, including delivery of the ATAIN programme to reduce avoidable admissions of term babies to neonatal unit to no more than 5% by 2019/20 (current performance 3%).	✓				
<b>Community Hubs and SPoA:</b> We have begun by scoping 'virtual' community hubs which foster closer working between staff groups in a particular locality and supporting our emerging Continuity of Carer teams, to set the foundation for a physical community hubs network offering a 'one stop shop' facility. Our aim is that services are coordinated by a single point of access and initially we will investigate how women may self refer for midwifery care and how contact with their midwife during pregnancy can be streamlined. We will develop the model based on the availability of digital infrastructure, estate (including our role in the CBE initiative) and the feasibility to coordinate care across our LMS and our borders, so that 50% of care is coordinated through a hubs and SPoA network by 2020/21.	✓	✓	✓		
<b>Choice and Personalised Care Plans (PCP):</b> All women can currently make choices about their maternity care, during pregnancy, birth and postnatally and utilise a variety of providers (ahead of national milestone for 100% of women by 2021), with the Mother Hub Derbyshire website providing trusted, unbiased information on the choices available since April 2019. We aim to empower women to take control of their birth choices and encourage more women to give birth in midwifery settings (at home and in midwifery units); 19% by 2020/21 increasing to 20% in 2021/22. At Q1 2019/20, 14% of women had been issued with a paper-based personalised maternity care plan (PCP), the design of which has been coproduced by service users. We will further develop the PCP in response to feedback from women and midwives and ensure that 100% are offered one by 2020. We will also consider how to digitise the PCP, alongside the development of ePHR (see below).		✓	✓		
<b>Continuity of Carer (CofC):</b> At March 2019, Derbyshire reported 14% women booked onto a CofC pathway, which is set to increase to 17% in March 2020. We have calculated a 5yr trajectory for expanding the offer of CofC to ensure more women can benefit, although we recognise our ambition falls outside of national milestones. We will implement locality based model of team continuity and further address inequalities and support some of the most deprived families, including targeted funding which will be applied to ensure 75% from vulnerable and BAME Groups benefit from CofC by 2023/24.	✓	✓	✓	✓	✓
<b>Postnatal care:</b> In response to guidance, we will develop a postnatal care improvement plan agreed by commissioners and providers by February 2020, to include postnatal physiotherapy offered to women with physical complications because of birth by 2023/24. All Derbyshire maternity services are accredited under the UNICEF Baby Friendly initiative. Maternity outreach clinics are in place in the south of the county for women experiencing mental health difficulties arising from or related to, the pregnancy or birth experience and by November 2019 will have been rolled out to all women in the footprint.	✓				✓
<b>Digital:</b> Currently, <10% of women benefit from access to an Electronic Personal Health Record (ePHR). We will learn from our pilot site and consider expanding the offer at each of our units, so by 2023/24 all women have to access ePHR which includes a digitised version of their personalised care plan (PCP) – see above.					✓



## Delivering Further Progress on Care Quality and Outcomes: Children & Young People

We will continue to develop age-appropriate integrated care, integrating physical and mental health services, enabling joint working between primary, community and acute services, and supporting transition to adult service. This will be achieved through a clinically led, holistic approach to improve outcomes for children and young people; delivered through four workstreams (SEND, Emotional Health & Wellbeing, Community Provision for physical health and Urgent Care)...

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Supporting the expansion of Children and Young People's mental health services - We will review community provision to inform development of a transformed model that meets the needs of children consistently across Derbyshire with greater integration between primary, community and specialist care; including local council provision.	✓				
We will engage with clinical networks as they are rolled out to support the work being led through the condition specific workstreams, to improve the quality of care for children with long term conditions such as asthma, epilepsy and diabetes. In doing so we will improve care for children with diabetes and complex needs, reviewing the pathway and services for treating and managing childhood obesity by 2022/23. This will be supported by a clearly defined childhood obesity strategy at all levels of need, implemented across the system. We will also work across the children's and condition specific workstream for Respiratory conditions to review pathways for children/ young adults with Respiratory Conditions.	✓	✓		✓	
We will develop a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults by 2023/24. This will be developed with SEND strategic boards so that the mental offer is also responsive to 0-25 year olds that also have SEND needs. This will mean both SEND and mental offers will be aligned and integrated where appropriate with clear pathways that are effective, responsive to need and maximise resource.	✓	✓	✓	✓	✓
We will review and establish a clear understanding of need of the Mental Health Support for Children in Care and care leavers who are placed in care out of area. We will work with our locally commissioned Emotional Health and Wellbeing Service to ensure each child placed out of area has a good quality effective and appropriate service that will be able to address assessed mental and emotional needs with a view to improving placement stability and reducing out of area placements from the baseline.	✓				
We will undertake an Eating Disorder service review to improve access and wait times, actively promoting the THRIVE model to deliver early interventions, with a new service by Sept 2019 to achieve the 95% standard in 2020/21 which will be maintained thereafter.	✓	✓			
Implementation of the system wide long term plan will be delivered and monitored through the STP and fully aligned with the Future in Mind local transformation plan. It will be refreshed annually.	✓	✓	✓		
Linking with the urgent care workstream and the estates enabler workstream, we will ensure the estates redesign across emergency departments and in the Paediatric wards align to the STP strategy.	✓	✓	✓	✓	✓
CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice [from 2022/23]. We will improve the mental and emotional well-being of young people known to the Youth Offending Service, ensuring support is in place in both CAMH Services and training in place across the JUCD system and review arrangements for children in care and care leavers who are in care out of area.	✓			✓	
During 2019/20 we will reduce waiting times by ensuring adequate access to community based early effective intervention services, ensuring an understanding of roles and responsibilities and clear timed process for completing Education Health & Care Plans; consistent service specifications and processes will be developed across the footprint as well as a review of core CAMH services.					
We will develop keyworkers for children and young people with the most complex needs and their carers/families from 2020/21 by developing robust multi-agency community provision that wraps around the child to effectively address their mental health needs and keep them safe.	✓		✓		✓
There will be 24/7 mental health crisis provision for children and young people accessible via NHS 111 by 2023/24, that combines crisis assessment, brief response and intensive home treatment functions. So that by 2028 we move towards a service model for young people that offers person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.					
We will develop a robust multi-agency community provision that wraps around the child to effectively address their mental health needs and keep them safe by developing our whole school approach to CYP's mental and emotional wellbeing. This will be done by implementing 4 x Mental Health Support Teams (MHSTs) The MHST's will be implemented within education settings across Derby & Derbyshire by January 2020 with full mobilisation from April 2020.	✓	✓			
We will work with Public Health commissioning colleagues to increase uptake, coverage for childhood vaccinations; diphtheria, tetanus, poliomyelitis, pertussis, HiB, hepatitis B, rotavirus, MenB, MenC, pneumococcal, MMR by 2020/21	✓	✓			

## Delivering Further Progress on Care Quality and Outcomes: Learning Disabilities & Autism

*We will reduce the causes of morbidity and preventable deaths and transform care for people with learning disabilities & / or autistic spectrum conditions who display behaviour that challenges including a mental health condition...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
We will ensure that at least 75% of people per year with a Learning Disability and/or Autism aged over 14 years receive an annual health check, carried out to a consistently high standard, and make sure that people with a learning disability get timely access to the healthcare they need in the right place, at the right time by : Improving access to annual health checks and diagnostic services, monitoring contracts held with primary care practices to ensure achievement of 75% uptake rate. Review of performance to identify best practice in increasing uptake for health checks for those with a learning disability and identification of areas of poor uptake to provide additional support to PCNs by 2020/21. We will also implement national guidance regarding eye, hearing and dental checks for young people in residential schools by 2021/22	✓	✓	✓		
We will ensure that we continue to learn from the deaths of people with Learning Disabilities; ensuring all deaths are reviewed within 6 months by 2019/20 which will be supported by the recruitment of a dedicated Learning Disabilities mortality review (LeDeR) reviewer and support	✓				
We will work collaboratively to reduce reliance on inpatient services so that by 2020/21 no more than 28 (currently 48) people are receiving inpatient care within both secure and acute hospital facilities, as they will be better supported in the community; leading to the eventual closure of hospital facilities from 2021/22. We will achieve this by: - Completing a Specialist LD inpatient Assessment and Treatment service review and agreeing a delivery plan for improvement in specialist LD inpatient services in 2019/20 We will continue to work as a system to reduce restrictive practices including the use of seclusion and long term segregation, ensuring all providers are using the 12 point discharge planning guidance. Put procedures in place to audit compliance with PBS training requirement in 2019/20 and develop plans based on outcome of audit by 2020/21. Further development of intensive support teams (crisis and forensic) to support greater levels of independent living in the community by: - Full implementation of new service model across counselling and psychology services - Standard multi-disciplinary intensive support service offer in place across both providers to provide intensive assessment and treatment for individuals within their own home and respond to urgent care needs to avoid admissions wherever appropriate. - Undertaking LD short breaks service user reviews and assessments to develop options regarding LD Short Breaks services in 2020/21	✓	✓			
We will further develop intensive support teams (crisis and forensic) to support greater levels of independent living in the community by 2020/21 by: - Undertaking a review of system wide crisis response (including feedback from individuals and carers) to develop the model for the integrated wrap round offer in 2019/20; ensuring mental health services offer crisis support for people with autism without a learning disability, LD & ASD forensic service in place with clearer links into mental health forensic services - Development of an Integrated earlier intervention model for crisis, further development of care provider market to increase personalised community care provision	✓	✓			
We will further develop our approach to personalised care and support planning by embedding the use of PHB's to deliver interventions as identified in individuals care and support plans, alongside CHC and S117 entitlements by 2020/21. This will be supported by comms plan to support roll out of key tools to support development of Personalised care and support / stay well plans and work with key providers to embed use of PCSP for all individuals on DSR, confirming the system approach to CPA and review of current use of PHB's to support people with LD &/or ASD outside of CHC.	✓	✓			
We will monitor and reduce the over prescribing of anti-psychotic medication (STOMP / STAMP) by establishing a baseline in 2019/20 and re-audit in 2020/21. A stakeholder group has been established, including PCN Clinical Directors to progress the areas identified in the national STOMP audit 2018/19	✓	✓			
We will ensure local systems are updated to meet national requirements of digital flag to identify patients who require reasonable adjustments by raising awareness and skills to establish a system wide action plan to enable use of digital flags by 2020/21, by developing a system wide workforce action plan and undertaking a skills audit across statutory health and social care services to identify areas for further training re LD & ASD in 2019/20 and developing a system wide training plan by 2020/21 to support.	✓	✓			
We will ensure all LD quality standards are met by undertaking a system wide audit/collation of performance against LD quality standards in 2019/20 to inform development of short and medium term action plans to deliver standards by 2020/21. This will include the digital flag to identify patients who require reasonable adjustments	✓	✓			
We will develop a system wide engagement strategy to support improvements and support quality monitoring and improvements by 2020/21	✓	✓			
We will continue to ensure Care and Treatment Reviews/Care Education and Treatment Review's (CTR/CETR) are undertaken when considering admission and in community settings so that 75% of adults and CAMHS patients have an inpatient CTR/CETR within agreed timeframes and 75% of adults and 90% of CAMHS patients having a pre or post admission CTR/CETR.	✓	✓			
Implementation of Key Worker role for all C&YP with complex needs by developing of business case and delivery plans based on national guidance to ensure rollout by 2023/24		✓		✓	
We will continue to ensure dynamic risk stratification and registers are in place throughout 2019/20 and maintained thereafter	✓	✓			

## Delivering Further Progress on Care Quality and Outcomes: CVD and Stroke

*Over the next five years, we will support people to manage their own health and train staff to have the conversations which help patients make the decisions that are right for them. As a system, we will improve the prevention, early detection and treatment of cardiovascular disease (CVD)...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
<p>Improving prevention and early detection of Cardiovascular disease (CVD):</p> <p>During 2019/20 we will strengthen links to be part of the Local ISDN development and redesign our current Cardiac Rehab Model, supporting improvements in Heart Failure pathways, implementation of community BP screening and a Familial Hypercholesterolemia Genetics Diagnostics Service. We also plan to implement a programme of workforce upskilling in relation to hypertension diagnosis and management, promoting increased AF detection in primary care.</p> <p>Our digital technology offer will be expanded from 2020/21 to further support prevention, self-management and early diagnosis through systematic case finding and risk stratification of people with hypertension, Blood Pressure Screening in community settings / pharmacies. We will expand our work with stakeholders to support readily accessible tests of high risk conditions with particular focus on people from deprived and disadvantaged groups.</p>	✓	✓			
<p>We will improve treatment of CVD and increase the number of people with CVD who are treated for the cardiac high-risk conditions; Atrial Fibrillation, high blood pressure and high cholesterol by reviewing and redesigning our CVD services for people with SMI and developing our workforce upskilling plans aligned to CVD interventions during 2020/21.</p> <p>We will work with the national stroke team to develop and roll out a digital approach to improving stroke pre-hospital pathways and communication, and work alongside the national CVD and Respiratory programme to implement the CVDprevent audit, delivering improved outcomes for CVD. We also plan to work with voluntary sector partners to launch a campaign to increase number of volunteer responders to help improve outcomes of out-of-hospital cardiac arrests.</p> <p>During 2021/22 we will develop the Derbyshire CVD Risk Stratification Strategy, review and scope to increase Defibrillator usage across Derbyshire, working with PCNs on Digital App expansion to increase referral and uptake of cardiac rehabilitation. We will further develop the House of Care model across Derbyshire to support all LTCs, including CVD.</p> <p>From 2022/23 we will work with providers to support the training of hospital consultants to offer mechanical thrombectomy, improving and configuring stroke services, to ensure that all patients who need it, receive mechanical thrombectomy and thrombolysis. We will further improve and align services to the GP Contract and allocate fair shares funding allocation (from 2019/20 to 2023/24) to support workforce development. We will review and identify further opportunities for Enhanced Services aligned to improved end to end pathways including the EoL CVD pathway.</p> <p>This will ensure that by 2023/24 our plans will be built on the increased availability of technology that will assist the expansion of life-changing treatments to more patients.</p>					
<p>As a system, we have developed robust plans, and effective local clinical and system leadership to develop and improve stroke services, centred around delivering Integrated Stroke Delivery Networks (ISDNs) and built upon the NHS Rightcare Stroke resource pack to identify further opportunities. We will continue to work with national stroke team during 2019/20 to implement revised payment structures for stroke services and the development of the CQUIN for post-stroke reviews and Thrombectomy staffing.</p> <p>We plan to facilitate Early Supported Discharge (ESD) for all patients for whom it is appropriate, during 2020/21, developing plans to integrate ESD and community services through revising and redesigning our post-hospital stroke rehabilitation models and further developing our community placed base services. During 2022/23, we will review and identify further opportunities for Enhanced Services aligned to improved end to end pathways.</p> <p>From 2023/24, we will commission to support an increase in the proportion of patients who receive a thrombectomy after a stroke so that year on year more people will be independent after their stroke, promoting the best performance in Europe for delivering thrombolysis to all patients who could benefit.</p> <p>We will develop and implement higher intensity care models for stroke rehabilitation, building on increased availability of technology that will assist the expansion of life-changing treatments to more patients.</p>	✓	✓	✓	✓	✓



