Public Document Pack

Date of meeting	**Wednesday, 10th September, 2014**
Time	**7.00 pm**
Venue	**Committee Room 1, Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffordshire, ST5 2AG**
Contact	Julia Cleary

Cabinet

AGENDA

PART 1 – OPEN AGENDA

a Appendix A - Staffordshire Better Care Fund (Revised Version) (Pages 3 - 50)

b Staffordshire Better care Fund (Annex A) Appendix 1 (Pages 51 - 102)

Members: Councillors Mrs Beech, Kearon, Turner, Stubbs (Chair), Williams, Mrs Shenton (Vice-Chair) and Hambleton

PLEASE NOTE: The Council Chamber and Committee Room 1 are fitted with a loop system. In addition, there is a volume button on the base of the microphones. A portable loop system is available for all other rooms. Should you require this service, please contact Member Services during the afternoon prior to the meeting.

Members of the Council: If you identify any personal training/development requirements from any of the items included in this agenda or through issues raised during the meeting, please bring them to the attention of the Democratic Services Officer at the close of the meeting.

Meeting Quorums :- 16+= 5 Members; 10-15=4 Members; 5-9=3 Members; 5 or less = 2 Members.

Officers will be in attendance prior to the meeting for informal discussions on agenda items.

This page is intentionally left blank

Staffordshire Better Care Fund

Version 05 09/09/14

NHS
Cannock Chase
Clinical Commissioning Group

NHS
North Staffordshire
Clinical Commissioning Group

NHS
Stafford & Surrounds
Clinical Commissioning Group

NHS
East Staffordshire
Clinical Commissioning Group

NHS
South East Staffordshire and Seisdon Peninsula
Clinical Commissioning Group

Staffordshire Better Care Fund

Introduction

This document has been developed by the partners to the Staffordshire Health and Wellbeing Board.

The people of Staffordshire need a new model of person centred coordinated health and social care. At the moment too many people spend too much time in health and care institutions that risk them losing their independence. In Staffordshire we have started the journey to this new model of care and the pooling of budgets with partners through the BCF will provide us with the next step. This will move us towards a transformation of health and social care which will focus on prevention, early intervention and integrated care as far as possible based around the home.

Staffordshire also needs to make this journey of transformation because we are one of the eleven 'national challenged' health economies. Alongside the needs of the public this economic background makes a further compelling and urgent case for change. The Health and Wellbeing Board recognised these pressures some time ago and the changes required have been clearly documented in the Joint Health and Wellbeing strategy.

To achieve this transformation we as partners must work much better together, to change behaviours. We must strengthen our population's capacity and desire for personal responsibility, independence, choice and control.

The current fragmented care does not maximise the effectiveness of the public sector purse. Our joint work means we will be able to much better use the assets that exist within service users, their carers and their communities to improve the capacity to better self-manage and maintain independence.

As a significant part of this journey, the Better Care Fund planning continues to be a work-in-progress, which aligns locally with plans for a wider-scale integrated commissioning and with the NHS 2- and 5-year plans. As we develop more detailed work plans and align our commissioning to meet agreed targets and population outcomes, we will continue to work through ongoing consultation with key stakeholders including local people, the voluntary and community sector, primary, acute and community health providers, and our social service teams.

It is recognised that the BCF and integrated commissioning work will evolve and change as we develop more detailed plans for individual schemes and service delivery areas.

As our move to integrated care is rapid, there are some areas where we have clear aspirations to commission jointly. However, plans in different parts of Staffordshire are not unified, reflecting the diversity of our population and service provision. We

embrace this variation, whilst remaining very clear in terms of the outcomes we want to deliver for local people.

The Better Care Fund has a focus on Older Adults at a national policy level, which is covered in this plan. Our plan covers broader parts of the population and includes some children's mental health services, prevention initiatives, and carer support and equipment services. In these cases, there is a clear link between interventions and a reduction in reliance on acute or long term care. This provides us with an opportunity to take full advantage of the good work already done to date in recent years around integrating resources and commissioning activity across these areas.

A number of supporting documents have been included which provide further background detail.

Contents

Appendix 1: BCF plan submission template

Staffordshire County submission

1. Plan Details

a) Summary of plan

Local Authority

Staffordshire County Council
Cannock Chase District Council
East Staffordshire Borough Council
Lichfield District Council
Newcastle-under-Lyme Borough Council
South Staffordshire District Council
Stafford Borough Council
Staffordshire Moorlands District Council
Tamworth Borough Council

Clinical Commissioning Groups

Stafford and Surrounds CCG
Cannock Chase CCG
East Staffordshire CCG
South East Staffordshire & Seisdon Peninsula CCG
North Staffordshire CCG

Boundary Differences

The CCGs together are coterminous with the County Council, subject to the usual differences between resident and registered populations

Date to be agreed at Health and Well-Being Board:

Final sign-off 11th September 2014

Date submitted:

19th September 2014

Minimum required value of BCF pooled budget	2014/15	£16,234,000
	2015/16	£56,108,000
Total proposed value of pooled budget	2014/15	£16,234,000
	2015/16	A minimum of £56,108,000 with likely total pooled budget being in excess of £150,000,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group 	Stafford and Surrounds CCG
By	Dr Anne-Marie Houlder
Position	Chair of Stafford and Surrounds CCG
Date	xxxxx

Signed on behalf of the Clinical Commissioning Group 	Cannock Chase CCG
By	Dr Johnny McMahon
Position	Chair of Cannock Chase CCG
Date	xxxx

Signed on behalf of the Clinical Commissioning Group 	East Staffordshire CCG
By	Tony Bruce
Position	Accountable Officer
Date	xxxxxx

Signed on behalf of the Clinical Commissioning Group 	South East Staffordshire & Seisdon Peninsula CCG
By	Rita Symons
Position	Accountable Officer
Date	xxxxxx

Signed on behalf of the Clinical Commissioning Group	North Staffordshire CCG
By	Dr Julie Oxtoby
Position	Clinical Accountable Officer
Date	xxxxx

Signed on behalf of the Council	Staffordshire County Council
By	Cllr Alan White
Position	Cabinet Member for Care
Date	xxxxxx

Signed on behalf of the Council 	Cannock Chase District Council
By	Councillor Muriel Davis
Position	Health and Wellbeing Portfolio Holder
Date	xxxxxx

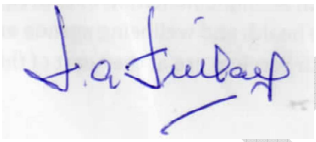
Signed on behalf of the Council 	East Staffordshire Borough Council
By	Councillor Dennis Fletcher
Position	Deputy Leader (Built Environment)
Date	xxxxxxx

Signed on behalf of the Council 	Lichfield District Council
By	Councillor Colin Greatorex
Position	Cabinet Member for Community, Housing and Health
Date	xxxxxx

Signed on behalf of the Council 	Newcastle-under-Lyme Borough Council
By	Councillor Gareth Snell

Position	Leader
Date	xxxxx

Signed on behalf of the Council 	South Staffordshire District Council
By	Councillor Roger Lees
Position	Deputy Leader and Cabinet Member for Public Health Protection Services
Date	xxxxx

Signed on behalf of the Council 	Stafford Borough Council
By	Councillor Finlay
Position	Cabinet Member for Environment and Health
Date	xxxxxx

Signed on behalf of the Council 	Staffordshire Moorlands District Council
By	Councillor Gillian Burton
Position	Cabinet Member for Communities
Date	xxxxxx

Signed on behalf of the Council	Tamworth Borough Council

By	Councillor Daniel Cook
Position	Leader
Date	xxxxxx

Signed on behalf of the Health and Wellbeing Board	Staffordshire Health and Wellbeing Board
By	Alan White
Position	**Co-Chair of Health and Wellbeing Board**
Date	xxxxx

Signed on behalf of the Health and Wellbeing Board	Staffordshire Health and Wellbeing Board
By	Johnny McMahon
Position	**Co-Chair of Health and Wellbeing Board**
Date	xxxxxx

Section 2: Vision for health and social care services

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

The vision for the health, social care and associated services of the future for Staffordshire are set out in the Joint Health and Wellbeing Strategy (Doc2) "Living Well in Staffordshire" 2013-18. At the basis of this strategy is an emphasis on preventative approaches which reduce dependency on the NHS and social care by preventing crises, and which increase people's resilience and independence: ambitions that have been consistently expressed in processes of engagement conducted with those that use services. Continuing as we are is not an option, with a predicted funding gap (by 2018) of £292m in Staffordshire if nothing were to change.