## Delivering Further Progress on Care Quality and Outcomes: Diabetes

*We will improve early identification, services and support for people with Type 1 and 2 diabetes, in line with the Long Term Plan commitments...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
We have set out local referral trajectories that will contribute to the national Diabetes Prevention Programme (DPP) to support 525 people through the programme by 2019/20. In order to achieve our trajectories, we will implement a targeted plan to increase uptake, which will be delivered by a 'Prevention Facilitator'. During the year we will recruit a second Prevention facilitator to provide greater impact with delivery of the targeted plan. We have established a communication plan to launch the updated Derbyshire wide prevention pathway and will complete the Phase 3 local procurement against the 2019 NDPP framework, which includes both a face to face and a digital offer.	✓	✓	✓	✓	✓
From 2020/21 Phase 3 NDPP roll out will commence and continue to deliver the targeted plan in primary care, improving quality of referrals to NDPP and increasing course take up as per our trajectories and in line with the national plan.					
Support for more people living with diabetes to achieve the three recommended treatment targets (3TTs);					
We plan to support improvement in achievement of the 3TTs during 2019/20, based on a review of the impact and learning from our north quality scheme, which supports practices to undertake more patient reviews. We will also review the impact and learning from the proof of concept in the south in which practices are delivering innovative 12 month Place level schemes to improve 3TTs.					
We will continue to up skill and support Primary and Community care staff to enable up to 20% of people living with Type 1 diabetes who are eligible under the clinical criteria for that funding, to access flash glucose monitoring devices and to better enable people with diabetes to self-manage their condition.	✓	✓	✓	✓	✓
Working alongside the maternity work stream, from April 2020 we will ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring , where clinically appropriate, establishing baseline data.					
During 2020/21 we will take learning from the 2019-20 primary care schemes to develop our PCN approach, continuing to support more people living with diabetes to achieve the 3TTs. Alongside this, we will continue to deliver the upskilling workforce training programme and monitor to ensure that all pregnant women with type 1 diabetes are being offered continuous glucose monitoring, reviewing the pathway for type 1 pre-gestational women in conjunction with maternity work stream to identify any areas of variation.					
We will review our pathway and services for treating and managing childhood obesity during 2021/22 in order to improve care for children with diabetes and complex needs; we will continue to monitor to ensure that all pregnant women with type 1 diabetes are being offered continuous glucose monitoring and develop our pathway for type 1 pre-gestational women in line with outcome of review completed in 2020/21.					
We will improve access to Diabetes Structured Education by expanding the provision of digital and face-to-face structured education and self-management support tools for people with Type 1 and Type 2 diabetes; providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20. We will utilise transformation funding to increase course capacity and reduce waiting lists for type 1 DAFNE courses, engaging with stakeholders to develop a strategy for delivering a range of type 1 structured education courses including DAFNE and digital, and a range of type 2 structured education courses including face to face and digital.					
In order to develop our sustainability plan to increase capacity for structured education across a variety of options, from 2019/20 we will support the roll out of clinical networks to ensure we improve the quality of care for children with diabetes.	✓	✓	✓	✓	✓
Our sustainability plan will be implemented in 2020/21 and will focus on increasing the uptake and completion of type 1 structured education courses by offering a range of course formats and making them more accessible and rolling out the National HeLP - Healthy Living for People with Type 2 Diabetes online self-management support programme and accompanying structured education pathway,					
Commencing in 2021/22, we plan to review our structured education options for children, parents, women with pre-gestational diabetes and women with diabetes planning pregnancy further increasing the update of structured education.					
From 2022 we plan to continue to use Tapered Diabetes Transformation funding to support increased capacity of type 1 and type 2 structured education					

## Delivering Further Progress on Care Quality and Outcomes: Diabetes

*We will improve early identification, services and support for people with Type 1 and 2 diabetes, in line with the Long Term Plan commitments...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Our plans for 2019 onwards include targeting variation in the achievement of diabetes management, treatment and care processes and addressing health inequalities through the commissioning and provision of services.					
We will continue to provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+, which will be adjusted appropriately for ethnicity and will have a significant impact on improving health, reducing health inequalities and reducing costs.	✓	✓	✓	✓	✓
We will reduce existing health inequalities by introducing a standardised care approach within GP systems, catering for multiple languages, and providing options for patients without digital skills. We also aim to engage more young people with type 1 and type 2 diabetes to improve self-management, attend clinic appointments and improve use of medication through a dedicated Transition worker.					
We will continue to make improvements to the foot care pathway across Derbyshire with the aim of reducing episodes of foot disease by ensuring universal coverage of multidisciplinary footcare teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care.					
We plan to work with Diabetes UK to complete a review of our current (four) foot care pathways in 2019/20 in order to understand where there is variation in service delivery and outcomes and to articulate one Derbyshire diabetes foot care pathway. Based on our review, we will develop a programme of consistent foot care training for primary and community care staff, enabling staff to complete good quality foot assessments and provide consistent self-management advice.					
We plan to transfer our outpatient activity to community podiatry and will develop a sustainability plan to be proposed for delivery in 2020 when the current licence expires. Following this, we will review the impact of the expanded north community interdisciplinary foot care team and develop a further sustainability plan proposal.	✓	✓	✓	✓	✓
From 2020, we plan to identify efficiency opportunities within the pathway and improve integration between providers. This will enable us to communicate a clear accessible Derbyshire foot care pathway to people with diabetes and healthcare professionals, which will raise awareness about diabetic foot risks.					
Diabetes Inpatient Specialist Nurse (DISN) pathways will be developed from 2019/20 with EMAS which will enable ambulance staff to speak directly to DISN from the persons home with aim to prevent conveyance, the aim is to prevent admission for people who can be managed from a rapid access clinic. We will continue to develop our plans to maintain increased capacity DISN within the acute hospitals, improving support for long term condition management for those with diabetes.					

## Delivering Further Progress on Care Quality and Outcomes: Respiratory

*We will support local identification of respiratory disease and increase associated referrals to pulmonary rehabilitation services for those who will benefit, supporting people to manage their own health, particularly for the most socio-economically disadvantaged people who are disproportionately represented in this patient cohort...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
By ensuring 76% of patients seen in HOT clinic are discharged home the same day, we aim to see a reduction in respiratory related non-elective spend from 2019.					
Following a review of the National Network Service Specification for Medication, we will adapt and develop the implementation strategy to localise it for Derbyshire during 2020/21. This will lead to a review of the Derbyshire Breathlessness pathway, and plans to utilise more digital technology, increasing the use of appointments and telehealth.					
During 2021/22, we plan to expand our pulmonary rehabilitation services and test new models of care for breathlessness management in patients with either cardiac or respiratory disease, working with the national Respiratory Team to test A1 technologies to interpret lung function test and support diagnosis. We will also complete a review of national programmes for respiratory diseases with testing in order to improve services in Derbyshire.	✓	✓	✓	✓	✓
We plan to commence a review of children/young adults with respiratory conditions during 2022/23, enabling us to complete a service benefit review of the existing respiratory model for Derbyshire, and working closely with providers we will ensure our models of care and pathways are efficient and effective. This will enable us to implement a 'new' respiratory service model for Derbyshire during 2023/24, based upon RightCare data, Model Hospital data packs and increased availability of technology which will assist us in providing life changing treatments to more patients.					
Our respiratory priorities for 2019/20 are focused on adopting a 'whole person' approach to respiratory care whereby those at risk of lung disease, or those with confirmed disease, are proactively supported earlier in their pathway to prevent health deterioration and unnecessary admissions.					
We will ensure that all people admitted to hospital who smoke are offered NHS-funded tobacco treatment services via provision of an inpatient smoking cessation service (currently at UHDB). We will continue to improve support for patients, carers and volunteers to enhance 'self-management' and increase systematic signposting to lifestyle services to support people to access stop smoking services, with the aim of improving upstream prevention of avoidable illness and its exacerbations through smoking cessation. It is our aim that 40% of patients who start inpatient smoking cessation successfully quit at 4 weeks.	✓	✓	✓		
Our plans will be developed during 2021/22 in partnership with Public Health to increase uptake of flu vaccinations to meet and exceed PHE immunisation targets and also to support expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments implemented.					
Alongside the above, we will continue to support implementation and delivery of the government's five-year action plan on Antimicrobial Resistance developing local plans to tackle Antimicrobial Resistance and reduce overall antibiotic use and drug-resistant infections.	✓	✓	✓	✓	✓

## Delivering Further Progress on Care Quality and Outcomes: End Of Life Care (EoL)

*Our EoL programme of work incorporates the six ambitions set out within the National Framework for EoL. Our ambition is to provide truly collaborative, co-ordinated care, standardised County wide but offering personalised care and support for individuals; allowing people to die in their preferred place of care with support, care and maximising symptom control...*

Key Deliverables	Milestones				
	19/20	20/21	21/22	22/23	23/24
Based on the foundations that support the ambitions for Palliative and EoL care, we will ensure that everybody approaching the end of their life is seen as an individual and offered the chance to create a personalised care plan based on their needs, preferences and wishes. We will ensure that opportunities for informed discussion and planning are universal and ongoing with options regularly reviewed. To ensure the plan guides a person centred approach we will ensure it is available to the person and, with their consent, can be shared with all those who may be involved in their care.	✓	✓	✓	✓	✓
We will utilise our IT infrastructure to share care plans and reduce unwarranted, unnecessary, expensive hospital admissions and so giving better quality of life to the person and their family. We have developed an electronic ReSPECT form which is ready and planned for County wide distribution in 2019/20. This will ensure a focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney and 'living wills'. The use of technology and other mechanisms will continue to be a priority to ensure those wishes are known and adhered to wherever an individual enters the health and care system.					
We recognise that there is currently a wide variation on the services available for EoL across the county and also by condition. Cancer EoL services are, in most cases, more available than those for Long Term Conditions for example. Therefore we will review services county wide to ensure we are consistently meeting the standards to provide the care that patients and their carers need to die comfortably, in the setting of their choice and with dignity.	✓	✓	✓	✓	✓
We plan to review and accelerate the roll out of Personal Health Budgets to give people greater choice and control over how care is planned and delivered. This will include expanding the offer for people receiving specialist end of life care, maximising comfort and wellbeing.	✓	✓	✓	✓	✓
We recognise that timely CHC input reduces inappropriate admissions, carer crisis, stress and distress. Therefore, we have developed an electronic Fast Track form which decreases the time needed to complete and process the form and will implement its use across the county during 2019/20. Further, we will develop a county wide policy of filling syringes based on the service established in the South of the County to ensure geographical consistency.					
The Derbyshire STP EoL Strategy will be signed off during 2019/20 with the aim of delivering consistent care across the county by 2020/21 and delivery of strategic intentions across the system by 2021/22. We will continue to build on the strategy which emphasises local leadership, service delivery and accountability.	✓	✓	✓		
We recognise that Palliative and EoL care requires collaboration and cooperation to create the improvements we all want. Therefore, cross-organisational collaboration is vital to design new ways of working that will enable each community to achieve better EoL care. We will consistently enable this through the STP EoL group which facilitates joint working by being a focal point for delivery.					
In Derbyshire we will ensure 'All staff are prepared to care' by completing a review of education requirements for the system, subsequently we will continue to roll out training to help staff identify and support relevant patients, and continue to promote proactive and personalised care planning for everyone identified as being in their last year of life.	✓	✓	✓		
From 2021 we will develop a County education plan which will support and train staff to have personalised care conversations, helping them to identify and care for patients in their last year of life with personalised, proactive care planning.					
We will continue to develop a county wide approach that supports open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care. This will ensure that each community is prepared and that opportunities for informed discussion and planning are universal.	✓	✓	✓	✓	✓
Our plans are focused around the individual and those important to them, so they will be locally led and delivered, supported by us all across all communities. We will continue to develop a county wide approach that supports open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care.					

## Giving our staff the backing they need

*The value we place on our collective workforce is of significant importance to Joined Up Care Derbyshire and is reflected in our ambition to deliver the quadruple aim...*

The Derbyshire system has come together to develop our strategic approach in relation to workforce which is overseen by the Local Workforce Action Board (LWAB). We have made significant improvements since our original STP plan in 2016, although we recognise that there is a considerable shift required to truly implement the broader workforce changes required to deliver the LTP ambitions and continue to ensure we improve overall staff experience and resilience.

We intend to make our health and social care system the best place to work, which is consistent with the ambitions set out in the NHS Interim People Plan. Our workforce plan will be structured to enable the system to:

- Improve our leadership culture at all levels
- Tackle the nursing challenge
- Deliver 21st century care
- Develop a new operating model for workforce

### Our Strategic Approach

We have agreed a set of system workforce objectives which move us towards a new operating model for workforce; these include:

- Streamlined recruitment and employment processes so that we 'recruit once for Derbyshire' wherever possible, enhanced mobility around the system and eliminating non value adding processes and duplication
- One set of employment policies and contract documentation for all organisations (starting with the Disciplinary policy).
- A single workforce dashboard which identifies a set of key system workforce metrics which will evidence workforce transformation and progress against shared objectives
- A whole system approach to developing new roles, specifically ACPs and advanced practice, Trainee Nursing Associates, including recruitment, training and deployment
- A whole system approach to the delivery of mandatory training
- A system well being offer for staff in Derbyshire including general practice
- Our aim is to reduce agency spending by 2023/24 through improved recruitment and retention, introduction of new roles and ways of working in the context of more proactive and preventative approaches in the community to reduce the need for secondary care services. Whilst we develop these plans we will maintain compliance with the agency spending cap.

### Transforming the way in which our staff work

We recognise that we have challenges in certain areas such as recruitment and retention; specifically medical staff in ED, qualified nurses, Ophthalmology, Urology, LD and Psychiatry. The local labour market in Derbyshire has high employment levels (79%, compared to 76% nationally) with the number of vacancies steadily increasing across all sectors, making recruitment of care staff increasingly difficult.

### Building leadership across all levels

The Derbyshire offer for our future workforce will include more flexible working patterns to appeal to generation X and Y, and we will ensure all our organisations have a positive, inclusive, person centred leadership culture at all levels. To enable this, we are developing a longer term system Organisation Development Plan which will complement existing OD and leadership plans within Trusts; building on the significant work undertaken to date within the system to develop the capability within the system to enable transformation. The system plan will be going to the STP Board in November 2019.

A collaborative approach to attraction and retention under the banner 'Joined Up Careers Derbyshire', with an initial focus on apprenticeships and promoting careers in health and care to school leavers, piloting an integrated health and care apprenticeship

### Improving mental and physical health and enabling flexible working

We have commissioned Sheffield Hallam University to support Derbyshire in developing a system wide approach to wellbeing. Through this approach we will:

- Develop a better understanding of how the organisations support workforce wellbeing; the current offer
- Derive data to determine need, improve monitoring and evaluation of impact
- Align approach to examples of best practice (within organisations/other NHS organisations/research)
- Identify gaps between current service provision and best practice (Overall wellbeing and OH)
- By the end of 2019/20 the Derbyshire system will have proposals and recommendations with regards to the next steps for workplace wellbeing.