Activity will focus on community and preventative services reducing the level of activity and the impact of costs on acute and NHS services and on on-going social care services, such as residential care. Coupled with this will be whole system efforts to maximise those factors that promote strengthened personal responsibility and independence amongst the population, facilitated through greater community cohesion. Districts and Boroughs have a key role in addressing the underlying determinants of health and independence as part of this strategy.

We want our population to feel able to take control of their own health and wellbeing so a large part of this plan focusses on what we can do to build on principles of self-management, engaged communities and patient activation.

Our aim is to address the following priority areas:

1. **Increase life expectancy** for all, and bring it in line with the rest of the country.
2. **Reduce health inequalities**, and close the gap between those most and least advantaged.
3. Properly **support people with long-term conditions** and/or complex needs to live independently.
4. Ensure that **people experiencing mental ill-health get equal access** to physical health and social care services.
5. **Improve mortality/survival rates for people with long-term conditions and cancer**.
6. Ensure that all NHS, social care and associated services are of a **high standard of quality and safety**, and deliver outcomes that improve people's lives.

In addressing these priority areas, we aim to create a place which:

1. Supports people to ***feel safe and well in their own homes***, through helping people to be a part of their local community and be supported to access a range of support solutions to ***maximise their independence*** for as long as possible.

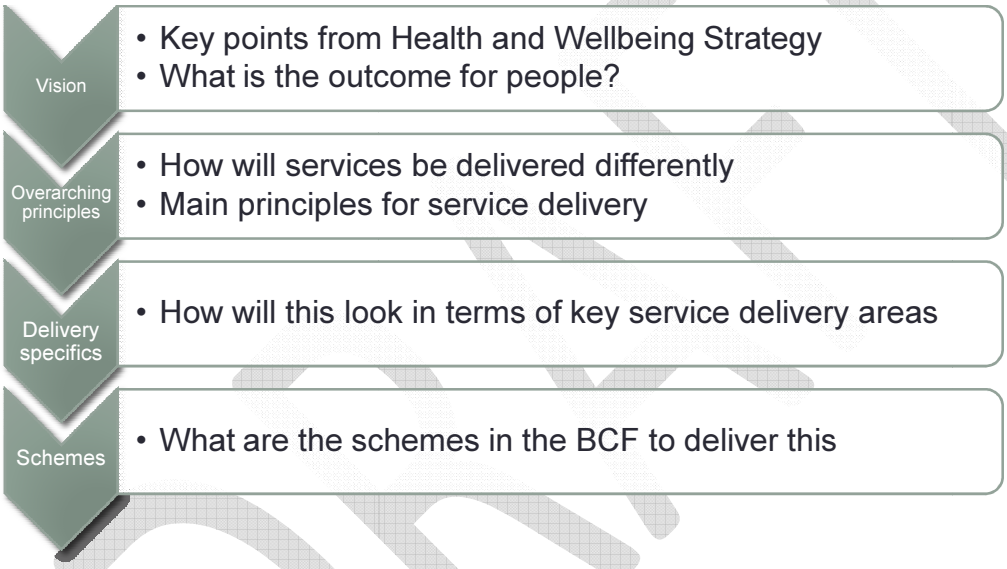
2. Empowers people to make their ***own choices*** and have ***control over their own lives***

3. Ensures that individuals are treated with ***dignity, fairness and respect***

4. Supports people to receive the ***right care at the right time***

5. ***Promotes self-care*** where safe and practical

This submission addresses the following points:-



1. What difference will this make to patient and service user outcomes?

The vision for people in Staffordshire is set out in the Joint Health and Wellbeing Strategy. This is what we aspire to deliver for our citizens:

Living safe and well in my own home

I will live in my own home and remain part of my local community as long as possible. I will be able to access support solutions that are built around my ongoing home life and independence, taking account of my housing needs. I feel safe in my local community and my community is supportive of everyone, especially those who are most vulnerable.

Living my life my way, with help when I need it

I will have control over my own life and be able to make choices about what happens to me. Information, advice and guidance will be readily available to me and will help me draw on the support I need. If I am particularly vulnerable, local services will be aware of this and will offer me targeted support early, to help me manage my situation well.

Treating me as an individual with fairness and respect

I will be treated as an individual, with respect, dignity and fairness, and as an expert in my own experience. I will receive support to a high standard and I will be able to feed my views easily to the Health and Wellbeing Board and to services, and my views will be listened to and acted on.

Making best use of taxpayers' money

I will be confident that public money is being spent well, and that I get quality, and value for money services locally, whether the services I receive are provided by the NHS, the Council or private and voluntary sector organisations.

This vision is fully consistent with the three outcomes that have subsequently been adopted through the Staffordshire Strategic Partnership:

1. *The people of Staffordshire will:*
    1. *Be able to access more good jobs and feel the benefits of economic growth*
    2. *Be healthier and more independent*
    3. *Feel safer, happier and more supported in and by their community*
2. What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

This vision will be delivered in consideration of the following overarching principles:

1. People will be supported at their lowest point of dependency
2. Better-coordinated treatment, care and support will be available for people in the place which is right for them, with an emphasis on keeping people in their communities building on local assets.
3. The local health, social care and housing economy will develop comprehensive generalist community-based care and support for people with frailty, complex needs and/or long term physical and mental health conditions, complemented by specialist input as required. Central to this will be robust, flexible domiciliary care capacity.
4. As we help people to avoid crises, we will expect to see resource presently committed to non-elective urgent care services in the acute sector shift to fund community-based activity.
5. People will be supported to take control of their health and wellbeing, and of the services that support them.
6. Services will be commissioned smartly and where possible for outcomes rather than activity-based targets

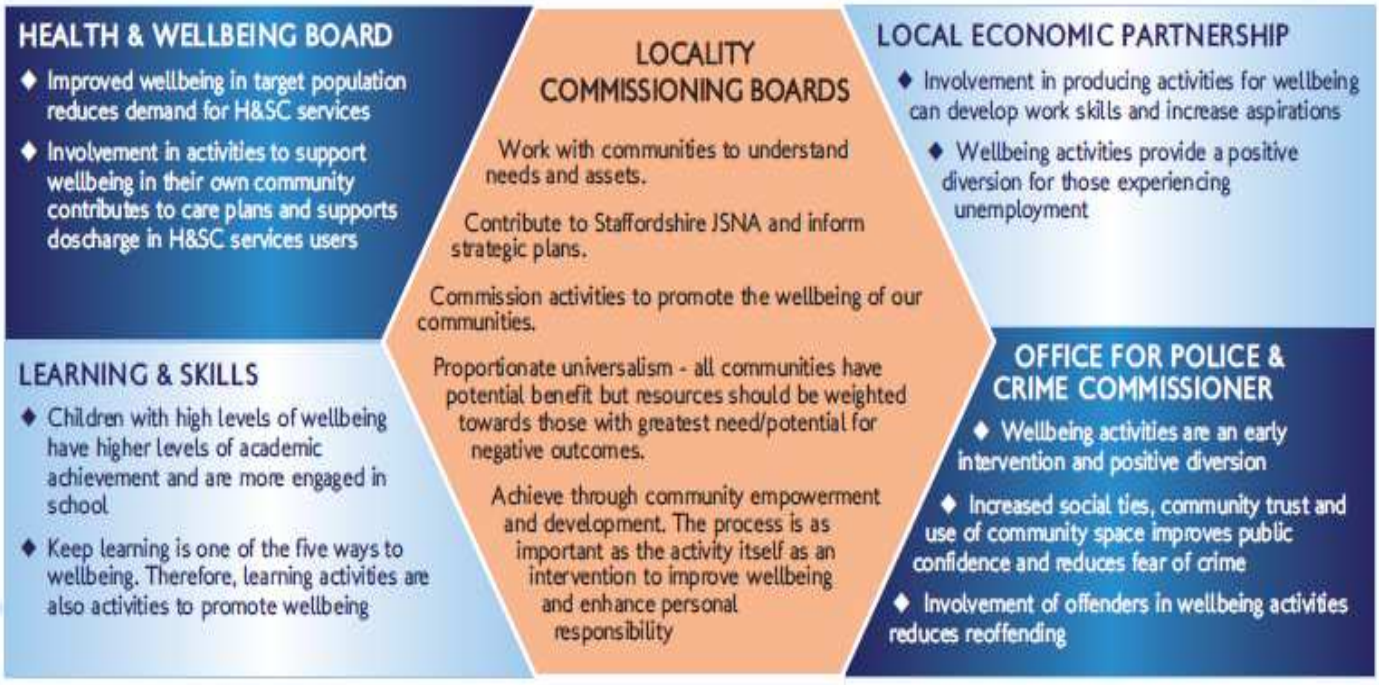
7. It is estimated that preventative health and care services delivered in the community save £4 for every £1 spent.