## Giving our staff the backing they need

*The value we place on our collective workforce is of significant importance to Joined Up Care Derbyshire and is reflected in our ambition to deliver the quadruple aim...*

### Enabling transformation and delivering our Model of Care

We have identified a number of actions earlier in this section to demonstrate our strategic approach to workforce which will enable transformational improvements, deliver our model of care along with the ambitions of the NHS LTP. In addition we will:

- Further develop our system approach to retention and wellbeing in general practice in collaboration with the LMC overseen by the GP Workforce Steering Group (e.g. first 5 years support, practice manager development programme)
- Explore the opportunity to develop a lead employer model to support increased training and deployment of Advanced Clinical Practitioners in collaboration with Nottinghamshire ICS to strengthen our capability and resilience
- Build on the Physician Associate training programmes in the north of the county and raise awareness of the potential of the role in all care settings
- Build postgraduate assessment and supervision into job plans
- Develop new approaches to expand capacity for trainee nursing associate placements in the private, voluntary and independent sector
- We will introduce new roles e.g. Psychology led services
- Develop a skilled and relevant pharmacist and pharmacy technician workforce both as part of PCNs and integrated care working within and across systems including specialisms

### Changing the Skill Mix and Introducing New Roles

Out of a current total health and care workforce of 19,625 (contracted available FTE), circa 14.5k work in an acute setting. As the expected growth in workforce is predominantly expected to be in community and non bedded care settings, this presents a challenge in terms of shifting staff into different settings, and working alongside a more diverse team from health, care and the voluntary sector.

We will continue to work closely with the Programme Leads for each of our programme areas to ensure the workforce implications in relation to the key deliverables set out in this plan are genuinely supported; we will identify how they envisage growing and transforming the workforce in line with the LTP ambitions, which will be triangulated with the organisational numerical forecasts. Appendix 5 summarises the key workforce implications identified from the delivery plans. From the strategic planning work we have done to date, we envisage a greater increase at advanced and foundation level roles than in core and extended level practitioners.

We have plans to further extend the Public Health and wellbeing agenda over the next two years by equipping 1400 Derbyshire health care, Derbyshire social care and primary care practitioner partners with skills in having 'Quality Conversations'. This will support person-centred interactions underpinned by a broader awareness of the wider social determinants of health and of asset and strength-based approaches to communication.

Furthermore, we will support the transformation programmes and our workforce through digital technology and innovation, through a digital skills training bid for European Social Fund funding, integrated health and care apprentice pilot, system wide Return to Practice scheme and system wide consistent training on service improvement and transformation.

### Local metrics

We are in the process of further developing our local metrics which will be reflected in our overarching workforce dashboard and will be aligned to national measures as and when these are confirmed. This will include measures in relation to staff well-being.

The following table summarises the current position for our 4 Foundation Trusts against some high level indicators:

Measure	Current position *	Planned actions
Staff retention rate	88% retention rate	We will further examine the figures by job type to identify any significant variances and address these
Workforce who identify as BAME	No specific targets currently although collectively there is a 11.5% average	We are developing our approach to enable agreed targets to be in place by 2021/22; including both leadership and overall workforce.
Vacancy rates and specifically nurse vacancy rates	Overall average 7% Nursing average 7.12%	We will identify specific hot spots e.g. LD and MH and refine current plans to address the gaps
Turnover rate	Average 9.65% compared with average for NHS Midlands & East of 13%	As above
Sickness absence/attendance	95.01%	We will identify areas of concerns and agree a sensible local target
Well Led Ratings	1 Outstanding, 2 Good, 1 requires Improvement	Programme of leadership development at system and organisational levels

In addition the Derbyshire system:

- Has low staff turnover rate compared to other Midlands systems
- Is on plan or ahead of plan for GP recruitment (3% improvement on plan), Physician Associates (0% variance from plan)
- Has recruited 2 Social Prescribers and 2 clinical pharmacists under the PCN additional role reimbursement scheme with a further 2 social prescribers to be in post by the end of November 2019.
- Respond to the requirements of the new Workforce Disability Equality Standard: All trusts will implement the requirements of the Standard and this will be incorporated into our work on EDS3 including diversity metrics.



## Using our estates to maximum effect to support a 21<sup>st</sup> Century model of care

*Working through our Local Estates Forum (LEF) we will continue to adopt our whole system approach in relation to our estates, ensuring opportunities to support integration are maximised...*

In response to our 2016 STP plan, Derbyshire established a Local Estates Forum (LEF) consistent of all system partners. Our LEF includes strong relationships with our local One Public Estates (OPE) as key strategic partners in our approach and we have strengthened this link through a jointly funded programme manager to support the entire STP and OPE work programme and ensure the link is maintained in everything we do.

The core purpose of the LEF is:

- Reshaping the estate to support wider system service redesign
- Improving effective utilisation of the estate
- Rationalising estate

We were required to develop a Local Estates Strategy (LES) in July 2018, which set out our current position and provided a stronger foundation to support and enable delivery of individual organisation, STP and the wider NHS and Government key priorities. The LES was rated as **good** by regulators and therefore provides us with a solid foundation. In response to the national requirement for all areas to update local LES' to reflect feedback received, the LES was further refreshed in July 2019. These updates included:

- Development of a Primary Care Strategy
- Articulation of the wider STP clinical strategy
- Progress on Disposals/improved use of the estate
- Revised governance arrangements
- Reflection of closer working with the One Public Estate

### The Derbyshire Estate

#### Acute and Community Care:

- 352 premises occupied
- 87 Ha known premises footprint
- 613,892 m2 gross internal floor area
- c£136m estate costs
- 30-33% non clinical space
- C£11m backlog maintenance

#### Primary Care:

- 160+ premises occupied
- C£2m backlog maintenance

Disposals opportunities: 11 Sites have been declared/identified for disposal which translates to 20 Ha total land area, c£19m estimated disposal value, 670 housing Units, and c£4.5m reduced running costs.

During 2017/18 and 2018/19 we have delivered:

- 6 sites have been sold c£20m disposal value
- Circa 600 housing units
- Circa £250k reduced running costs
- Achieved the national Naylor fair share allocation
- Secured funding for bids in each of the first 4 waves of STP funding (total capital funding circa £60M)

Our 2019/20 LES Implementation Plan contains the following key workstreams which will guarantee best use of the NHS estate and ensure the estate is a key driver in ensuring the STP/ICS clinical need is met:

- Improving estate efficiencies
- The realisation of disposals to directly improve patient care and further investment
- Capital pipeline and funding, including accessing further S106 monies
- Development of a Capital Financing Strategy encompassing BAU, equipping, BLM, capital developments etc across all sectors
- Further partnering with Local Government colleagues via OPE and LEPs

Specific areas of LEF focus within the Implementation Plan include:

- Reduction in non clinical space
- Reduction in unoccupied floor space
- Space utilisation review of South Derbyshire LIFT Co premises
- A better understanding of current and emerging Clinic Service Strategies
- Improved support and oversight of the LEF and One Public Estate
- Support of a part time Programme Manager – STP/OPE
- OPE Grant Funding for feasibility studies – Health and Social Care Hubs
- Better relationships and knowledge sharing
- Commissioning of a Primary Care Estates Strategy
- Working towards a more cohesive approach to s106 applications
- ETTF secured to make improvements in GP Estate

The LEF continues to support Trusts in the delivery of existing capital developments:

- Acute Front Door redesign – UHDB
- Urgent Care Village – UHDB
- Outwoods Development – UHDB (within Staffordshire STP)
- Improved Urgent Care Pathways – CRH
- Belper Community Hub – DCHS
- Additional bed capacity/Recommissioning of Endoscopy Services - UHDB
- Bakewell Community Hub – DCHS/EMAS

Early pipeline proposals have been identified in relation to a local PICU unit and the replacement of dormitory facilities across the Derbyshire mental health estate; these will be reflected in any future system estates plans.

## Delivering Digitally Enabled Care

*We will further develop our comprehensive approach to joined up digital care acting as a true enabler for transformation...*

<p><b>Our Vision and Priorities</b></p> <ul style="list-style-type: none"> <li>Digital services are at the heart of the JUCD shift from Managing Illness to Supporting Wellness – A clear Clinical Digital Vision underpins the Digital strategy, demonstrating how the ‘quadruple aim’ will be delivered;</li> <li>A Clear Digital Strategy has identified 5 themes – Citizens, Professionals, Foundations, Innovation and Analytics – that together build a robust approach to delivery of vital new services and technologies;</li> <li>The Derbyshire Digital family – Commissioners, providers and local government working together at every level to ensure seamless integration of products and services for end-users throughout Derbyshire, delivering fully integrated care records</li> <li>Flexibility to changing digital circumstances – through a principle of ‘converge and connect’ – implementing common shared systems wherever possible, and providing excellent interoperability products where necessary</li> <li>Value for money – Ambitious investment plans for Digital services are balanced with careful financial stewardship of existing resources;</li> <li>We are committed to supplying NHS mail accounts to all Derbyshire care homes that wish to use the service. So far, 46 (out of an estimated 310) care homes have been issued with accounts</li> </ul>	<p><b>Leadership and Governance</b></p> <ul style="list-style-type: none"> <li>Strong System Governance – A JUCD Digital Board, chaired by a provider Chief Executive, and with senior representation from all partners;</li> <li>The Digital board has a clear mandate (with TORs) a set attendance with Agenda / Minutes. All System organisations are represented and the board receives timely and accurate updates on Transformation programmes, finances, risks, issues, workforce, clinical priority changes etc.</li> <li>Clinical Leadership – Through a JUCD Chief Clinical Information Officer (CCIO) group, chaired by the CCG Medical Director;</li> <li>Technical leadership through the Derbyshire Heads of IT (HoIT) group;</li> <li>There is JUCD board visibility of digital programmes and initiatives across the system and the associated detailed plans are regularly discussed and monitored.</li> <li>There is appropriate Digital Board representation from Academic Health Science Networks (AHSNs) and strong evidence of close liaison between system organisations, digital leaders and AHSNs. There is a clear ambition on partnership working with research and industry partners.</li> </ul>
<p><b>Risks, Issues and Constraints</b></p> <ul style="list-style-type: none"> <li>Citizen Engagement – continue the development a digital awareness amongst citizens, building on the strong achievements made to date</li> <li>Staff Engagement – At a time of significant change, the digital strategy recognises the need to support colleagues through the complex changes;</li> <li>Specialist Digital Skills – Maximising the use of scarce human resources;</li> <li>Resourcing – demonstrating clear value for money is essential if the ambitious funding needs of the system are to be met;</li> </ul> <p><b>2019/20 Operational risks</b></p> <p>Delays in the release of national capital (HSLI – Health System Led Investment in Provider Informatics, ETTF – Estates and Technology Transformation Fund, BAU – GP Business as usual) may delay delivery of respective programmes of work;</p> <ul style="list-style-type: none"> <li>Emergency Care Data Set (ECDS) – delivery of ECDS for University Hospitals of Derby and Burton is delayed, with a current projected delivery date of M6/19</li> </ul>	<p><b>Next Steps</b></p> <ul style="list-style-type: none"> <li>Apply to participate in the Global Digital Exemplar (GDE) programme;</li> <li>Work towards integrating Digital services across JUCD, providing seamless services to health professionals throughout the county;</li> <li>Delivery of an ambitious work programme of activities based around the following work programmes:             <ul style="list-style-type: none"> <li>Convergence at scale of out of hospital care records, through standardisation on a single platform throughout community, mental health and (where appropriate) primary care settings;</li> <li>Increasing the digital maturity of Secondary care acute providers in the Derbyshire footprint, moving to a true ‘paper free’ status by ;</li> <li>Delivery of a comprehensive package of interoperability tools, including fully supporting social care integration;</li> <li>Support for ambulance service integration with local providers;</li> </ul> </li> <li>Active participation in the Local Health Care Record Exchange programme, supporting care for Derbyshire patients in out of County locations;</li> <li>Continuing to strengthen system resilience and security to achieve 100% compliance by summer 2021;</li> </ul>



# Delivering Digitally Enabled Care

We have made significant progress to date and will further accelerate our approach through our refreshed digital strategy...

## Our Achievements – the journey so far

- Clear Digital Leadership and Governance
- 28% of patients have electronic access to GP systems, via POLAR project;
- 100% of GP practices are enabled to have access to NHS app;
- 100% of GP practices have patient Wi-Fi available;
- 100% of GP practices offering extended hours appointments;
- 35% of patients already have access to online consultation, with plans to reach 100% by 31/01/20;
- 20% of GP practices are enabled to receive appointment from 111 services, with plans to reach 100% by 31/01/20;
- Preparations in hand for implementing GP futures and Digital first;
- HSCN data networks in deployment;
- Delivery of the MIG Interoperability system;
- Delivery of windows 10 upgrade programme is on track to meet national deadlines Q4 2019/20;
- Strengthening cyber security capabilities;
- Delivery of year 1 HSLI projects;
- Commitment to supply NHS mail accounts to all Derbyshire care homes that wish to use the service. So far, 46 (out of an estimated 310) care homes have been issued with accounts.'
- Agreed an ambitious new digital strategy, which has significant resource implications. System-wide discussions are taking place to review options for prioritising current digital spend across all partner organisations, to enable local resources to be released to support key deliverables

Detailed information in relation to workstream alignment and our digital strategy can be found in Appendix 6.