The Staffordshire Health Economy has been one of the eleven national areas identified as challenged as part of the Intensive Support for Planning work. A report has been produced which talks about the need to focus on frail elderly pathways as a large part of the quality and sustainability challenge. Our ambition for Integrated Commissioning across Staffordshire means investing in an ambitious programme of work to integrate our commissioning in a number of areas. They include:

Ageing Well
Support to Live at home
Carers
Frail Elderly
End of Life

The BCF is not a vehicle for delivery of all of our plans for integrated commissioning, but has been designed to focus on the last three of these areas i.e. carers, support to live at home and frail elderly. In addition we have developed plans around 'Aging Well' to recognise that we require support to keep people well and out of the health and social care system for as long as possible.

In parallel to our work on integrated commissioning, we have been working collectively on strategic change led by district councils to develop the concept of locality based commissioning. This focusses on wellbeing and devolves down the commissioning to



support community asset to the district and borough partnerships; the role of locality commissioning boards is demonstrated in the diagram below:

Provider organisations were not involved in depth in the development of the Health and Wellbeing Strategy; however, they have expressed agreement with the general principles.

Frail Elderly Strategy

A key enabler to the delivery of the vision for Health & Social Care is the development of a Staffordshire wide '**Frail Elderly Care'** Strategy. This drafted Strategy has been developed with health economy partners and sets out agreed fundamentals for Frail Elderly Care, recognising the diversity of the populations we serve and allowing for different operating conditions and challenges that each commissioners faces. This drafted Strategy is about securing a sustainable and effective health and social care system which is both local and responsive to the needs of our populations.

This strategy draws together the work underway to transform Frail Elderly Care across Staffordshire and ensure a continuum of care aligned to the ambitions set out within our Staffordshire Health & Wellbeing Strategy.

The Health and social care economy are committed to the NHS England mission of high quality care for all; that Commissioners are striving for parity for mental health; and that the Commissioners respond to and seek to promulgate the best practice guidance from the Royal College of Physicians, the British Geriatrics Society and Kings Fund.

Fundamental 1: Elderly Care should be a whole system approach where all elements of the system link by design and work together to proactively support the patient anticipating, planning and delivering for their needs;

Fundamental 2: There should be timely, proportionate and appropriate communication between all those involved in a person's care and support that always engages the person and their carer(s) where the ability to provide for excellence in a person's care is enabled by access to information;

Fundamental 3: That irrespective of where people present in the system, they have access to an appropriate and rigorous assessment of their needs, that this assessment is trusted and informs the diagnosis of their health, social care and wider well-being needs and that they are able to access treatment and care services in the setting appropriate to their assessed needs promptly without unnecessary transfers of their care and without unnecessary admission to hospital;

Fundamental 4: That the quality of care received and the experience of individuals should not be adversely affected by where they normally reside, the time their care is needed, the place where their care is delivered, or by the person or organisation delivering their care;

Fundamental 5; There is a requirement for case finding and case management that navigates people through to the services they need that leads to achievement of outcomes, these outcomes being determined by screening and assessment processes that inform the care plan and the actions taken to deliver care;

Fundamental 6: An emphasis on prevention and support for living well, including after episodes of illness or where an individual's well-being has been compromised, is essential and at all times individuals should be supported to achieve optimal recovery, their best level of reablement, rehabilitation, and confidence; and

Fundamental 7: Preserving dignity, respect and privacy for all must be at the heart of our model of care and by design we should eliminate health inequalities.

The strategy outlines a continuum of care, summarised below:-

The Continuum of Care												
Prevention	Empowering Self-Care and Education	Support at Home	Enhanced Services at Home	Managed crisis and planned responses to need	Step Up	Acute services including admission where necessary	Manage Discharge effectively avoiding readmissions	Step Down	Enhanced Services at Home	Support at Home	Empowering Self-Care and Education	Community and Voluntary Sector support
An integrated delivery system involving public health, community and voluntary sector, primary care, community service, acute and secondary care services and the patient .												

Detailed work is ongoing to identify the best vehicle and footprint to commission this holistic pathway.

Section 3: Case for Change

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

The BCF will be used to improve outcomes for the following target populations: **frail elderly**, people with a **long term condition** (with a focus on people with dementia and people with a common mental health disorder) and **carers**. None of these groups are mutually exclusive and all are predicted to grow significantly.

It is estimated in Staffordshire that there are currently 24,000 frail elderly people, 240,000 people with a long term condition (including 11,000 people with Dementia and 80,000 people with a common mental health disorder) and 27,000 Carers (of people in receipt of services).

Staffordshire is facing the following challenges: increased population – people living longer, with 2 or more long term conditions, explosion of lifestyle and obesity related conditions e.g. diabetes and heart disease, expectations of the public regarding access, safety, standards of care and outcomes and expectations that technological advances in medicine keep people alive and active longer.

The result is an increased demand for elective NHS, non-elective NHS and social care services. A 'do nothing' option would result in a massive increase in the need for services, be unaffordable (an estimated deficit in excess of £400m by 2018/19) and lead to system collapse. The scale of change required is dramatic. It has been estimated that this will involve a shift of £200m currently spent in acute hospitals and residential social care (equivalent to 400 beds) to be used to support more effective preventative services in the

community. This cannot simply involve a shift in the geographical location of services, doing in the community what used to be done in hospitals. Instead, what is required is a major redesign of the very nature of the care system, doing different things in the community so that needs are met effectively which in turn means there is less demand for bed based acute hospital and residential social care services.

The table below stratifies the population of people aged 65 and over in Staffordshire by their level of need.

	2013	2021
Level 4 - Complex co-morbidity	2,900	3,700
Level 3 - Long-term condition with co-morbidity and social needs	5,100	6,500
Level 2 - Long-term condition and additional needs	15,100	19,000
Level 1 - Self management	95,700	114,600
Level 0 - Targeted high risk primary prevention	25,000	28,000
Population wide prevention	22,900	25,600
Total population aged 65 and over	**166,800**	**197,400**

Data compiled and analysed by Public Health Staffordshire, Staffordshire County Council

The current and predicted costs relating to this population are shown in the table below:

	2012/13 (000s)	2019/20 (000s)	Growth (000s)
Social care – adults aged 65 or over[1]	£118,300	£149,900	£31,600 (27%)
NHS – adults aged 65 or over [2]	£538,657	£796,808	£258,151

The costs are currently disproportionately distributed with the majority of spend on people with complex co-morbidities and very little spent on population wide prevention, targeted high risk primary prevention or self-management.

In Staffordshire, there is a plethora of responsive and intensive community based services in place but they currently operate in isolation of each other in many cases and without clear agreed care pathways to offer the right level of intervention.

Integration of services aims to facilitate more efficient services for those at higher need facilitating more investment in preventing future need in those currently at lower levels.

By the end of 2015/16, 24,000 people with long term conditions in Staffordshire and Stoke on Trent will be actively case managed. . Do we know how many for just Staffordshire? And do we know how many currently.

Activity and costs of Frail Elderly

- During 2012/13 there were around 35,100 non-elective (unplanned) admissions to people aged 65 and over making 43% of all non-elective admissions but 60% of non-elective admission costs. Around 24,200 of these admissions were to people aged 75 and over and 10,600 to people aged 85 and over. Admission rates for people aged 65 and over in Staffordshire are higher than the national average, in particular for strokes and hip fractures.
- The number of delayed transfers of care from hospital per 100,000 population in Staffordshire has increased slightly 9.8 per 100,000 in 2011/12 to 10.2 per 100,000 in 2012/13 (not statistically different). The proportion of delayed transfers in Staffordshire that were attributable to social care is higher than the England average.
- During 2012/13 there were around 1,095 permanent admissions to people aged 65 and over to residential and nursing care homes, the rate being similar to the national average.
- In 2012/13 more older people (aged 65 and over) who were discharged from hospital to intermediate care / rehabilitation / reablement were still at home after 91 days (86% compared with 81% across England). The proportion at home at 90 days does reduce with age with around 90% of Staffordshire's residents aged 65-74 being at home 90 days after discharge compared with 82% of people aged 85 and over.
- Non-elective spells, elective spells and residential care admissions are all increasing.
    - Non-elective spells are predicted to increase at a rate of 2.4% per year
    - Elective spells are predicted to increase at a rate of 13% per year
    - Permanent admissions to residential care are predicted to increase at a rate of 4.2% per year.

Articulate at a high level how integration (of systems, processes, teams, budgets) could be used to improve this issue – i.e. set out in broad terms the theory of change or logic that supports your BCF plan

We are well placed in Staffordshire in that we have made good progress in integrating provision. We know we have much more to do. We will continue to implement our plans to use integration of systems, process teams and budget to:

Simplify care services by breaking down organisational and administrative barriers, so that people can access the right care at the right time (our approach to integrated commissioning is the means to deliver this)

Coordinate service delivery enabling earlier and faster delivery of more effective care in cooperation with GP practices, community health, mental health, acute providers and the 3rd sector

Align our approach to prevention , self-care and support for people, their families and carers to increase the individuals and family/carers' capability to manage care needs

Commission responsive and intensive community based services supporting people and their families /carers to manage their needs at the least invasive level as possible (our approach to managing risk is key to delivering this)

Understand individual needs by personalised care planning and effective case management in primary /community care, linked to effective proactive case finding and early intervention

Use workforce changes and training to fundamentally shift the culture of staff delivering health and social care.

Section 4: Plan for Action

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

In order to achieve our ambitions around the BCF, we will focus in the following areas.

Programme
Ageing Well
Support to Live at Home
Carers
Frail Elderly
End of Life

A series of initiatives have been identified to help us achieve against these headings. This is consistent with the narrative in the CCG two and five year strategies and the local authority plans.

The delivery of whole-system transformational change will only be achieved if a range of coordinated developmental programmes are instituted to ensure that key enablers to service delivery also transform to meet the challenges of the future. Programme management will be employed to this end, and a programme management office set up for the purpose.

It is likely that the Better Care Fund will be overseen by a new Joint Executive Board which will be a subgroup of both the Staffordshire and Stoke on Trent Health and Wellbeing Boards.

In terms of milestones key dates are:-

- Joint Executive Board established October 2014
- BCF Delivery Plan finalised November 2014
- Frail Elderly Strategy finalised December 2014
- Providers agree joint pathways for community hospitals December 2014

Each of the individual initiatives will have detailed project plans and an overarching progress report will be developed for the Joint Executive Board.

Where clear project methodology is not in place, risks on a per scheme basis will be developed during 14/15 as part of the development of individual projects. Agreement has been reached on existing activity (funding) which is being transferred to the BCF, and what activity this will translate to in order to deliver against BCF targets and vision (see BCF doc8). Work remains to clarify – where not already developed – additional/new activity to deliver the BCF vision.

Finance leads and commissioner leads have been agreed for each scheme, and meetings are taking place on a bi-weekly basis to agree detailed financials and commissioning plans.

Further sub-groups have been set up as follows:

- Metrics
- Modelling
- Care Bill
- 7-day working

These groups are being tasked with working up the detail to support the BCF vision, reporting along programme management lines.

Considerable work is being undertaken around the governance arrangements which need to underpin any integrated commissioning arrangements.

8. Please articulate the overarching governance arrangements for integrated care locally

In order to meet these challenges, strategic commissioning must focus upon whole systems of activity, and adopt methods that will guarantee coherent service delivery. Use of new methods of commissioning (e.g. 'capitated' budgets, prime providers for specific pathways, the encouragement of alliances or consortia of complementary provision, etc.) alongside the reemphasis of the centrality of General Practice in the future model of care, are essential prerequisites of a whole system solution to the issues of the moment.

Over the next five years, the BCF will enable more consolidated commissioning of better services and support for people, with consequent improvements in service effectiveness and qualitative outcomes.

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

Current arrangements are that the HWB has overarching responsibility for the achievement of the BCF plan, with executive responsibility delegated to the co-chairs of the Integrated Commissioning Executive Group. This is a mature group, with well-established working relationships, whose membership reflects that of the HWB with representation of senior officers from Councils, CCGs, Public Health, Police Commissioner and HealthWatch.

For delivery of the Better Care Fund Plan, it is likely that the Joint Executive Board which sits beneath both Staffordshire and Stoke on Trent Health and Wellbeing Boards will take overall responsibility for assuring delivery. :

One of the key gaps in terms of the existing arrangements for coordinated delivery is the lack of providers on the HWB. This will be addressed and the Joint Executive Board will include both commissioners and providers and develop mutual accountability.

Any decisions affecting the delivery of local services (CCG aligned) will be agreed by local commissioning and finance committees/board as appropriate to enable partners to exercise their statutory duties before final sign off at the Health and Wellbeing Board. Commissioners must clearly understand arrangements and key personnel at locality level to ensure local delivery opportunities are co-ordinated and maximised.

It is expected that in addition to the overall scrutiny of delivery the JEB will : -

1. Identify services, funding and strategic objectives where a PAN CCG/county approach or a locally specific CCG approach is required as appropriate
2. Oversee the implementation of the projects for review and redesign within geographical areas as appropriate
3. Oversee the co-ordination of appropriate engagement with local patients, clinicians and commissioning networks
4. Ensure quality patient/user care and the best value for services
5. Monitor the performance (agreed outputs, outcomes) and financial aspects at a local/county level
6. Review the effectiveness of the collaboration
7. Establish working groups as appropriate

The governance arrangements for client specific boards are being fully reviewed to ensure the delivery mechanisms are fit for purpose and there is clear delegation.

The BCF will be delivered through a pooled budget under s75 arrangements. Discussions have begun as to how this s75 agreement will be arranged and which organisation(s) will be responsible for holding the fund.

d.) List of planned Better Care Fund Schemes

In terms of our strategic intent, these are the schemes which form the basis of this Better Care Fund submission are currently.

Existing Plans

We will need to develop different solutions for different geographical areas, based on the varying risk profiles and local population needs of those areas.

For this reason, approaches are legitimately being developed for different localities within Staffordshire. The BCF is not a vehicle for delivery of all of our plans for integrated commissioning, but has been designed to focus on the last three of these areas i.e. carers, support to live at home and frail elderly. In addition we have developed plans around 'Aging

Well' to recognise that we require support to keep people well and out of the health and social care system for as long as possible.

Frail Elderly

We have identified as part of the BCF that the need to provide a coherent continuum of care for frail older people is key to delivering better outcomes. Have adopted the following definition of frailty: 'a state of vulnerability resulting from the cumulative decline in physiological systems which occurs progressively over a lifetime'

Our aim is to support people to stay well and independent for as long as possible. The initiatives described in this section represent some of the big transformational changes to shift that balance.

Ageing Well

[Lucy Enter narrative here]

Scheme	Projects	Scheme Ref:
Ageing Well	Falls Prevention	1.1
	Locality Asset and Capacity Building	1.2
Support to Live at home	Disabled Facilities Grant	2.1
	Adult Social Care Capital Grant	2.2
	Technology Enabled Care Services (TEC) and Assistive Technology	2.3
	Integrated Community Equipment Service (ICES)	2.4
	Support to Live at Home Voluntary Sector Day Services	2.5
Carers	Carers Breaks	3.1
	Mental Health Carers Support	
	Carers Information	
Frail Elderly	Social Care Transfers – Recurrent Funding (S256)	
	Discharge and reablement	4.1
	Market Development and Domiciliary Care	4.2
	Implementation of the Care Act	4.3
	Frail Elderly - Admission avoidance and delayed discharges & SSoTP Community Frail Elderly	4.4

	(Stafford & Cannock CCG) Frail Complex – Intermediate Care (South East & Seisdon CCG) Frail Elderly – Cross Economy Transformation Programme "Big Tickets" (North Staffs CCG) Reablement Services (North Staffs) Frail Elderly – General Practice Plus (South East & Seisdon CCG) Frail Complex – End of Life care (South East & Seisdon CCG)	 4.5 4.6 4.7 4.8 4.9
	Dementia Care Services	4.10
	Care Act Implementation (Revenue Funding)	4.11
End of Life	Macmillan End of Life (Stafford & Cannock)	5.1

Wider Plans

In practice the vision and overarching principles will translate into different approaches for different service delivery areas. The current detailed financial submission does not fully reflect our level of ambition for integrated commissioning, as there is more work to do in some areas, in particular around services for older people and people with long term conditions.