## Moving forward enabled by the Joined Up Care Derbyshire Digital Strategy

System Outcomes

*'For people to have the best start in life, stay healthy, age well and die well'*

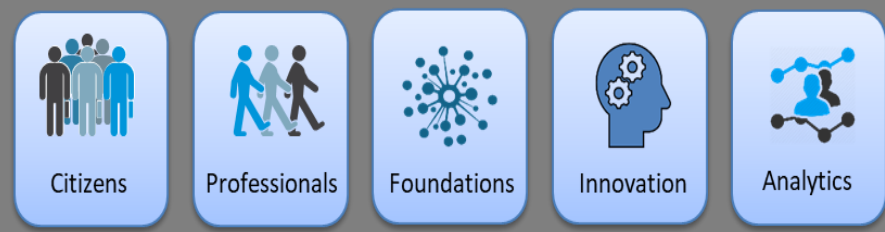
Clinical Priorities

Quadruple Aim: Improve Population Health; Patient experience; Staff Experience and per Capita Cost

Digital Health Vision

*"We will use digital services to facilitate system change, across the whole health and social care economy. To ensure appropriate and accurate information is available and accessible to our patients and their clinicians, supporting the provision of high quality outcomes, in the delivery of joined up care"*

Strategic Themes

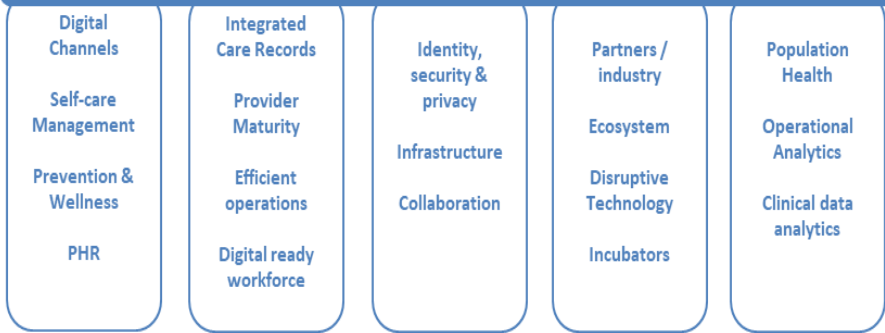


Leadership | Governance | Accountability | Skills & Resources

Principles

Patient centric | Safe & Secure | Collaborative & Integrated | Efficient delivery

Digital offers

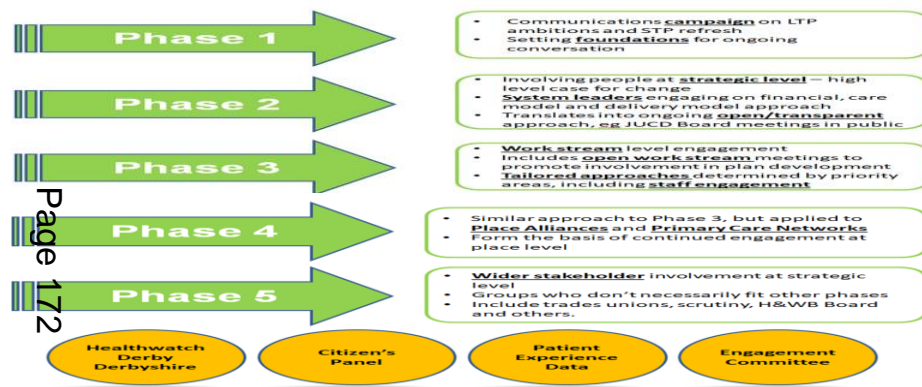


# Communication and Engagement Approach

We have undertaken a comprehensive engagement approach in developing our 5 year plan and will continue to build upon this going forward. The themes which resulted have shaped and informed the plan, or have influenced on-going planning work for the STP are identified in Appendix 7.

## Our approach

- Took place between April and September 2019.
- Ensured that a wide range of stakeholders, including staff, patients, their carer's and members of the public had the opportunity to help shape the plan.
- Underpinned by 5 phases, inviting engagement at a variety of different levels.
- Included the development of the Joined Up Care Derbyshire (JUCD) Citizens' Panel, which now has in excess of 1,600 members
- Supplemented by engagement conducted by Healthwatch Derby and Derbyshire, which included workshops aimed at seldom heard and marginalised groups.
- Will form the basis of continuous engagement in the work of JUCD going forward.



## What engagement took place?

- All work streams utilised either established engagement mechanisms, open meetings and/or confirm and challenge sessions with their stakeholders to test out thinking and priorities during July and August
- Five Place Alliances held events during July 2019 to discuss the model of care, the NHS long Term Plan and wider determinants of health. Two other places used existing engagement forums and south Derbyshire will hold their event shortly. 35 - 60 people attended per event.
- 80 stakeholders from broad range of backgrounds (politicians, voluntary sector, NHS staff, patient groups) attended discussion session with JUCD Board in September 2019 to comment on strategic aims of the plan
- Healthwatch received input from more than 500 people through surveys and focus groups. Key questions included:
  - What services can do to provide better support (particularly for specific conditions, such as cancer, mental health, dementia, heart and lung conditions, learning disabilities, and autism)
  - How the NHS can make it easier for us to take control of our health and wellbeing
  - How they people be supported to live healthier lives from birth to old age
- 40 members of Citizen's Panel attended confirm and challenge sessions, hearing the details of

- urgent care, children, Learning Disability and disease management plans
- First Citizen's Panel issued in August on 'online access to health services'.

## Governance

- The JUCD Board received monthly updates on the communications and engagement approach.
- The joint DDCCG and JUCD Engagement Committee had oversight and sought assurance on the process.
- The operational implementation of the approach was overseen by the JUCD Communications and Engagement Group, which acts as a coordinating body for all system-relevant communications and engagement activity.

## Key stakeholders

A wider range of stakeholders have been involved in the 5 phases of our approach, including MP's, Local Councillors, campaigners with an active interest in health and care services, Foundation Trust Governors, CCG lay members, Local Authority partners, clinicians, VCS, Healthwatch, Patient Participation Group members, clergy, carers and the general public. The plan has also been considered through the local Health & Wellbeing Boards and Health Overview and Scrutiny Committees; in addition we have discussed the plan with the Derbyshire District Council Chief Executives.

A media release and stakeholder briefing were issued in June promoting to a wide external audience the aims of the refresh and the opportunities to get involved.

There was also a drive via the partner communications and engagement teams to use all existing channels and opportunities to promote the STP refresh to system staff and encourage them to get involved in the opportunities available, or feedback via staff discussions and online.

## Beginners Guide to JUCD

We have developed a 'Beginners Guide to JUCD' to send out to Citizens Panel members, give out during workshops and display at events, to give people an understanding of our work and what we are aiming to achieve in terms of improvements in services for people in Derbyshire.

It covers the case for change, the need to consider the wider determinants of health, our priorities, our journey to becoming an Integrated Care System (ICS) and an overview of the work taking place in JUCD work-streams.

It will be available on our website

[https://www.joinupcarederbyshire.co.uk/application/files/3415/6750/5838/Introduction\\_to\\_JUCD\\_leaflet\\_Sep\\_2019.pdf](https://www.joinupcarederbyshire.co.uk/application/files/3415/6750/5838/Introduction_to_JUCD_leaflet_Sep_2019.pdf)

## Newsletters

JUCD has a quarterly newsletter which is distributed to a wide range of stakeholders and the latest edition can be found on the website here

<https://www.joinupcarederbyshire.co.uk/news/newsletters>

# The impact of our plan: Activity and Finance

We have worked in collaboration to develop this plan and will continue to do so to ensure a jointly owned approach is embedded to enable delivery of our plan....

## Our Approach

The system has worked collectively to ensure we have a clear understanding of our in-year financial position and forecast deficit position to 2023/24 assuming an unchanged state which has provided us with a clear baseline position. We have further developed the future years forecast position by assuming at a high level the valuation of the transformation programmes of work and broader redesign initiatives for 2020/21 and beyond.

Recognising that activity/demand pressures are a key driver to the financial and operational pressures facing the system, the model has been developed to clearly articulate the “do nothing” and “do something” plan.

The modelling work has been overseen through the system Directors of Finance aligned to each of the transformation programmes to work through as a bottom up approach as far as possible.

## Assumptions

Our approach is based on the following key planning assumptions which drive the financial model:

- Forecast outturn (FOT) based on month 6
- Forward projections were based on three year rolling averages, adjusted for non-recurrent impacts and known changes
- Review of planning policy changes and assessment of required activity levels to deliver the planning requirements
- All 2019/20 QIPP is delivered in the position
- £5m set aside for investment (in addition to LTP Investments)
- 0.5% contingency per annum
- Mental Health Investment Standard (MHIS) is met
- Assumed growth:
  - Acute growth based on 3 year average (avg 3.73%)
  - Ambulance 1.68%
  - Prescribing 5%
  - Continuing HealthCare (CHC)4.5% to 5.8%
  - Community 1.1%
  - Running costs 3%
- This plan is predicated on achievement of the system control total by 2023/24, recognising that there are system and organisational risks associated with achievement of that position which will be to be further understood and worked through.

## Impact

The workstream mitigating actions, identified at this stage will contribute £12.9m towards achieving a financially balanced position by 2023/24.

Final: 15 November 2019

This impact on activity is reflected in the table below.

	Growth	Mitigations	Net position
Commissioner Expenditure area			
Secondary care	3.73%	(2.52%)	1.21%
Non Electives	3.27%	(3.27%)	(0.00%)
Elective Spells	4.13%	(4.77%)	(0.64%)
Outpatients	2.41%	(3.14%)	(0.74%)
A&E	5.63%	(5.61%)	0.01%
Other	4.18%		4.18%
Associates	3.51%	(3.60%)	(0.09%)

## Impact on capacity (including beds)

The 535 beds reduction calculation originally submitted in the 2016 Derbyshire STP is no longer feasible. The local landscape has changed since then, with reduced length of stays in hospital beds and improvement to pathways that impact on the way beds are used. In addition, the merger of burton and derby hospitals has required additional acute beds to support redesigned clinical pathways. As a result we have done further modelling on growth of admissions which shows that if we do nothing and activity grows by 4.2% then we will need 2546 beds\* in the Derbyshire system in five years’ time compared with 2345 today, an increase of 286 beds.

We know that our main pressure on beds is happening in acute trusts, and this is where the anticipated growth will take place as greater numbers of poorly people require admission to an acute hospital bed. Our proactive and preventative work, and linking into the wider determinants of health are crucial parts of the plan to ensure that we are not ‘doing nothing’ and are actively tackling the growth in admissions.

In addition, our model of care in the community remains that care is better provided closer to home. We are therefore introducing more Pathway 1 (Home) and Pathway 2 (Care Home) care to ensure that patients can be discharged to the most appropriate care setting. This results in a net reduction of community hospital beds.

The two issues – acute beds and community beds – are clearly inter-related but we can reduce the number community beds at the same time as needing more acute beds as they provide different types of care. Retaining community hospital beds does not solve the acute hospital bed issue and it is our work in other programmes – disease management, prevention and planned care - which will help to solve the acute bed issue. The above provides a baseline position from which we will model our assumed growth rates for 2020/21 and beyond to better understand the anticipated bed capacity requirements for Derbyshire.

\*The 2546 figures quoted are total beds across the system, including community, mental health and acute beds.

## The impact of our plan: Activity and Finance

The summary below provides a high level overview of the financial plan for the Derbyshire STP.

### Investments

We will commit the additional LTP investments as identified in the table below to support delivery of specific LTP commitments. Where appropriate further targeted investment opportunities will also be explored.

	2019/20	2020/21	2021/22	2022/23	2023/24
	LTP allocation	LTP allocation	LTP allocation	LTP allocation	LTP allocation
	£000	£000	£000	£000	£000
<b>Joined Up Care Derbyshire STP</b>	10,709	10,901	15,059	22,104	31,915
1. Mental Health	1,107	1,196	3,785	7,590	10,175
(a) CYP community and crisis		58	1,161	1,792	2,948
(b) Adult Crisis		1,138	540	722	941
(c) New integrated models of Community and Primary care for SMI			2,084	5,076	6,286
2. Primary Medical and Community Services	6,456	7,205	8,284	10,822	13,180
(a) Primary Care	6,456	6,677	7,051	7,225	7,125
(b) Ageing Well		528	1,233	3,597	6,055
3. Cancer	2,383	1,701	1,331	1,277	1,280
4. Other	763	799	1,659	2,415	7,280

### Financial Plan

- The STP plans to return to a surplus position of £14.9m by 2023/24.
- 2019/20 will be the baseline period which will form future year projections based on forecast out-turn
- The baseline will be uplifted for growth (based on activity assumption identified earlier) and inflation
- Commissioners and providers will also deliver technical efficiencies
- The future financial plan will be underpinned by agreed risk share and risk management arrangements; managed through the system governance
- The STP will use the financial plan as the basis for agreeing contracts with providers to ensure the sustainability of the system but there will need to be a critical refresh associated with the systems actual recurrent outturn position and the bottom up calculation of the availability of efficiencies in year 1.
- Work is continuing to further map the impact of the transformational changes to mitigate the challenges identified in our case for change including financial, workforce and activity

### Outstanding Issues and Next Steps

Whilst we have made significant strides in our collective approach, we will continue to work collaboratively to effectively manage demand and resource which will be reflected in our future operational plans. We will do this by:

- Develop our transformation planning on an efficiency basis
- Develop a better understanding in relation to the impact of the Staffordshire plans on the Derbyshire system, given one of our main acute providers sits across both footprints
- Further development of the mitigations within the STP plan and their impact inside and outside the STP where those providers cross a number of STP boundaries.
- Firm up our underlying recurrent position going into 2020/21
- Further enhance system mitigations to ensure full reflection of transformation deliverables
- Continue working from the bottom up
- Develop a single system transformation plan for 2020/21 and beyond
- Further assessment of risk associated with plan delivery and development of mitigations
- Assess options to reduce the level of premium cost activity
- Identify additional step cost reduction opportunities particularly in relation to estates

### System In Year Underspend/(Deficit)

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
NHS Derby and Derbyshire CCG	(29,000)	(29,000)	(10,780)	(610)	4,320	6,480
Chesterfield Royal Hospital NHS FT	6,858	6,858	7,515	1,287	1,327	1,367
Derbyshire Community Healthcare Trust	1,832	1,832	2,200	1,032	1,062	1,092
Derbyshire Healthcare NHS FT	615	615	1,192	635	645	655
East Midlands Ambulance Service	(5,069)	(5,069)	(4,068)	(2,348)	(238)	1,072
University Hospitals of Derby and Burton NHS FT	(12,146)	(15,261)	(4,251)	1,469	4,269	4,269
<b>Underspend / (Deficit) - (Excl. CSF, PSF, FRF Incl. MRET)</b>	<b>(36,910)</b>	<b>(40,025)</b>	<b>(8,192)</b>	<b>1,465</b>	<b>11,384</b>	<b>14,935</b>

Note: The CCG 2019/20 FOT position is based on confirmed quarter 1 Commissioner Sustainability Funding

Information in relation to system capital expenditure can be found in Appendix 8.