Joining Up our Transformation Plans

Staffordshire health and social care economy has no financial flexibility and all organisations are in deficit. That means there is very little flexibility to divert money in terms of cash investment. We now have the recommendations of the KPMG report and there are suggested areas of savings. In addition, we have had a small task group further reviewing the evidence around other initiatives we could implement to create financial headroom.

They are:-

	Estimated Saving
Continuing Health Care	£2m
Expanding falls prevention	£3m
Patient Activation	£1m
Capitated Budgets for frail elderly and MSK	£2m
Shared decision making for surgery	£1m
Changing criteria for adult social care	£1.5m

Developing extra care housing options	£1m
Increasing access for IAPT	£1.5m
Stroke prevention	£1m
Increasing uptake of flu vacs	£0.5m
Disinvestment	£1.5m

We are doing further work up on these proposals and will seek agreement to monitor progress as part of the overall Joint Executive Board.

[enter text here about Integrated Commissioning and wider context]

Plans to protect social care

[Rita to enter list of things]

Section 5 Risks and contingency

At present, the Staffordshire Better Care Fund comprises a range of directly relevant but free-standing strategies and programmed activities, each of which contain their own risk management and mitigation. In many respects, the Plan represents the health and social care system response to the Joint Health and Wellbeing Strategy. As such, it ranges far beyond the narrow scope of the services noted in the national guidance and application of the local share of the national funding of £3.8bn. As the Joint Health and Wellbeing Strategy drives the health and social care economy towards increasingly integrated modes of commissioning and delivery, the elements of the contributing programmes (including risk) will also be coordinated.

The BCF partnership is at present being established through the Health and Wellbeing Board and its supporting infrastructure. There is a firm commitment to this consolidation. The mechanism for the governance of the work will prioritise risk management, and whole-system learning from the experience of areas of the work will be a key feature.

10. Risk Log

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

Risk	Risk rating/ Likelihood	Mitigating Actions	Owner	Timeline
High level of savings required across the health and social care economy (c.£45m) in	High	Implementation of KPMG recommendations. Further work has been done to		

2015/16 are unachievable		identify savings plans to create financial headroom. Develop a whole system service and financial transformation programme, which addresses the challenges facing each of the partners. Some elements of this plan may be focused on specific parts of the system, building on existing change initiatives. Review good practice from elsewhere, including LGA value cases and outcomes of Anytown modelling to identify opportunities for greater impact.		
CCGs and providers are unable to deliver plans to reduce hospital emergency admissions leading to inability of the system to make savings intended through the plan	High	Good programme management in place. Work to develop strong resilience plans to ensure delivery.		
Money going into BCF already tied up in mainstream services, therefore cannot fund additional activity	High	Plans already in place for re-commissioning of services at lower cost which will fund expansion of preventative / community investment.		
Potential impact of Mid-Staffordshire NHS Foundation Trust changes where redesign is focused on maintaining financial viability of the Hospital rather than supporting changes set out in BCF	Medium	Gradual transformation with staged approach to investing in preventative options. MSHFT changes invest in acute care. Negotiation on new contracts with Hospitals agreeing caps on intake numbers and shared risk with Hospitals on overspends.		
Lack of clear national guidance on the following	High	To be raised with national team LAT		

may prevent signatory partners gaining sufficient assurance to develop s75 agreement(s). *11.* Arrangements for (S75) budget pooling. *12.* Establishment of reasonable local improvement trajectories and targets. *13.* Mechanism for determining 'failure', apportioning responsibility, and withholding resource.		following submission of 4/4 BCF.		
National benchmarks/baselines upon which performance is to be premised may present unrealisable trajectories/targets for local health economy/CCG areas. (See appended metrics document)	Medium	LAT to support the development of locally relevant trajectories/targets where applicable.		
Lack of progress against BCF plans leading to not meeting targets and achieving benefits across the system as a whole	Medium	Robust approach to Programme Management. Development of principles around 'rules of engagement' between all partners for the BCF. This will include the development of a number of risk sharing agreements which will clearly articulate the impact of not achieving the deliverables in the BCF Plan. Any		

		risk sharing will include clear lines of responsibility and accountability against performance within the Plan.		
Challenge of delivering 7-day working	Medium	Expand 7 day working group in north to the South. Pick up in Joint Executive Board. . With regard to third party social care provision, steps to expand the ability of the system to extend the times during which assessments can be carried out will be built into wider work to redesign the sector.		

Contingency plan and risk sharing

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

Section 6 Alignment

With other initiatives related to care and support underway in your area

Locality Based Commissioning

The Health and Wellbeing Board has identified three approaches to achieving the Health and Wellbeing strategy: 1) Influence, 2) Integrated Commissioning (which was described earlier) and 3) Locality based commissioning.

Locality commissioning boards (LCBs) are being developed on a district footprint, generally hosted by the district/ borough council. All strategic commissioning organisations are represented on the LCB and are committed to the principle of pooling/aligning resources. Work has already commenced in all districts using resources identified by public health commissioners and the police and crime commissioner. Other county council commissioners, CCG commissioners and district council commissioners are actively identifying resources that can be aligned for 2015/16.

The LCBs are focussing on commissioning and influencing activity that improves wellbeing in their local population. Older people are a target population in all localities and improvement in wellbeing in this group will support them to 1) connect – thus reducing social

isolation, 2) be active – thus improving physical health particularly risk of falls, 3) keep learning – with a focus on self-care, 4) take notice – with a focus on noticing those in their community who need support and 5) give – thus developing community assets to address need.

All this activity will lead to a reduction in demand for health and social care services and support people to feel safe and well in their own communities.

Falls Prevention

Falls are the largest cause of accidental injury, particularly in older people. In Staffordshire it estimated that 55,000 adults aged 65 years and over fall each year, 8,400 call an ambulance, 4,200 attend A&E, 3,400 are admitted to hospital (1,400 with hip fractures), 840 will require a home care package and 140 will require a care home admission as a result. The response to falls cost the health and social care system in Staffordshire an estimated £21 million.

There are plans in development to reduce this demand by 20% (i.e. preventing 680 non-elective admissions and saving the health and social care system £4 million. These plans include reviewing falls services which is included in the frail elderly work stream described earlier. In addition the plans include, through locality based commissioning: 1) increasing physical activity opportunities that promote lower limb strength and balance, 2) improving uptake of NHS England funded eye tests, improving uptake of NHS England funded Medicines Use Reviews and 4) addressing home and outdoor environmental hazards.

Mental Health

It is estimated that an average of £3,500 is spent per year on a person with a long term condition and 12-18% of this is linked to poor mental health. It is estimated that 93% of the older adult population with depression also have a long term condition.

Psychological therapy services have been commissioned in Staffordshire to meet 15% of population need per year. However, this resource is underused by adults aged 65 years an over, where only an estimated 6% of need is met each year.

Access to psychological therapy services is being reviewed to improve access for older adults. It is anticipated that the redistribution of psychological therapy capacity will support an additional 2,250 adults aged 65 years and over to receive psychological therapy. It is anticipated that 1,125 (50%) will move to recovery. This will lead to savings of between £418k and £628k a year due to reduced demand for NHS long term conditions services. It should also reduce demand for adult social care services estimated at approximately £300k. A total saving of nearly £1 million.

Business cases are also being progressed to develop lower level psychological support which could also contribute to reducing the impact of mental health on needs relating to long term conditions.

Alcohol

Over 50% of alcohol related admissions in Staffordshire are in adults aged 65 years and over. Alcohol and Drugs commissioning is completely integrated in Staffordshire with resources from Staffordshire County Council, the CCGs and the police pooled and a single responsible integrated commissioner. Services have been redesigned and implementation of the new model started in July 2014.

Alcohol related admissions have been on an upward trajectory over the last 10 years. The impact of the redesign is yet to be realised but recent data suggests the trend is slowing down.

A reduction in alcohol related admissions in adults aged 65 years and over will directly contribute to the Better Care Fund outcomes. In addition, it indicates a change in behaviour which will have much wider positive implications on demand for frail elderly services.

Stroke Prevention

Strokes can be prevented through better identification and treatment of Atrial Fibrillation (AF). In 2013 only 37% of people with AF who had a stroke were on anticoagulation. A plan has been developed to increase the numbers on anticoagulation to 93% which will prevent between 64 and 77 strokes in Staffordshire.

The plan include: 1) proactive identification of people in AF through NHS Health Checks and opportunistically during flu vaccination clinics 2)systematic implementation of new NICE guidelines which will increase the proportion identified as high risk and the proportion that receive anticoagulation (as opposed to aspirin) 3) review of patients who are not optimally managed on warfarin for consideration for new oral anticoagulants.

The business case has yet to be improved as an investment of approximately £2 million is required. However, it is estimated that preventing 64 strokes would lead to savings of over £5 million for the health and social care systems.

Housing

There has been significant investment in recent years in Staffordshire in Extra Care Housing and Flexicare Homes. A number of these schemes have been recently been completed and the impact of these on demand for NHS and Adult Social Care services should be seen over the next few years. It is estimated that the impact on demand for NHS is over £2k per unit.

There are further opportunities that are starting to be explored including: 1) identifying NHS properties that can be developed into housing schemes, 2) proactively identifying potential tenants and supporting decision making, 3) developing focussed support for dementia, 4) developing short term step down opportunities as part of current schemes.

With existing 2 year operating and 5 year strategic plans, as well as local government planning documents.

The Staffordshire Health and Wellbeing Strategy has identified frail elderly, support to live at home, carers and end of life care as four of it nine key priorities. This has influenced the development of the Staffordshire and Stoke NHS 5 year plan, the individual CCG 2 year operating plans and Staffordshire County Council's Strategic Plan.

These plans have all been presented to the Health and Wellbeing Board and taken through a process of challenge to assure the Health and Wellbeing Board that they align and contribute to the Health and Wellbeing Strategy.

The interventions described in the CCG 2 year operating plan and the 5 year strategic plan will achieve the 3.5% reduction in non-elective admissions required in this Better Care Fund submission. However, they will not bridge the £15 million financial gap. Therefore, this submission has identified additional transformation change both in the Better Care Fund schemes and the aligned initiatives that will bridge this gap.

With your plans for primary co-commissioning

Co-commissioning of services by the Local Area Team and the 5 Staffordshire CCGs will develop a strong sustainable Primary Care service over the next five years. This will consider different ways of commissioning additional primary care either through using current providers or opening up the market and considering alternative suppliers in effort to stimulate improved quality, reduced variation and achieve financial sustainability

Our plans for primary co-commissioning involve six change programmes:

1) "At Scale Work stream" Where appropriate we will explore the shift to working at greater scale through networks, federalisation or mergers. This will involve:

a. Collaboration between groups of practices and other providers, this may include community nursing services and GPs with extended clinical roles, workforce flexibility and sharing of back office functions.
b. Community services will be collocated with GP services Practices will offer more community services e.g. dietetic services, podiatry and outreach services dependent on GP skills (e.g. minor surgery and complex contraceptive services). This will require consideration of the current estates utilisation.

The Primary Care Joint Commissioning Board will work to ensure there is both capacity and capability across the federations. Where appropriate we will look to achieve economies of scale in administrative and business functions of practices.

2) Improved Access We will explore innovative approaches to improving access to general practice services. We will look to support the changes to the urgent care system to make 7/7 working a reality across the whole system

3) Workforce We will build on existing good work and look to address the workforce problems facing general practice in Staffordshire and neighbouring Shropshire. The General Practitioner community and health centre teams face great challenges ahead where there are a high proportion of GPs leading up to retirements (often earlier at 55yr) and some areas are historically difficult to recruit new staff. A higher ratio of women who may prefer part-time due to childcare arrangements could possibly impact on resourcing. The CCGs, LMC and AT are taking a proactive stance on recruitment and retention including bursaries for relocation to the area, re-starter schemes , innovative training posts etc

A new way of thinking about how 7 day accessible Primary Care services will be delivered, including greater roles for practice nurses allowing them to use a broader range of skills. There will be opportunities for new roles and ways of working to ensure sufficient capacity is available across the network to deal with the increasing demand. This needs to be sustainable and does take some time to implement as often training programmes take a year or more.

The profile of practice administration and support services will need to be redesigned by a modernised practice management approach. This will in turn minimise the demands on clinician time but will require a flexible and experienced set of practice managers as part of the federated approach.

4) Unwarranted Clinical Variation We will look to systematically identify and address the systemic and clinical causes of variation and significantly improve the poorest practices.

5) Pharmacy, Optometry and Dentistry We will look to these professions to play a greater role in treating minor ailments; empowering patients with long term health conditions to manage their own health more effectively; improving the efficiency across the whole system. It is envisaged that this programme will be intrinsic to the primary care at scale solution, and it is recognised that the inter-dependency of these clinical specialties means they are equal partners in defining and delivering the programme of transformation.

6) Infrastructure This programme will look to develop a coherent primary care estates strategy. We will look at the estates and IT infrastructure across the health economy and identify actions required to ensure that these key components enable the delivery of the changes identified within the other programmes. We will ensure that estate is fit for purpose and that have compliant disability access fulfils statutory requirements for clinical environments (CQC).

7) Change in Public Behaviours We will work to support the development of a culture of self-reliance and self-care with our population in Staffordshire. See the right patients at the right time which may be earlier that previously organised by professionals. Change in clinical practice and guidance given to patients, moving from a paternalistic approach to more of a partnering approach so that people may feel

empowered to self management and take control of their care where appropriate. The primary care clinician still needs to assess and treat but should also enhance the focus on providing information and sometimes challenge to existing behaviours, which assists people to navigate the services available.

8) Demand Management - primary care developments to encourage demand management initiatives:

- Increase vaccination uptake in adults aged 65 years and over. In 2013, 70% of adults aged 65 years an over had the influenza vaccination and 66% had the PPV vaccination. If this was increased to the national target of 75% it is anticipated that approximately 200 admissions could be avoided and £850k saved (£600k to NHS and £250k to adult social care).
- Increase referral rates to psychological therapies in adults aged 65 years and over. This is discussed in section 6a).
- Identification of those who could benefit from falls prevention activities. This is discussed in section 6a).

System Wide Enablers and Initiatives:

The following system wide **key enablers and initiatives** will assist in the delivery of our vision for health and social care services:

Findings from the national intensive Support for Planning – early indication of plans for building a more co-ordinated and responsive primary care and community service, supports our plans around Integrated working with multi-disciplinary teams

Frail Elderly Strategy – the drafted Staffordshire Frail Elderly Strategy, sets out the intentions to deliver a more joint up, portable and seamless service across Staffordshire for our frail elderly populations;

Primary Care Strategy – the Shropshire & Staffordshire Area Team drafted Primary Care Strategy, sets out clear objectives for providing pro-active co-ordination of holistic care, which promotes self-care and fast, responsive access to care. The principles in this strategy align with those within our overarching vision for health and social care.

Integrated Commissioning – working collaboratively through the leadership of Staffordshire Joint Health & Wellbeing Board, partners will harness the opportunity of working together to get the best value for money for the people of Staffordshire.

Systems Resilience Plans – sets out the collaborative approaches to understand the system wide pressures and solutions to enable 'systems resilience' within Staffordshire not only focussing on unplanned acute admissions but the planned care system, including Referral to Treatment Times.

A key development in terms of the role of districts/boroughs in developing work around health and well-being is the **review of 'locality working'**, commissioned by the Health and Well-Being Board and led by the a borough council Chief Executive. This review is referred to earlier in this report. In essence, the review found that districts/boroughs were not being

considered as a matter of course when it came to developing strategic approaches to health and well-being and commissioning decisions were being taken that lacked the necessary sensitivity to issues in local areas such as Newcastle under Lyme. The approach which has been agreed, therefore, is for districts/boroughs to be a part of the strategic picture at all times and for both local commissioning approaches to be established at borough/district level and for all agencies from all sectors to be seen as potential providers.

9) With existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Five Year Plan provides a platform for the strategic leadership to influence and pool resources collectively in order to make step changes towards delivering the vision **for health and social care. This is the same vision as outlined within this plan.**

CCG's are currently in the process of refreshing their two year operational plans including the development of commissioning intentions for 2015/16. These intentions include the integrated intentions laid out with this BCF Plan.