## The impact of our plan: Improving Population Outcomes

*Delivering our Joined Up Care mission to improve population health outcomes for the people and communities we serve will enable us to ensure that the people in Derbyshire have the best start in life, stay well, age well and die well. Working together, and with strong and vibrant communities through our Places, we will keep people safe and healthy – free from crisis and exacerbation, at home – out of social and healthcare beds and independent – managing with minimum support. To do this we will ensure all our services are well run, integrated and make the best use of the available resources...*

### So what is our plan saying?

Population Level Outcome	For the people of Derbyshire this means that.....
<b>Best Start in Life</b> A healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition, healthcare and support	Expectant mothers will be better supported through personalised care planning, continuity of the person caring for them , access to digital health records and enhanced postnatal support .
	Children and young people will receive improved mental and emotional wellbeing support, with improved access to urgent care and psychological support when they need it, including 24/7 mental health crisis provision
	A Community Wellness approach will be developed where individuals and families can receive the support they need to improve their physical and emotional health and wellbeing;
<b>Stay Healthy</b> Helped to live a healthy life, make healthy choices and protected from threat. Able to maintain quality of life and recover from ill health or injury	Care for people with learning disabilities and autism will be transformed. Intensive support teams will be developed to support independent living in the community
	Mental Health services will receive increased investment . We will reduce the length of time people spend in hospital and end the need for out of area placements. More people will be supported through a Primary Care and Mental Health wellbeing approach, including increasing access to psychological therapies
	People have access to care at the right time and in the right place. With more staff, and through a diverse skill mix , we will improve access to General Practice including same day urgent care services in primary care and in our community-based Urgent Care Treatment centres.
	Where people do need hospital care , access to urgent and routine care will be improved and services will be tailored to their needs. This way we will enable people to recover from ill health or injury quickly and to return home at the earliest opportunity. We will transform the way outpatient services are delivered, reducing the need for face to face outpatient appointments by a third and using digital technology to support prevention and self-management
	Primary Care Networks will develop and deliver multidisciplinary care and services that meet the needs of the patients and communities and operate as a single team to wrap care around a person and their family. Care and treatment will be provided closer to home, such as treating minor eye conditions and support to patients' wellbeing through social prescribing.
<b>Age Well, Die Well</b> Fit, safe and secure, able to maintain independence and actively participate. A personalised, comfortable and supported end of life	Cancer outcomes will be improved. We will improve the early diagnosis of cancer by increasing the uptake of screening programmes and extending access to diagnostic tests. We will ensure that people living with cancer have improved access to high quality treatment and care, including psychological support.
	People with dementia will be supported through the Derbyshire Well Pathway for Dementia ; providing the best care possible for people living with dementia, their carers and those important to them.
	Older people will receive proactive, person centred and integrated care. We will embed the frailty model of care for Derbyshire to manage frailty as a long term condition in its own right, rather than treating it as a label
	People living in care homes will receive more NHS support ,ensuring their needs assessed and met and reducing the need for unnecessary and avoidable hospital admissions
	People approaching the end of their life will have fair access to personalised end of life care and support and to die in their preferred place of care. We will promote honest and open conversations about death across communities. and that those caring for the dying person are involved and supported .



## Timetable for STP plan approvals

The draft plan has been shared and considered by all partner organisations as part of ongoing engagement and involvement into the development of the final plan. The plan will be agreed by system leaders ahead of the 15 November submission. The JUCD Board agreed at the meeting on 18 October that the System Executive: CEOs group would have delegated authority to approve the detailed modelling and triangulation required to be incorporated into the plan narrative. This would ensure that contentious issues were understood by system partners and collectively managed with appropriate risk mitigations where necessary.

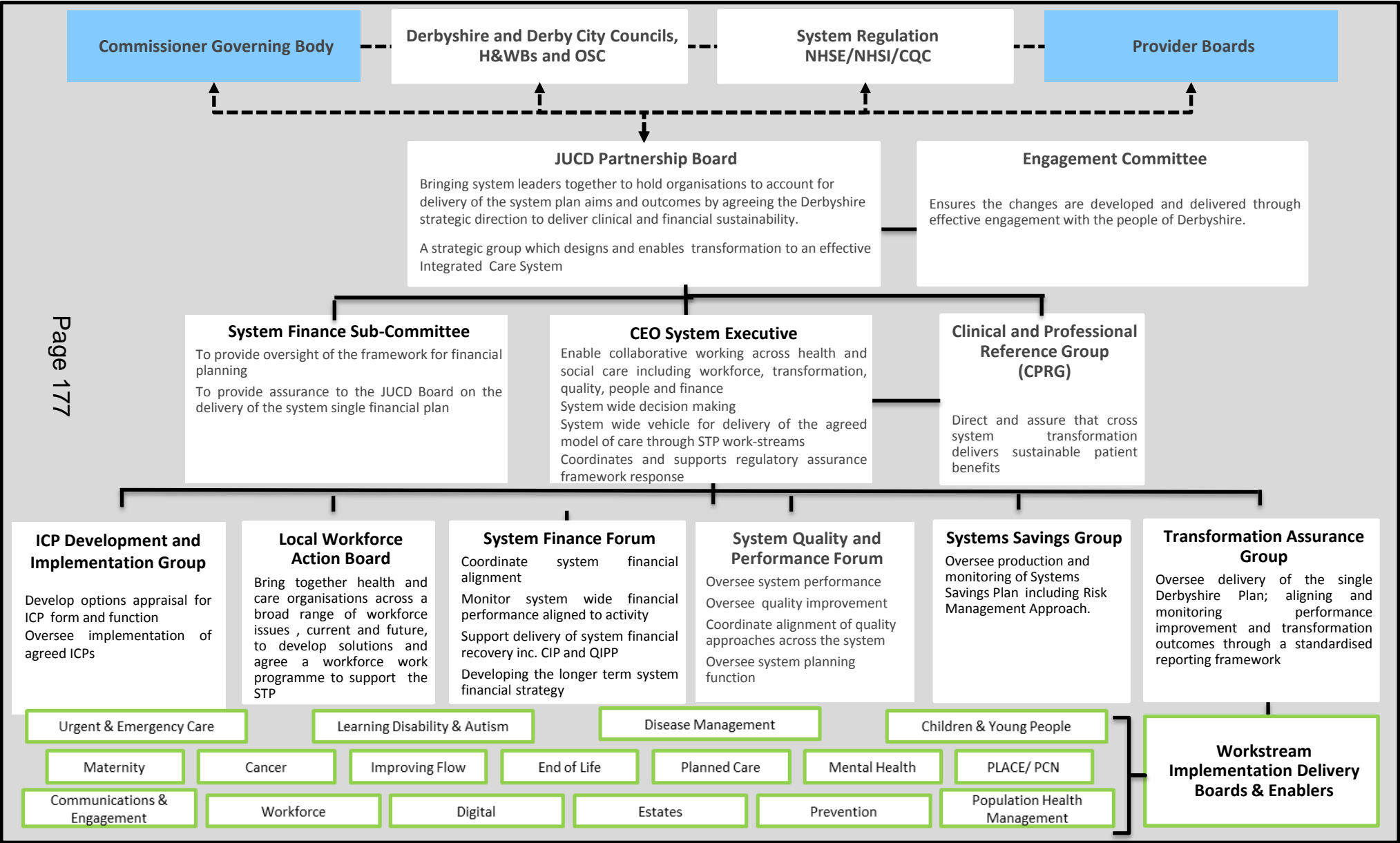
Action	Deadline
Submission to JUCD Board	13 September
Derbyshire County Council Adults Health Improvement and Scrutiny Committee (1)	16 September
JUCD Board sign off (draft plan)	20 September
Derby City Council Adults Health Improvement and Scrutiny Committee (1)	24 September
Submission to NHSE/I (draft plan)	27 September
Submission to JUCD Board for approval	11 October
JUCD Board (2)	18 October
Trust Boards, Governing Body, Local Authorities and Health & Wellbeing Boards approval (3)	
Derbyshire County Health & Wellbeing Board	3 October
DCHS	31 October
Submission to NHSE/I (draft plan)	1 November
DCFT	5 November
DH	6 November
DHU	6 November
DG	7 November
CEO Plan Triangulation Review	11 November
UHDB	12 November
Derby City Health & Wellbeing Board	14 November
Plan finalised and submitted to regulators for approval (also see note 5)	13 November
Submission of Final Plan to JUCD Board (4)	14 November
Final submission (5)	15 November
Final JUCD Board (6)	21 November
EMAS (7)	3 December
Publication of Plan – Date to be confirmed dependent on outcome of the General Election	

### Notes.

- Both Scrutiny Committees do not sit again ahead of final submission (the next county meeting is on 25 November and City do not meet again until February 2020). However the draft plan has been taken to both committees in September and further updates will also be taken to future meetings
- The JUCD Board received and approved further amendments to the plan to confirm version being taken through organisational governance processes
- Due to the scheduling; particularly with regards to feedback from region, it may be necessary for Boards/ Governing Body to receive the final plan which is subject to further amendments (depending on the nature of the feedback). The principles in terms of the narrative have been supported by the JUCD Board with delegated authority to the System Executive to approve the financial modelling and triangulation (impact of the plan) as these areas develop prior to 15 November. A CEO review meeting has been scheduled for 11 November.
- Papers will be submitted to the Board one day before final submission to NHSE/I but the Board meeting itself will take place after. The JUCD Board have agreed that the System Executive: CEO group will have delegated authority for final sign off of the plan ahead of the submission.
- Although this is the final submission to NHSE&I discussions will need to take place before this date to ensure plans are agreed with system leads and the regional team**
- The JUCD Board will receive the final plan; including any final feedback from region
- The EMAS Board date falls after the plan submission and therefore consideration/ agreement is required in relation to interim approach ahead of the plan being published to ensure fit with timescales

Monitoring Delivery of Our Plan

Our existing governance structure will be the mechanism by which we hold each other (the system) to account for delivery of our plan. This will be underpinned by a system PMO, regular workstream risk reporting and an escalation route to the JUCD Board. The JUCD Board are responsible for monitoring and managing the strategic risks across the system. A summary can be found at Appendix 9.



# APPENDICES

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# Improving the health of the population

## Profile of Environmental, Behavioural and Socio-economic Determinants of Health and Wellbeing Outcomes at Place Level

## APPENDIX 1

	England	Derby City	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
<b>Structural Socio-Economic Factors</b>										
Working age adults with HND, Degree and Higher Degree level qualifications	39.0	34.6	31.8	28.7	28.7	48.2	34.1	42.5	34.1	34.7
Working age adults with no formal qualifications	7.6	9.1	5.9	6.7	8.4	4.0	3.8	4.9	4.7	5.7
Employment rate (aged 16+)	75.4	74.2	83.5	77.7	72.0	84.0	78.3	75.2	78.0	82.4
Unemployment rate (aged 16+)	4.1	4.6	3.6	4.4	5.2	2.8	5.0	3.9	4.0	3.3
Workless Households (Unemployed/Inactive)	14.0	16.5	11.5	11.1	22.1	10.8	14.4	14.0	11.6	10.7
Job Density	0.87	0.89	0.75	0.65	0.87	1.03	0.62	0.65	0.54	0.55
Gap in the employment rate between those with a long-term health condition	11.5	9.0	13.3	16.5	10.6	15.0	16.6	17.8	15.5	11.6
Average weekly earnings	£440	£444	£417	£355	£388	£438	£423	£429	£395	£466
Gender pay gap	19.1	38.3	31.5	17.7	12.1	17.2	29.5	21.6	16.1	25.6
Children in low income families	17.0	21.0	15.1	19.8	19.6	9.4	17.2	11.9	15.3	11.9
Income Deprivation Affecting Older People	16.2	18.6	13.8	17.0	17.6	9.1	14.4	12.7	13.6	11.6
Employment and Support Allowance Claimants	5.4	7.2	6.0	8.0	8.4	4.0	5.3	5.4	6.6	4.4
<b>Health Behaviours</b>										
Smoking prevalence in adults	14.4	19.2	15.4	18.2	17.3	9.5	11.0	15.5	9.3	14.4
Smoking prevalence in adults - Routine and Manual Occupations	25.4	33.2	31.0	25.1	34.2	22.2	13.5	30.3	9.6	16.8
Smoking in pregnancy	10.8	16.2	16.2	18.6	11.7	13.5	18.1	13.1	15.6	16.2
Excess weight in children (4-5 year olds)	22.4	22.4	21.2	25.3	25.5	23.4	24.9	24.9	23.1	23.5
Excess weight in children (10-11 year olds)	34.3	36.8	31.1	39.5	34.1	26.5	33.9	31.3	33.6	33.2
Excess weight in adults	62.0	65.5	62.8	69.7	71.1	54.2	65.8	57.3	70.8	66.9
Physically inactivity, 18+ years	22.2	65.1	21.3	25.3	19.8	19.0	22.6	21.6	21.2	23.7
Alcohol specific hospital admissions - Under 18 years	32.9	33.8	27.9	53.1	46.7	31.5	30.3	61.7	50.8	27.7
Alcohol specific hospital admissions	569.9	780.4	491.9	577.3	938.2	471.0	553.8	644.0	551.6	430.1
Chlamydia detection rate (15-24 years)	19.7	22.3	19.7	16.6	22.7	13.1	22.1	9.4	17.6	18.8
Self-harm - emergency admissions	185.5	259.2	179.7	288.5	444.5	166.5	226.0	183.4	229.0	172.7
Suicides	9.6	7.3	8.7	8.9	10.8	8.5	7.8	7.1	9.2	9.0
<b>Natural, Built and Living Environment</b>										
Mortality attributable to air pollution	5.1	5.7	4.8	4.6	4.0	3.8	5.6	3.5	4.1	5.1
Average particulate matter	9.3	11.3	9.7	9.3	8.5	7.9	11.1	7.4	8.7	10.3
Density of fast food outlets	88.2	104.2	78.3	86.8	117.9	67.3	87.7	98.5	68.4	59.0
Average minimum travel time in minutes by public transport or walking to reach key services	17.7	16.5	19.0	20.0	16.2	25.6	18.9	19.8	19.3	21.6
Housing affordability ratio	7.9	5.1	5.3	5.3	5.5	7.9	5.4	6.1	6.6	6.3
Owner occupied tenure	62.9	60.2	76.5	63.1	61.1	75.7	64.9	69.1	68.7	78.3
Older people living alone - Estimated Households (65+ years)	45.1	47.2	41.7	44.9	45.7	42.7	43.9	44.6	41.2	39.1
Emergency admissions due to falls, 65+ years	2170.0	2306	2071	2343	2678	2118	2242	2327	2172	2390
Statutory homelessness	2.4	4.5	1.4	0.8	0.5	1.4	0.3	0.8	0.3	2.9
Housing in non-decent condition - proportion of LA owned housing stock	4.4	0.0	0.0	7.2	0.0	0.0	0.0	16.3	10.3	0.0
Fuel poverty	11.1	13.2	12.4	11.7	11.9	10.9	12.3	10.6	11.4	10.5
Crime Severity Score	3.8	16.7	9.5	9.9	10.7	6.9	10.3	8.1	7.3	9.2

	England	Derby City	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire
<b>Health Outcomes - Length and Quality of Life</b>										
Life Expectancy at birth - Females	83.1	82.7	82.6	81.5	82.1	84.2	83.4	83.3	82.9	82.5
Life Expectancy at birth - Males	79.6	78.5	79.6	77.9	77.9	80.8	79.5	79.9	79.7	79.3
Difference in average life expectancy years between most and least deprived - Females	7.4	8.5	8.5	4.5	8.1	3.0	4.6	7.5	7.6	7.7
Difference in average life expectancy years between most and least deprived - Males	9.4	10.0	10.0	6.2	9.9	3.5	9.6	9.1	8.2	6.9
Neonatal Mortality and Stillbirths	7.1	8.2	7.3	7.1	5.4	2.1	7.2	7.6	4.3	9.1
Premature Mortality - CVD	72.5	83.5	69.6	68.2	89.7	48.1	73.6	62.3	61.2	58.6
Premature Mortality - Respiratory	34.3	42.9	34.6	44.2	49.4	20.9	26.9	34.2	29.2	32.3
Premature Mortality - Cancer	134.6	142.2	127.5	169.3	155.7	121.6	138.4	130.3	129.6	142.6