Local Government planning documents are aligned to the Health and Wellbeing Strategy "Living Well in Staffordshire" included in Appendix. The vision of this Strategy "*Staffordshire will be a place where improved health and wellbeing is experienced by all. It will be a good place to live. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as part of strong, safe and supportive communities."*
Is aligned to the outcomes of the Better Care Fund.

Providers will also be refreshing their Integrated Business Plans and will reflect any joint agreements through the Joint Executive Board.

With your plans for primary co-commissioning. The majority of CCGs in the area have expressed an interest to co-commission at Level 2 i.e. actively have joint plans with the Area Team of NHS England but not formally receive delegation to hold primary care contracts. It will be vital that the plans described in this BCF are coordinated with commissioning of primary care. Where there are areas of significant overlap e.g. the DES for long term conditions management, CCGs are working closely with NHS England to align.

Section 7 National Conditions

a) Protecting social care services

Protecting social care services is not the same as protecting current spend on social care, or the existing configuration of service delivery. Nor is it simply about the narrow social care system in isolation from the wider health and social care system. As leaders of the overall system, we recognise the need for us to work together to join up our existing transformation plans and, using this as a foundation, develop our further ambition to establish truly integrated solutions that meet the needs of Staffordshire people.

As outlined in our JHWS, we are agreed that protecting social care services in Staffordshire means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand for health and social services and increasing budgetary pressures on councils and CCGs. We will maintain current social care eligibility criteria, until these are replaced by the national thresholds, and focus on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence and personal control over their lives, with benefits to both themselves and their communities, and to the local health and care economy as a whole.

By proactively intervening to support people at the earliest appropriate opportunity and ensuring that they remain well, are actively engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services once people have experienced a crisis. In many cases, this will require a new way of looking at ensuring people's needs are met, with consequent implications for service redesign.

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

There are huge pressures on Adult Social Care budgets across the country. The County Council has already made significant savings in recent years to enable social care outcomes to be maintained. The 2013 Spending Review takes these already-severe funding reductions still further. In recognition of the potential for this to have negative consequences for the NHS, one of the six national conditions for access to the Better Care Fund is that it is used to protect social care outcomes. At the same time, Staffordshire's CCGs are significantly underfunded compared to their 'fair shares' allocation and are expecting a combined underlying deficit across the county of some £30m in 2014/15. The CCGs have transformation plans in place to address some £18m of this during 14/15.

Funding currently allocated under the s256 transfers from NHS England to the County Council has been used to enable the local authority to sustain the current level of eligibility criteria and hence to provide timely assessment, care management and review and

commissioned services to clients who have substantial or critical needs. In addition, funding has been employed to ensure effective information and signposting is available to those who are not FACS eligible. In Staffordshire, these existing £16m of transfers from the NHS to social care will be continued under the BCF.

Due to further reductions in the County Council's base grant, a range of further savings have been identified as necessary in social care services. These include a £6m reduction in preventative former 'Supporting People' funding, and an additional £5m saving from core social services delivered through Staffordshire & Stoke on Trent Partnership NHS Trust.. In addition, it is estimated that the County Council will incur £4m of extra Care Bill implementation costs without any balancing increase in its core budget. Notwithstanding this range of planned savings, we estimate that a further £15m will be required to enable social care outcomes to be protected during 2015/16, on top of the existing s256 transfers carried forward into 2014/15. When added to the CCG deficit, this leaves a potential shortfall across the system of some £45m. Moreover, there are also significant deficits on the part of provider Trusts. This financial pressure across the whole of the health and social care system has been a major factor in the Staffordshire and Stoke system being identified as one of the 11 challenged systems nationally and requiring additional analytical and planning capacity to develop sustainable options.

This level of financial challenge in the system as a whole demands that we identify new solutions that deliver sustainability across all partners. The County Council and the CCGs are therefore actively seeking to draw together their respective financial and transformational planning. The CCGs and the County Council therefore continue to work together to enhance the transformation programme required to meet this significant challenge. This will build upon the initial recommendations recently received through the challenged health and social care system work.

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

At present, the financial pressures on the CCGs, outlined above, are such that it has so far not been possible to identify more than the existing £16m of s256 funding to protect adult social care services. One consequence of this is that the local proportion of the £135m for Care Act duties (£1.9m) has also not yet been identified. Work is being taken forward to develop solutions that address the overall financial issues facing all partners, thereby addressing the question of protecting adult social care.

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

Staffordshire County Council has established a formal change programme to ensure robust and effective implementation of the Care Act. This comprises a range of work streams, addressing all of the strands of service and policy change, supported by a programme office employing full programme management technologies. The programme reports into the

County Council's governance structures and is designed to secure full engagement from all relevant partners. At present, work is underway to identify the key responsibilities and tasks for each work stream, with a set of implementation plans to be developed before the end of September. The plans will set out key tasks, milestones, stakeholders, resources required, risks and issues.

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

The Staffordshire Carers Partnership was established in February 2014 to provide strategic direction, governance and accountability for Carers outcomes in Staffordshire. This includes work on a 'Carers Whole System Redesign' including the modernisation of the Staffordshire Carers Journey, in line with the statutory requirements within the Care Act.

A large scale tender across Staffordshire and Stoke on Trent is currently underway to deliver a co-ordinated and coherent universal service and a specific scheme has been detailed within the Better Care Fund allocation for the delivery. The resources detailed within the attached Annex equate to £692k.

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

Staffordshire County Council had originally assumed that the existing s256 funding of £16m would be carried forward from 2013/14, along with an additional £15m from the NHS £1.9bn transfer in 2014/15. Further, it was assumed that there would also be additional funding received, whether through the BCF or directly, to cover Care Act implementation. As has been noted above, the financial pressures on the CCGs have to date meant that neither of these two funding streams can yet be identified. This leaves the County Council with a shortfall, compared to its budget forecasts, of £16.9m.

b) 7 day services to support discharge

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

The recent calls for better service models in hospitals at weekends and to deliver the NHS offer, has a focus on Acute Trusts and hospital patient care at weekends.

The Staffordshire and Stoke-on-Trent Partnership Trust (SSoTP) which covers all Staffordshire LAs and CCGs already delivers in most areas an integrated Community Intervention Service providing crisis, admission avoidance and rehabilitative services, these services being accessible 7 days a week. These services enable a 24 hour response with hospital and community elements providing clinical and social intervention to maximise independence, prevent acute admission and the need for long term care, and facilitate hospital discharge. These integrated teams include Service Managers, Team Leaders, Nurses, Social Workers, Occupational Therapists, Physiotherapists, Health Care Assistant, Integrated Support Worker and Community Psychiatric Nurses.

In the North of the economy a 7 day working group has been established as a sub group of the Urgent Care Operational Group, in order to focus on further opportunities for enhancing 7 day services. A full report on this is attached as Doc2.

Private and voluntary sector social care providers are already contracted to deliver services on a 7-day basis.

There is a national mandate to include an SDIP in the contracts for future seven day working

In Staffordshire, the following arrangements apply.

North Staffordshire Combined Healthcare Services – Already working on a seven day basis so Commissioners agree there is no need to pursue contractual inclusions for development with this Provider

Community (SSOTP) – There is an acknowledgement that there needs to be a move to seven day working. Commissioners have established a joint working group with SSOTP to pursue. Given this position, the group was not in a position to propose a detailed SDIP for inclusion in the contract but has included a requirement to participate with the group and agree a plan by May 14.

UHNS – a range of seven day working expectations have been incorporated into the CQUIN schemes for UHNS, focusing on focus on availability of services, flow and discharge.

c) Data sharing

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

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

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

Yes all health and care systems will use the NHS Number. The proposed integrated care record will use the NHS number as the primary identifier for all NHS and Social Care activities.

Staffordshire County Council (SCC) has been using the NHS Demographic Batch Services (DBS) for the past year or so to enable us to match, collect and store NHS numbers for adult services clients. We have been carrying this out prior to go live of CareDirector, the new social care IT system, and by September 2013 had achieved approximately 94% of clients having a valid NHS number stored in our system. The number is then available for staff and partners to use the NHS number on relevant correspondence and this auto populates from the IT system on to key assessment documentation, plans etc.

In primary 'NHS' information systems the NHS number is complete for 97.1% of records within the Partnership Trust. Core systems are batch traced on a monthly basis. This is anticipated to rise to over 99% in 14/15 with scheduled system replacements.

The Partnership Trust is working with Health Informatics partners to develop a data warehouse where extracts from all systems will feed in – this will enable the full analysis of client pathways across health and social care using the NHS Number as the primary key to link records.