Sources: Public Health Profiles, Available at: <https://fingertips.phe.org.uk> and NOMIS Local Authority Profiles, Available at <https://www.nomisweb.co.uk/> , Accessed September 2019

*The Derbyshire Model of Care is built upon delivering more personalised care approaches and this is embedded throughout our programmes of work and our focus on prevention. The table below provides a snapshot of personalised care LTP commitments and alignment to the JUCD programmes of work.*

	A Snapshot Summary of JUCD programmes of work in relation to the 6 principles of personalised care.
Personal Health Budgets	<ul style="list-style-type: none"> <li>PHB as default in Continuing Healthcare (Domiciliary care) and Wheelchair budgets are already implemented in Derbyshire. Children &amp; Young People with Continuing Care eligibility are also offered a PHB.</li> <li>LD/ Autism – Where possible people will be enabled to have a personal health budget, with plans to review current use of PHB's to support people with LD &amp;/or ASD outside of CHC, identify gaps (19/20) and develop implementation plan (20/21).</li> <li>Mental Health – People entitled to Section 117 aftercare have been identified as the next cohort of people who will have a legal right to have PHBs; implementation plan is in development.</li> </ul>
Social prescribing	<ul style="list-style-type: none"> <li>Primary Care Networks - formation and the roll out of employing Social Prescribing link workers</li> <li>Place - identify the action to understand the existing Social Prescribing offer and identify potential improvements to support Frailty.</li> <li>Social Prescribing and Health Coaching is included in Future Service Model for Long Term Conditions (Disease) Management.</li> </ul>
Personalised Support and Care Planning (PSCP) and Enabling choice	<p>Approaches are identified in many care pathways via JUCD workstream Outline Business cases – examples of which are:</p> <ul style="list-style-type: none"> <li>Maternity - Continuity of Carer model and Derbyshire Personalised Maternity Care Plan.</li> <li>CVD - upskilling and building confidence for front line staff in early identification and personalised support of people with CVD conditions.</li> <li>MSK Individual Placement and Support (IPS) in regard to peoples goals about work.</li> <li>Learning Disability/Autism People with learning disabilities and/or autism must feel that they own their (co-produced) plans so we all know how best to look after them.</li> <li>EoL Care Planning and Respect: Ensure a focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney, 'living wills' and Respect Forms</li> <li>PHB SEC 117 aftercare PSCP is integral to all PHB offers</li> </ul>
Shared Decision Making	<ul style="list-style-type: none"> <li>We will work with RightCare colleagues to identify the most impactful situation to develop Shared decision Making in Derbyshire in order to reduce clinical variation.</li> <li>This will be based on completion of the SDM checklist and self assessment to support the Derbyshire System in establishing a baseline and next steps.</li> </ul>
Supported self - management	<p>Health coaching, peer support, education programmes:</p> <ul style="list-style-type: none"> <li>Public Health - Staff trained in coaching approaches. This allows service users and service providers to work together to work out what matters most to them. These conversations take place in a wider context of health messaging, conversation tools and promotion of NHS digital resources.</li> <li>Living well with autism self-management programme in place for all recently diagnosed adults</li> <li>LD/ Autism - Develop a greater focus on person centred care across the system. including digital flag to identify patients who require reasonable adjustments.</li> <li>Self-management, Education, Social Prescribing and Health Coaching etc. included in Future Service Model for Long Term Conditions Management</li> <li>CRHFT Transition worker to engage young people with type 1 and type 2 diabetes to improve self-management attend clinic appointments and improve use of medication.</li> <li>Staff to complete good quality foot assessments and provide consistent self-management advice and Health Coaching (diabetes).</li> <li>Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20;</li> <li>Maternity - Information &amp; involvement – Personalised care planning; every woman and her partner feels they were listened to and involved in their care</li> <li>CYP - Advice and prevention – Parents and practitioners will be able to obtain advice within the community to give them the confidence to support the child appropriately. If they are still not confident in addressing the need they will know when, where and how to seek early intervention.</li> <li>MSK - Improved self-management by patients and reduced necessity to access services and clinically avoidable interventions</li> <li>Mental Health - Plans for the delivery and required investment for digitally enabled transformation across mental health pathways will be developed in 2019/20:: <ul style="list-style-type: none"> <li>Pathways identified to test digitally enabled care</li> <li>Every person will be able to access their care plans</li> <li>Digitally enabled models of therapy being rolled out in specific mental health pathways.</li> <li>Digital processes to support clinical monitoring</li> <li>A range of management apps/ digital consultations</li> <li>Digital clinical decision making tools</li> </ul> </li> <li>Cancer - Patients are supported to live well for longer in the community through the offer of a health and wellbeing programme - Active Recovery and 'Wellbeing for All' programmes will also support the patient experience and satisfaction</li> <li>Respiratory - Expanded provision of access to digital and face-to-face structured education and self-management support tools.</li> <li>Dementia extend Dementia Connect programme</li> </ul>

The table below sets out the sequential planning of the Personalised Care trajectories for the Derbyshire system; as we develop our approach the governance processes for managing the programmes of work and how they will feed into system priorities and reporting structures will also be confirmed.

5 year ambition – Personalised Care and Support Planning	19/20	20/21	21/22	22/23	23/24
<b>Personal Health Budgets</b>	Target 1,080 to be met by: <ul style="list-style-type: none"> <li>Confirming priority cohorts and trajectories</li> <li>Developing s.117 PHB offer</li> <li>Reviewing current use of PHBs to support people with LD &amp;/or ASD outside of CHC, identify gaps and developing plan.</li> </ul>	Target 1,620 to be met by: <ul style="list-style-type: none"> <li>Development of implementation plan based on gaps identified within review of current use of PHBs outside of CHC.</li> <li>Commencing s.117 PHB offer implementation.</li> <li>Identifying new s.117 cohort.</li> <li>Embedding PHB's to deliver interventions as identified in individuals care and support plans, alongside CHC and S117 entitlements.</li> </ul>	Target 2,160 to be met by: <ul style="list-style-type: none"> <li>Rolling out s.117 PBH's</li> <li>New cohort in place, further priority cohort identified.</li> </ul>	Target 2,700 to be met by: <ul style="list-style-type: none"> <li>s.117 fully in place</li> <li>Two cohorts fully in place, final priority cohort identified.</li> </ul>	Target 3,240 to be met by: <ul style="list-style-type: none"> <li>s.117 fully in place</li> <li>All additional cohorts in place.</li> </ul>
<b>Social prescribing (SP)</b>	<ul style="list-style-type: none"> <li>Complete recruitment of SP link workers</li> <li>SP advisory group and agreed plan developed.</li> <li>Recruit to Mental Health SP roles in Hubs.</li> <li>Plans identified for targeting 1,026 referrals through SP link workers.</li> <li>Scope 'community connector' programmes across system via Integrated Volunteering Approaches Programme.</li> </ul>	<ul style="list-style-type: none"> <li>Plans identified for targeting 4,105 referrals through SP link workers and MH link workers in MH Hubs.</li> <li>Replicate and develop best practice, by exploring current programmes such as 'community connectors', and adding value to social prescribing services and outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>Plans identified for targeting 8,209 referrals including SP link workers, community connectors and MH link workers.</li> <li>Scope the next LTC pathway to target for PCSP development</li> <li>Develop at scale implementation plan for community connectors</li> </ul>	<ul style="list-style-type: none"> <li>Plans identified for targeting 12,314 referrals through current and new routes.</li> </ul>	<ul style="list-style-type: none"> <li>Plans identified for targeting 16,419 referrals through current and new routes.</li> </ul>
<b>Personalised Support and Care Planning (PSCP) and Enabling choice</b>	PCSP Trajectory: 2996 <ul style="list-style-type: none"> <li>Work with the national team to develop planned cohorts for interventions.</li> <li>SEND - Review the graduated approach to ensure the right support is available at the earliest opportunity and ensure access to therapy services is available, personalised, in the right place and at the right time to help C&amp;YP access education.</li> <li>Confirm our approach to ensuring everybody approaching the end of their life is offered opportunity to create a personalised care plan.</li> <li>LD/ Autism - Development of comms plan to support roll out of key tools to support development of Personalised care and support / stay well plans.</li> <li>Cancer - Patients will have a follow-up pathway in the right setting for them.</li> </ul>	PCSP Trajectory: 4,404 <ul style="list-style-type: none"> <li>Community provision for Physical Health Services - Review of top 5 'high needs' C&amp;YP and their combined packages to establish pathways specific to them.</li> <li>Disease management - support upskilling and building confidence for front line staff in early identification and personalised support</li> <li>LD/ Autism - Further development care provider market to increase personalised community care provision</li> <li>Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at throughout the pathway.</li> <li>All pregnant women have a personalised care plan.</li> <li>Confirm system approach to supporting patients with cancer to undertake a holistic needs assessment and care plan based on examples of good practice.</li> </ul>	PCSP Trajectory: 8,307 <ul style="list-style-type: none"> <li>Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway.</li> <li>All pregnant women have a personalised care plan.</li> </ul>	PCSP Trajectory: 13,342 <ul style="list-style-type: none"> <li>Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway.</li> <li>All pregnant women have a personalised care plan.</li> </ul>	PCSP Trajectory: 18,068 <ul style="list-style-type: none"> <li>Cancer - All patients will be offered the opportunity to undertake a holistic needs assessment and care plan at different stages throughout the pathway.</li> <li>All pregnant women have a personalised care plan</li> </ul>
<b>Shared Decision Making</b>	<ul style="list-style-type: none"> <li>Liaise with Rightcare colleagues to establish areas of unwarranted clinical variation, checking alignment with the national 30 'high value' clinical situations.</li> <li>Engage with national team to source Shared Decision Making checklist and self assessment</li> </ul>	<ul style="list-style-type: none"> <li>Develop action plan based on SDM checklist and self assessment.</li> </ul>	<ul style="list-style-type: none"> <li>Implement action plan</li> </ul>	<ul style="list-style-type: none"> <li>TBC</li> </ul>	<ul style="list-style-type: none"> <li>TBC</li> </ul>
<b>Supported self - management</b>	PAMS target - 2,052 to be met by: <ul style="list-style-type: none"> <li>Engaging with national team for support on PAMs.</li> <li>Identify priority area for implementation – potentially this would be the Long term Conditions pathway</li> <li>Reviewing work completed in other areas with cancer survivors including peer support and social prescribing to inform a Derbyshire approach.</li> <li>Cancer - patients will be offered enhanced supportive care at the earliest opportunity and will be supported to self-manage their condition following treatment.</li> </ul>	PAMS target - 4,105 to be met by: <ul style="list-style-type: none"> <li>Development of plan for PAMS training implementation in priority area.</li> <li>Identify additional priority area.</li> <li>Share success of PAMs impact to build system wide support.</li> <li>Cancer - Breast patients will receive personalised care, tailored to their needs.</li> </ul>	PAMS target - 7,183 to be met by: <ul style="list-style-type: none"> <li>Development of implementation plan for second priority area</li> <li>Identify additional priority area and PAMs administrators</li> <li>Cancer - Prostate and Colorectal patients will receive personalised care, tailored to their needs.</li> </ul>	PAMS target - 11,288 to be met by: <ul style="list-style-type: none"> <li>Development of a plan to for PAMs implementation in third priority area</li> <li>Identify additional priority area and administrators</li> </ul>	PAMS target - 15,393 to be met by: <ul style="list-style-type: none"> <li>Development of a plan to for PAMs implementation in fourth priority area</li> <li>Identify additional priority area and administrators</li> </ul>

<p><b>Improving experience of care : High quality and safe use of medicines</b></p> <ul style="list-style-type: none"> <li>• System partnerships working to develop a STP/ICS/ICP vision and strategy for Pharmacy &amp; medicines optimisation</li> <li>• Work with system counterparts, pharmacy/GP/nursing/AHPs to deliver the strategy</li> <li>• Maintain and develop the STP wide medicines safety network, including responding to serious incidents and learning plus systems to avoid harm from errors and sub optimal medicines use</li> <li>• Integrated working to support the Antimicrobial Resistance Strategy</li> <li>• System strategies to avoid risks due to transfer of care including digital solutions</li> <li>• Ensure strategies support urgent care focusing on self care to manage minor conditions and to prevent avoidable medicines harm</li> <li>• Promote medicines safety through the use of clinical systems, including decision support tools, clinical audit and risk stratification, repeat prescribing, patient Apps</li> </ul>	<p><b>Improving the health of the population: Delivering effective interventions</b></p> <ul style="list-style-type: none"> <li>• Strategic and professional leadership to ensure medicines decisions are evidence &amp; outcome based, safe and cost-effective</li> <li>• System partnership working to ensure medicines are prescribed, supplied and managed safely providing maximum health benefits through enabling and delivering medicines optimisation</li> <li>• Set and maintain a collaborative style of working across the STP to ensure best outcomes, avoiding waste and duplication, and identifying care gaps</li> <li>• Ensure system strategies are in place to involve public consultation on commissioned services where relevant for medicines</li> <li>• Support strategies for patient shared decision making and concordant use of medicines promoting high quality medication reviews addressing polypharmacy and de-prescribing in line with the national agenda</li> <li>• Promote and act as an enabler to support wider prevention strategy including self care, health optimisation policy, proactive use of medicines and health tech in care pathways</li> </ul>
<p><b>Reducing the per capita cost of healthcare: Value use of medicines</b></p> <ul style="list-style-type: none"> <li>• Oversight of the Provider Trust CIPs and CCG medicines QIPP (value programme) – ensure cross sector collaboration with all providers including PCNs/GPs and community pharmacy to maximise opportunity</li> <li>• Utilise system wide business intelligence to identify clinical variation and prioritise opportunity for reducing unwarranted variation e.g. RightCare</li> <li>• Provide professional leadership on the development of transformational medicines optimisation initiatives across the system to drive future value</li> <li>• Ensure robust strategic level clinical decision which both informs and enables cost effective local use of medicines, clinical interventions and technologies</li> <li>• Scope future prescribing financial models to establish benefits of ICS/ICP system control totals and drug expenditure incentives</li> </ul>	<p><b>Improving staff experience and resilience: Skilled and agile Pharmacy workforce</b></p> <ul style="list-style-type: none"> <li>• Develop and implement a pharmacy workforce plan across the STP</li> <li>• Work with PCNs to support the development of GP practice clinical pharmacists and technicians as per the LTP</li> <li>• Enhance and develop integrated care pharmacist and technician specialists working for both primary and secondary care</li> <li>• Offer professional clinical leadership, education support and strategies to improve competencies for the use of medicines for prescribers across an integrated care system</li> <li>• Work with system providers, NHSE, AHSN to develop a Derbyshire career pathway for the pharmacy workforce to include trainee to senior management levels. Enabling opportunities for cross sector workforce experience and development to aid and improve transition between sectors</li> </ul>

Mental Health Investment Standard								
	2019/20	2020/21	2021/22	2022/23	2023/24	LTP Investment Ambitions	Total Investments	Total Investment %
Children & Young People's Mental Health (excluding LD)	10,843	12,892	13,441	14,490	15,667	3,422	4,823	141%
Children & Young People's Eating Disorders	835	1,033	1,046	1,055	1,065	230	230	100%
Perinatal Mental Health (Community)	1,338	2,501	3,113	3,907	4,021	2,683	2,683	100%
Improved access to psychological therapies (adult and older adult)	10,970	12,048	13,393	14,748	17,170	5,579	6,200	111%
A and E and Ward Liaison mental health services (adult and older adult)	3,271	3,768	3,768	3,768	3,768			
Early intervention in psychosis 'EIP' team (14 - 65)	3,750	3,750	3,750	3,750	3,750			
Adult Community Crisis (adult and older adult)		39,921	40,636	40,666	40,695	1,945	2,996	154%
Ambulance response services		435	661	897	1,270	1,270	1,270	100%
Community mental health, including new integrated models (adult and older adult, excluding dementia)		44,171	44,433	45,282	48,822	7,583	7,863	104%
Crisis resolution home treatment team (adult)	5,783							
Community Mental Health	40,959							
Mental Health Act	1,500	1,500	1,500	1,500	1,500			
SMI Physical Health	350							
Suicide Prevention	0	0						
Acute inpatient services (adult and older adult)		141	234	473	839	839	839	100%
Other adult and older adult - inpatient mental health (excluding dementia)	53,729	56,623	59,863	62,194	60,771			
Other adult and older adult mental health - non-inpatient (excluding dementia)	31,916							
Mental health prescribing	10,807	7,628	7,628	7,628	7,628			
Mental health in continuing care	0		0	0	0			
<b>Sub-total - MH Services (exc LD &amp; Dementia)</b>	<b>176,050</b>	<b>186,410</b>	<b>193,466</b>	<b>200,357</b>	<b>206,965</b>			
<b>Growth in CCG allocations</b>	<b>5.4%</b>	<b>3.9%</b>	<b>3.8%</b>	<b>3.6%</b>	<b>3.3%</b>			
Required growth above allocations	0.7%	1.7%	0.0%	0.0%	0.0%			
Total required growth in MH spend	0.7%	5.6%	3.8%	3.6%	3.3%			
Required MH spend to meet MHIS	176,050	186,410	193,466	200,357	206,965			
MHIS achieved (Planned spend is equal to or greater than Required MH spend)		OK	OK	OK	OK			

The MHIS investments contained within the LTP submission have been realigned into the LTP categories and assessed against the Mental Health ambitions tool. Most of the categories should align with the additional investment contains within the ambitions tool kit and to clarify investment in other community based crisis and acute adult mental health services have been included in the Adult Community Crisis category. However there are some services where investments are over and above the ambitions tool kit however this is due to a higher forecast outturn for 2019/20 which has continued into future years due to the commitments already made. For example CYPMH investment through the life of the plan is higher than required investment in the ambitions tool kit but this is due to the recurrent investments made in 2019/20 which are higher than the original plan for 2019/20.



## Workforce Implications of transformation delivery plans

## APPENDIX 5

*Workforce Development Leads from across the system are working with Transformation Workstreams to identify and implement the implications of the transformation plans on our people, and to ensure that our workforce and OD support offer is aligned to their needs.*

The following table summarises the key workforce themes from the delivery plans set out previously in this document and gives examples under each which will be addressed through our workforce and OD plans:

Introducing New Roles	Establishing New Teams	Changes in care setting	Training and Development
We have run a pilot for a Health and Care Worker apprentice who we envisage working in our integrated Place based teams	LD and autism - development of intensive support teams (crisis and forensic)	Mental Health focused Maternity Outreach Clinics	New cancer screening pathways, increasing uptake of screening and self management particularly among BME communities
Implementation of Key Worker role for all C&YP with LD and autism complex needs	increase access to specialist community perinatal mental health services	Left shift of ophthalmology and MSK services	Changes in the models of care for CVD and stroke and respiratory
Develop keyworkers for children and young people with the most complex needs and their carers/families	Bring IAPT therapists into integrated PCN teams,	County wide approach to theatre utilisation	Recognising and addressing cognitive impairment as part of the Aging Well Programme
Consider increase in midwife sonographers	Establish MH Urgent Care Crisis Teams across the county	Urgent Care Treatment Centres as part of integrated urgent care community offer	Introduce 'All staff are prepared to care' education programme to promote proactive and personalised care planning for everyone identified as being in their last year of life.
Diabetes Inpatient Specialist Nurse (DISN) pathways will be developed from 2019/20 with EMAS which will enable ambulance staff to speak directly to DISN from the persons home with aim to prevent conveyance	4 x Mental Health Support Teams (MHSTs) The MHST's will be implemented within education settings	Introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls	Support the optimisation of digital solutions across all care settings specifically in CVD, stroke, planned care, cancer, LTC's, Diabetes
Trial a Medical Assistant role as part of the General Practice team	Clinical Assessment Service accessible via 111	Enhanced provision in Care Homes	System training plan for midwifery staff to support Continuity of Care

**Mental Health and LD and Autism:** The ambitions for improvements in mental health and LD and Autism services will require a specific focus on workforce.

We aspire to train and develop our workforce and offer a career development pathway to support staff. We have plans in place to develop the skills of our existing workforce to enable them to adapt to the changing service model. Continuing professional development funds will be maximised to ensure our staff have the skills and competencies to respond to changes in how and where we deliver care, reflecting the changes in acuity and dependency of our patients. We are developing new roles including the Nursing Associate and Advanced Clinical Practitioner, and extending our offer for apprenticeships. The detail of the Mental health workforce is now analysed and being worked through as the financial envelope is confirmed. Further work will explore opportunities to join up services working with our system partners including the private and voluntary sector

To ensure we have the workforce required to meet service development we are developing a range of initiatives including:-

Develop and support new roles and inter-disciplinary credentialing programmes enabling increased workforce flexibility across an individual's NHS career and between individual staff groups.

Further develop the "grow our own" initiative such as apprenticeships, work experience and volunteer schemes.

Increasing the number of Clinical Placements, we provide for students by 25% in year 1, with the expectation this will increase further in the next 3 years. Currently we provide 171 students with placements and this will increase by 54 this year.

Increasing our flexible contracts to meet the needs of a multi-generational workforce.

Currently we have a small but valued pool of active volunteers who have roles where they are directly enhancing the experience of the service receivers, supporting our inpatient and community teams. Their roles enable our staff to improve service provision and we are exploring options to increase this workforce.

## Delivering digitally enabled care

## APPENDIX 6

Our digital strategy themes have been aligned to key deliverables set out in this plan, which is demonstrated in the table below; the funding streams where relevant are also highlighted.

Key:

**Funding Sources:** 111 booking resources ✓ On-line consultation funding ✓ ETT ✓ GPFF ✓ GP Business as Usual ✓ TBA ✓ HSLI ✓ Local Resources ✓ STP Resources ✓

**Links to Strategy Themes:** Citizens ▲ Professionals ▲ Foundations ▲ Analytics ▲ Innovation ▲

	Key Deliverables	Year 1	Year 2	Year 3	Year 4	Year 5
		2019/20	2020/21	2021/22	2022/23	2023/22
Primary Care Priorities	NHS app ▲	100% of practices engaged with NHS app 1% of patients using NHS app	5% of patients using NHS app NHS app used for all Online consultation products	20% of patients using NHS app	50% of patients using NHS app No excluded patients	NHS app used for all routine non face to face contacts
	111 Direct Booking ✓ ▲ ▲	100% of GP practices receiving direct booking from 111 service	111 service booking all relevant patient contacts into GP practices	Business As Usual	Business as Usual	Business as Usual
	Online Consultation ✓✓✓ ▲ ▲ ▲	100% of practices engaged with online booking programme 70% of Derbyshire population with access to Online consultations All GP extended access hubs engaged with Online consultations	100% of Derbyshire patients with access to online consultations, either directly with the practice or through the extended access hubs	Business as Usual	Business as Usual	Business as Usual
	GP connect ✓ ▲ ▲	GP Connect deployed in EMIS GP Practice sites	GP connect deployed in all practices	Business as Usual	Business as Usual	Business as Usual
	GP systems ✓ ▲ ▲	TPP S1 75%; EMIS 25%	GP Futures contract implemented	Business as Usual	Business as Usual	Business as Usual
	Referral Support ✓ ▲	Local Referral support system 'Pathfinder' deployed in pilot practices	Pathfinder used throughout Derbyshire	National products phasing in	National products	National products
	Lloyd George Record Scanning ✓ ▲	Evaluation of local scope	Pilot project(s) implemented	100% LG records scanned	Fully electronic records	N/A
Common Applications (Cross-workstream support)	Single Health Record ✓ ▲ ▲ ▲	Consolidation of non-acute patient records on TPP S1 platform Acute secondary care systems interfacing across UHDB (South Derbyshire) Review GDE FF bid options	Implement GDE FF bid recommendations Develop LHCRE response including review of MIG ( Medical Interoperability Gateway) future development/replacement	Procure/early adopter single patient record system	Single health record in place across all key services/sites	Completion of Single health record deployment and move to Business as Usual
	Patient access ✓✓ ▲	NHS app deployed in primary care (see above) Patient direct access to maternity systems (North Derbyshire) Patient access to UHDB letters via PKB	Expansion of secondary care patient access systems via PKB and other systems	Combined primary care/secondary care access projects	National applications available (working assumption)	National applications adopted
	Specialist Analytics ✓ ▲	Local models based on RAIDR and other supplementary systems	Pan-Derbyshire data model Procurement of joint system early adoption of national products (working assumption)	Pan-Derbyshire data service supplemented by implementation of national 'data lake' applications	Full adoption of national models	Business as Usual
	Telehealth ✓✓ ▲ ▲	Pilot projects, based on individual workstream needs Early adopter GP practices	Roll-out of telehealth through primary care & secondary care settings	Integrated options available for patients participating in MDT consultations	Business as Usual	Business as Usual

## Delivering digitally enabled care

## APPENDIX 6

Our digital strategy themes have been aligned to key deliverables set out in this plan, which is demonstrated in the table below; the funding streams where relevant are also highlighted.

Key:

**Funding Sources:** 111 booking resources ✓ On-line consultation funding ✓ ETTF ✓ GPfV ✓ GP Business as Usual ✓ TBA ✓ HSLI ✓ Local Resources ✓ STP Resources ✓

**Links to Strategy Themes:** Citizens ▲ Professionals ▲ Foundations ▲ Analytics ▲ Innovation ▲

	Key Deliverables	Year 1 2019/20	Year 2 2020/21	Year 3 2021/22	Year 4 2022/23	Year 5 2023/24
Non-Core Functionality (specific to individual providers)	Cancer ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps	Deploy apps at scale	Business as Usual	Business as Usual	Business as Usual
	Children's ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps Develop 'patient story' specification	Deploy apps at scale procure and implement 'patient story' functionality	Business as Usual	Business as Usual	Business as Usual
	CVD ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps	Deploy apps at scale Develop a business case for 'intelligent devices'	Deploy 'intelligent devices'	Business as Usual	Business as Usual
	Diabetes ✓ ▲ ▲	Specify telehealth options Develop 'patient story' specification	Procure and implement 'patient story' functionality Telehealth functionality in place	Patients routinely communicate blood results electronically	Business as Usual	Business as Usual
	End of Life ✓ ▲ ▲	Implement cross organisational EoL functionality	All partners have online access to patient care preferences Review assisted technology options	Implement assisted technology to patients	Business as Usual	Business as Usual
	Improving Flow ✓ ▲	Full specification of 'Improving flow' requirements	Implementation of 'Improving flow' recommendations Review assisted technology options	Implement assisted technology to patients	Business as Usual	Business as Usual
	LD and Autism ✓ ▲ ▲	Define requirements for patient apps Procure pilot apps  Ensure patient 'reasonable adjustment' flag is provided	LD and Autism patient records fully integrated (with appropriate security) within overall patient record Deploy apps at scale. Implement data set for flag to indicate where patients have needs for 'reasonable adjustment'	Business as Usual	Business as Usual	Business as Usual
	Maternity ✓ ▲ ▲	Three separate maternity systems in place Complete deployment of electronic access to patients in North of the County	Review options for single Pan-Derbyshire maternity system (either fully integrated within mainstream patient record, or as interfaced offer) Expand patient access to UHDB patients	Implement combined maternity digital offer	Business as Usual	Business as Usual
	Mental Health ✓ ▲	Consolidation of mental health systems on TPP S1 Review future of 'locked estate' systems	Define requirements for patient apps Procure pilot apps	Business as Usual	Business as Usual	Business as Usual
	Place ✓ ▲ ▲ ▲	Strengthen 'Place-based' Digital option through consolidation on TPP S1 platform and MIG ( Medical Interoperability Gateway)	Single 'Place' platform throughout Derbyshire MIG ( Medical Interoperability Gateway) phased-out except in exceptional circumstances	Review unified 'Place' system requirement, potentially moving to procurement of new system	Implement review implementations	Business as Usual
	Planned Care ✓ ▲ ▲	Define planned care-specific options for integrated patient record Specify 'tactical' PBC apps with aim of supporting specific patient channel offers	Utilise 'pathfinder' referral support systems, together with cross-setting joint working solutions to develop strategic planned care systems Integrate planned care systems with intelligence-based analytic systems	Implement strategic planned care system	Business as Usual	Business as Usual
	Respiratory ✓ ▲	Specify telehealth options Develop 'patient story' specification	Implementation of 'Improving flow' recommendations Review assisted technology options	Patients routinely communicate respiratory results electronically	Business as Usual	Business as Usual
Other	Urgent Care ✓ ✓ ▲ ▲ ▲	Define Urgent care-specific options for integrated patient record Specify 'tactical' UEC (Urgent and Emergency Care) apps with aim of supporting specific patient channel offers	Utilise 999 and 111 system integration with local systems, supported by online patient access offer to develop strategic urgent care systems Integrate UEC (Urgent and Emergency Care) systems with intelligence-based analytic systems	Implement strategic urgent care system	Business as Usual	Business as Usual
	Support for Social Care achieving DSPTK ✓ ▲	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas	Social Care (Derbyshire County Council and Derby City Council) achieves minimum DSPTK standards in all areas



## Themes arising from engagement in the plan

## APPENDIX 7

Our plan was underpinned by a comprehensive programme of engagement activities see page 48, which resulted in the themes below being highlighted.

These themes have shaped and informed our STP plan submission, and influenced on-going planning work for JUCD, the full details can be found in the 'News Section' of our website.

	Theme
1	<b>PRIORITIES</b> <ul style="list-style-type: none"> <li>• People generally welcomed all the priorities in the plan but wanted more assurances that the programmes of work would be 'joined up', and not working in silos.</li> <li>• It was felt that it would be a good idea to identify extra-ordinary priorities requiring extra-ordinary effort, as it is unlikely that we can focus on all the priorities at once.</li> <li>• The 'how' was important to people, i.e. how would the priorities be implemented.</li> </ul>
2	<b>COMMUNICATION AND ENGAGEMENT</b> <ul style="list-style-type: none"> <li>• People welcomed the opportunity to comment on the plans, but wanted more ongoing communication and the opportunity to get involved, so they could influence decision making.</li> <li>• It was felt that more engagement was needed to change mind-sets, behaviours, and promote self-care amongst the general population.</li> <li>• People want to be engaged in a timely manner about potential cuts, and changes to services. They want to be informed about the benefits to them of the changes. Where they have been asked about their experience or opinion, they would like to have feedback.</li> </ul>
3	<b>PERSONALISATION</b> <ul style="list-style-type: none"> <li>• The plan needs more emphasis on personalised care.</li> <li>• People felt that throughout transformation choice is important and maintaining it.</li> <li>• It was felt that patients and professionals should make joint decisions on any health or care treatment</li> </ul> <p>• It needs to be clear that patient is at the centre of all decisions in JUCD, not felt that this is emphasised enough currently, e.g. not in executive summary.</p> <p>• It should be acknowledged that the patient is often the expert in their own condition. Important for people to be empowered to take control of their condition.</p> <p>• It was highlighted how important it is for people to receive sufficient information to be able to make choices about their health and care treatment. Information should be forthcoming and in a way that patients and carers can understand. People preferred this information to come from their GP. People feel confident with good information.</p> <p>• Health information needs to be shared widely in as many settings and via as many mediums as possible in order for these plans to work</p>
4	<b>NHS FOCUSED/WIDER DETERMINANTS OF HEALTH/INTEGRATED CARE</b> <ul style="list-style-type: none"> <li>• People felt the plan was still very NHS focused, and needed more reference to integration, acknowledging the different layers of the local authority, e.g. district councils.</li> <li>• People welcomed the move to focusing on the wider determinants of health, but felt that the priorities still reflected improvements in services, rather than wealth, education, and prevention.</li> <li>• The link between the wider determinants of health and the STP's Quadruple Aim needs to be made more explicit.</li> <li>• Voluntary Sector key to addressing Wider Determinants of Health</li> <li>• People wanted to emphasise the importance of ensuring different services communicate with one another.</li> <li>• People felt seeking help for more than one condition was much harder.</li> </ul>
5	<b>IT, DATA INTELLIGENCE AND SHARING INFORMATION</b> <ul style="list-style-type: none"> <li>• Better collection, sharing, and use of data was seen as key.</li> <li>• Choice around use of online services.</li> </ul>
6	<b>CULTURAL CHANGE -</b> <ul style="list-style-type: none"> <li>• People felt the plan needed more emphasis on the cultural change need to ensure joined up working and an acknowledgement of the enormity of this task.</li> </ul>
7	<b>VOLUNTARY AND COMMUNITY SECTOR (VCS)</b> <ul style="list-style-type: none"> <li>• There is a need to see the VCS as partners, and engage with them as a provider of services.</li> <li>• Recent cuts have caused concern to Social Prescribing Offer.</li> </ul>

## Themes arising from engagement in the plan

Our plan was underpinned by a comprehensive programme of engagement activities see page 48, which resulted in the themes below being highlighted.

These themes have shaped and informed our STP plan submission, and influenced on-going planning work for JUCD, the full details can be found in the 'News Section' of our website.

## APPENDIX 7

8	<b>FINANCE</b>
	<ul style="list-style-type: none"> <li>The finance is confusing, and this is impacting on the trust people have in the plans.</li> </ul>
9	<b>WORKFORCE</b>
	<ul style="list-style-type: none"> <li>Workforce is seen as a huge challenge, but also a big opportunity to join up, if we stop working in silos.</li> <li>There was concern around how the changes taking place were impacting on staff causing uncertainty and instability.</li> </ul>
10	<b>PLACE BASED WORKING</b>
	<ul style="list-style-type: none"> <li>The term Place was not felt to be widely understood, or whether indeed people would identify with Place.</li> <li>There was concern over the tension/confusion between Primary Care Networks and Place.</li> <li>Links to other Governance structures should as Health and Wellbeing Boards wasn't clear.</li> </ul>
11	<b>PREVENTION</b>
	<ul style="list-style-type: none"> <li>There were concerns over the commitment to prevention.</li> <li>Importance of education to be more healthy.</li> <li>Prevention considered fundamental but funding needs to follow.</li> </ul>
12	<b>URGENT CARE</b>
	<ul style="list-style-type: none"> <li>People were concerned over capacity of 111 to be the single point of action for all urgent care.</li> <li>One size fits all approach doesn't take into account needs of rural areas.</li> <li>People felt there needed to be more information about where to go if they get ill or injured.</li> <li>Quick and easy access to the relevant help and treatment was seen to be vital.</li> </ul>
13	<b>IMPROVING FLOW</b>
	<ul style="list-style-type: none"> <li>Concerns over Pathway 2 capacity.</li> <li>Concerns over closer of beds at community hospitals.</li> <li>People want to be able to stay in their own home for as long as possible with the right support</li> <li>What evaluation has been done/evidence this is the right model</li> </ul>
14	<b>END OF LIFE</b>
	<ul style="list-style-type: none"> <li>People want to feel well supported at the end of life.</li> </ul>
15	<b>CARERS</b>
	<ul style="list-style-type: none"> <li>Want to feel listened to, and included in early conversations (where appropriate), about their loved ones health.</li> <li>Carers need their own health and wellbeing needs supported.</li> <li>Need to stop having to repeat the same information over and over.</li> </ul>
16	<b>ACCESS</b>
	<ul style="list-style-type: none"> <li>To be able to access timely help and treatment when needed, e.g. access to a GP, or support groups.</li> <li>Access to support following diagnosis e.g. specialist nurses and support groups</li> <li>Reasonable adjustments for people with LD to support access</li> </ul>
17	<b>JOINING UP ACROSS BORDERS</b>
	<ul style="list-style-type: none"> <li>People wanted assurances that JUCD works with other STP's and ICS's to join up pathways across borders.</li> </ul>
18	<b>FRAILITY</b>
	<ul style="list-style-type: none"> <li>Identification, assessment, and management of frailty should be a priority for JUCD.</li> <li>It was suggested that we might want to change terminology from elderly to older or frail throughout the plan.</li> </ul>
19	<b>MENTAL HEALTH</b>
	<ul style="list-style-type: none"> <li>Needs to be a priority.</li> <li>Seen as the poor relation to physical health/Need to join up Mental and Physical Health services</li> <li>Better urgent and emergency provision.</li> </ul>

*CDEL Calculation*

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Property, Land and Buildings	61,756	53,200	106,923	113,356	81,268	40,877
Plant and Equipment	29,753	19,831	23,377	22,553	22,092	21,187
IT	10,075	9,732	14,829	32,811	11,513	9,337
Other	4,056	8,245	6,400	6,400	6,400	6,400
<b>Gross Capital Expenditure</b>	<b>105,640</b>	<b>91,008</b>	<b>151,529</b>	<b>175,120</b>	<b>121,273</b>	<b>77,801</b>
Disposals / other deductions	(1,300)	(2,419)	0	0	0	0
<b>Charge after additions/deductions</b>	<b>104,340</b>	<b>88,589</b>	<b>151,529</b>	<b>175,120</b>	<b>121,273</b>	<b>77,801</b>
Less Donations and Grants Received	(4,538)	(2,682)	(1,100)	(1,100)	(1,100)	(1,100)
Less PFI Capital (IFRIC12)	(5,300)	(5,300)	(5,300)	(5,300)	(5,300)	(5,300)
Plus PFI Residual Interest	4,879	4,879	4,966	5,121	5,282	5,449
Purchase/Sale of Financial Assets/Prior Period Adjustments	0	0	0	0	0	0
<b>Total CDEL</b>	<b>99,381</b>	<b>85,486</b>	<b>150,095</b>	<b>173,841</b>	<b>120,155</b>	<b>76,850</b>

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*Funding Sources of CDEL*

	2019/20 Plan	2019/20 FOT	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Self Financed - Depreciation	41,478	40,818	46,256	45,796	45,629	44,199
Self Financed - other internal capital cash	57,433	16,480	26,217	10,393	8,480	1,559
Less Capital loan repayments, PFI capital repayments and Finance Lease payment	(16,632)	(16,626)	(18,548)	(18,514)	(18,361)	(16,804)
Interim Support Capital Investment Loans - To be Approved	0	13,528	58,384	101,595	64,602	42,447
Interim Support Capital Investment Loans - Approved	0	11,000	0	0	0	0
Other Loans inc Salix	0	0	1,500	2,000	0	0
STP Wave 1 - 4 PDC - Approved	5,344	6,352	19,983	22,514	11,485	0
Efficiency programme PDC - Approved	0	220	0	0	0	0
Other Central Programme PDC - Approved	220	0	0	0	0	0
Other PDC (incl Major Schemes) - To be Approved	6,659	8,319	11,337	4,936	3,338	0
Other PDC (incl Major Schemes) - Approved	0	556	0	0	0	0
Residual Interest	4,879	4,879	4,966	5,121	5,282	5,449
Purchase/Sale of Financial Assets/Prior Period Adjustments	0	0	0	0	0	0
<b>Net CDEL</b>	<b>99,381</b>	<b>85,526</b>	<b>150,095</b>	<b>173,841</b>	<b>120,455</b>	<b>76,850</b>

Date	Theme	Risk Description	High Level Mitigation Plans
01/03/2017	Strategy	Risk that STP Programmes of work will not deliver the agreed model of care and system wide transformational change.	STP plan refresh to strengthen alignment of transformation programmes with delivery of the model of care and financial recovery, with associated Outcomes Based Accountability (OBA) approach to clearly identify outcome indicators and performance measures.
22/08/2019	Strategy	Efforts need to be focused on ensuring that pathway and activity changes result in removal of cost across the system not simply a shift in cost.	Workstream confirm and challenge meetings scheduled to take place before the end of December 2019 to support development of workstream maturity.
22/08/2019	Strategy	Assumptions in relation to activity and finances are at a high level, the actual benefits from the initiatives described can only be accurately worked up at a specialty or procedure level as the work progresses	The action required to ensure cost out across the whole system will be established on an individual pathway and specialty basis as the opportunities are validated
01/03/2017	Delivery	There is a risk that insufficient programme resourcing across the system compromises delivery and implementation at the pace and scale required	The activity and financial impact will be established on an individual pathway and specialty basis as the opportunities are validated.
09/09/2018	Delivery	Constitutional standards and key performance indicators will not be met	All workstreams submitted their capacity requirements which have been reviewed by the CEO/FDs Group. Agreed to consider what organisations need to stop doing or do differently to release this capacity. Gaps continue to be reviewed and addressed through the CEOs group to ensure workstreams are properly resourced.
14/12/2018	Delivery	There is a risk that failure to deliver the prevention agenda by embedding within all areas of work will fail to deliver the upstream changes required to improve longer term sustainable outcomes	Workstream plans for 2019/20 developed which incorporate OBA indicators some of which are also constitutional standards. Improved monitoring and reporting of delivery through the Transformation Assurance Group to support earlier identification of remedial actions required. Quality & Performance Group established with responsibility for ongoing monitoring and reporting of system level constitutional standards. The increased focus on the prevention agenda will be driven through the Prevention strategy which was approved through JUCD Board and continues to be embedded locally with all organisations taking this through internal governance arrangements.
19/08/2019	Delivery	That the plans in neighbouring LMS will not fit well with those in Derbyshire, jeopardising what JUCD wishes to achieve and creating inequity in the offer to women who choose to access care over the Derbyshire borders.	The System Opportunities Programme identified the need to focus on the prevention agenda given the priority areas identified; this provides the opportunity to develop pathways end to end to include primary and secondary prevention. Through the Prevention Board greater alignment to workstreams taking place with named public health colleagues working with programme leads to ensure delivery plans include prevention and make stronger links to the strategy.
16/09/2019	Delivery	Continued increase in demand for Mental Health (MH) inpatient service means that LoS reduction outweighed by admissions resulting in inability to reduce out of area placements	Liaison with neighbouring LMS PMOs and sight of transformation plans. Detailed discussions over shared opportunities and risk and issues, regarding border flows. Stronger relationship and exploration of shared opportunities with Pan-Staffordshire LMS in particular.
12/09/2019	Delivery	Risk to patient safety & system reputation due to the potential cessation of inpatient MH and LD services by independent providers as a result of the national transformational care partnership work.	Crisis and Home treatment service investments during the course of 19/20 and 20/21.
06/08/2019	Delivery	Changes to models of care, activity growth, and/or commissioning adversely impacts upon the future efficiency, capacity and suitability of the project design.	Attendance at national & regional NHS E contracting meetings to gather intelligence Development of system wide contingency plan
01/03/2017	Engagement	Lack of 'buy-in' to STP due to inadequate engagement with stakeholders	Close working with users and commissioners to understand the direction of healthcare service provision, along with a flexible design solution. Monitoring of actual activity growth compared to forecasts used in modelling.
22/02/2018	Digital Technology	Service delivery and transformational change programmes are compromised due to inadequate digital technology strategy and operationalization	Engagement Committee established as part of revised STP governance. Communications and engagement (C&E) strategy refreshed. Significant engagement undertaken to support the STP Plan refresh, including the using members of the citizens panel (1500 members) to hold confirm and challenge sessions, wider stakeholder events including members of the public, MPs, voluntary sector. C&E alignment to transformation programmes strengthened with offer developed for all workstreams to utilise as part of their ongoing approach. Improved GP representation throughout STP governance Strengthened governance in place and workstream now gathering momentum and making stronger links to workstreams.
25/07/2019	Analytics	Access to data and the ability to use this to provide intelligence will prevent effective planning and monitoring of delivery	Digital strategy developed with alignment of digital technology plans to workstream transformation priorities and plans; decreasing the risk that products and services will not meet the evolving needs of the system. Pathway transformation is being designed in alignment with the Digital programme of work and the development of a digital solution to support delivery.
09/08/2018	Workforce	Increasing trend for GPs to retire early/work significantly less than full time hours impacting on primary care capacity within the system	Considerations taking place through the CEO/FDs meetings to review capacity available across the system and how it is being utilised, taking into account various strands of work in train. Meeting arranged to review and align approaches; with a proposal to be taken back to CEOs.
16/05/2019	Workforce	Insufficient emphasis and consideration of workforce challenges across the system will result in integrated care delivery being compromised	GPFV workforce plan focused on retention of GPs in the latter part of their career Programme of work commissioned through the LMC to implement targeted interventions for that cohort.
			Given the increasing focus on workforce in response to the NHS People Plan, a focused workforce discussion took place at the July JUCD Board. Through the STP refresh greater alignment and understanding of workstream plans undertaken to support development of workforce plans in response . Ensure a suitable programme of staff engagement, training, recruitment and retention is implemented