In addition to the above the Partnership Trust plans to reduce and consolidate the number of clinical systems in use across the region Trust through the procurement of a new clinical system in mid 2015.

Staffordshire partners are committed to using systems based upon Open API's and standards and are keen to explore the opportunities for greater systems integration and information sharing.

Staffordshire County Council have comprehensive IG policies/procedures in place, however are not accredited to the IG toolkit, which is primarily a Health Sector requirement. We are prepared to make an application for accreditation and committing to attaining the Toolkit, Caldicott 2 et al.

d) Joint assessment and accountable lead professional

The health and social care system has traditionally been focused on the provision of community services through direct interaction between patients / service users and professional staff, whether district nurses, care assistants, or therapists, to name but a few. The underlying philosophy has been that things need to be done for or to citizens if they are to be able to remain living at home, rather than enter institutional care. It is increasingly recognised, however, that this model of care is not only extremely expensive but can also have the unintended consequence of reducing people's ability to manage their own lives. The result can be that they are more dependent upon the care system, thereby facing worse health outcomes, experiencing a reduced quality of life, and requiring greater expenditure still. Across the Staffordshire health and social care system, we are convinced that there needs to be a major shift in culture and approach.

Rather than direct provision of care be seen as the default, we want to move to a position where our population expects to take maximum personal responsibility for their own lives, seeking care only when absolutely necessary. We recognise that many people find themselves struggling to cope as they get older or their health declines. In such situations, we want it to become the norm for people to make maximum use of technology to assist them in maintaining independence within the community. The population we serve are increasingly looking to such solutions to support them to better coordinate their health, care and wellbeing as part of their everyday lives. This may take the form of adaptations and improvements to their homes through the use of Disabled Facilities Grants and the Home Improvement Agency, the use of equipment through the Integrated Community Equipment Service to help them continue to undertake normal household functions when they are

disabled or recovering from a crisis, or through drawing on the wide range of technological solutions through the Technology Enabled Care Services programme to help their carers support them remotely, making maximum use of mobile phones and the Internet.

These approaches together support our goals to reduce admissions and readmissions to hospital and long-term care among older people, as well as support people of all ages to take greater responsibility for their own health and wellbeing and that of their families. We can build them into the increased adoption of personal health and care budgets to improve person-centered outcomes and support self-care.

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

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

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

A number of developments are taking place in relation to joint assessments and lead professionals with the aim of creating an integrated case management approach utilising risk stratification tools and approaches. A previous CQUIN existed in relation to Case Management in 2012/13.

There is partnership working in place between assessment teams and GP practices to implement risk stratification approaches. Whilst in some areas of the County the model of care is supported by a detailed service specification, in other areas this is in development, there are however a set of generally accepted assumptions about what the model of care is intended to achieve: -

- Coordination of resources around individuals with multiple chronic disease from one single health or social care professional. Thus recognising the growth in numbers of these individuals and the limitations of traditional 'single disease specific' strategies.
- Reducing the impact of these individuals on acute care resource through prevention (admission avoidance) and slowing of disease progression.
- Potential efficiencies in the delivery of care, particularly against a back drop of rising demand from an ageing population and increase in multiple chronic disease prevalence.

Factors that influence the level and intensity of activity within the model are: -

- The accuracy of the case finding process where the main aim is to prevent acute care episodes.
- The degree to which identified individuals are already known to community resources and the implications this has on capacity to implement the model of care.
- The degree to which GP's influence the implementation of the model of care within their individual practice.

The local health economy in the north is developing an integrated risk stratification tool that will support the work of the integrated locality care team and the delivery of the LTC Year of

Care project. This project will deliver a joint, integrated risk identification tool that will ensure that the people at the highest anticipated risk will become known and can be supported in an integrated, preventative way. MDTs are in place and most surgeries are now engaged with MDTs taking place across both Newcastle and Moorlands that include GPs, Community matrons, District Nurses and Social Care. Their frequency varies dependent on size of practice, demographics and preference. In North Staffordshire, 1,200 people are being actively case managed through these arrangements at the end of 2013/14.

Progress continues in the south of the County, and SSoTP, which delivers assessment and case management is working closely with respective CCGs. In Cannock, admission of individuals to the model of care in Cannock has being significantly more straightforward given that resource for case management was integral to the Adult Community Nursing Service service-specification, which was commissioned in 2010. Within the Cannock locality a focus on the top 1% of respective practice populations and the identification of suitable individuals has enabled in Nov 2013, 370 care plans to be produced for individuals requiring case management.

A range of information has been agreed with respective CCGs to be collated these include as examples

- Number of individuals identified and referred for case management per practice
- Number of individuals opting out of case management at initial stage per practice
- Number of individuals assigned a case manager within the Trust (split between health and social care)
- Number of individuals with completed care plan following assessment
- Number of individuals with open episode of care/number of patients stepped down
- Number of MDTs held per practice

Alongside a range of performance measures

- Percentage of care plans in place
- Percentage of individuals seeing a reduction in risk score
- Percentage of individuals/carers reporting they are confident in managing their own health
- Percentage of individuals reporting an improvement in quality of life
- Percentage of individuals achieving goals set
- Admission avoidance

In some CCG areas engagement has already taken place with their member practices to understand the implications of the new 2014 DES for Admission Avoidance and Proactive Case Management, including the identification of the most vulnerable and complex patients, clarity around the named accountable GP for patients over 75 years and how GPs can provide timely telephone access.

The development of a Joint Assessment is a key principle for Integrated Local Care Teams and includes a single patient record.

As the development of Integrated Teams is evolving, certain elements will come on line before others, therefore plans for training will be developed as plans for the implementation of Joint Assessments are defined.

SSoTP under Phase 2 of its integrated services programme will focus on developing a standardised approach, taking lessons learnt from both North and South approaches to fully integrate its case management and 'single assessment'. In anticipation a model for integrated Health and Social Care Case Management has been developed. This model offers a definition of Case Management, its principles and case management approaches for individual's dependant on their level of need. The model has defined a case management competencies framework and been approved for further exploration and development by Phase 2. A project steering group will be established with the following objectives:

- Identify the people who meet the different levels in the triangle of need and agree who will need to be case managed (e.g. through appropriate risk stratification, dependency weighting and assessment of complexity of need etc.)
- Clarify criteria for who is best placed to case manage different groups of people
- Develop systems and networks that ensure case managers can easily access all external services they will need to be effective.
- Develop two pilot sites for integrated case management to test out what works and how to overcome barriers to implementation.
- Involve stakeholders such as individuals, carers, CCGs, local health and social care independent and voluntary resources.
- Ensure a named worker/professional system is in place for people on the lowest level of the triangle who do not need intensive case management or who just require a single service.
- Ensure competency framework for case management is in place and understood.
- Develop training and development programme for professionals who will take on case management
- Build competency framework for case management into appraisal system for professionals who will case manage and use them as a tool for personal and professional development.
- Use the case management competencies to support integrated service redesign and performance management

There is tremendous potential with this model for developing a truly integrated model for case management including risk stratification. For Adult Social Care approx. 20,000 people are in receipt of services within the County, approximately 10,000 of these in receipt of some form of community based provision, a proportion of which may benefit from more intensive case management approaches based on risk stratification.

Section 8 Engagement

a). Patient, service user and public engagement

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

CCG's have developed models of 'patient engagement' which supports the local planning processes and strengthens the prioritisation of commissioning decisions. Local district patient groups and Patient Councils have been established with many reporting into governance arrangements within CCGs.

Local evidence through 'Call to Action' events have supported the vision for a new Health and Social Care vision and the transformation required.

As the recent report of the Francis Inquiry makes clear, the voice of the local population must be at the heart of our debates, just as our communities must be at the centre of everything we do. The experience at Stafford Hospital is especially powerful in this respect and we are united in our commitment to ensure that we avoid such failures in care affecting Staffordshire's people ever again. In order to strengthen the voice of people who use services, in 2012 we established a new organisation called Engaging Communities Staffordshire (ECS).

Building on the experience and expertise of the Local Involvement Network (LINk), ECS goes beyond the remit for HealthWatch to become a centre of expertise and knowledge about the people of Staffordshire. It has a key role as an independent organisation to collate and challenge all the available information about how people experience health and social care services, undertaking new research where necessary and drawing on this to present a clear and persuasive contribution to the debate.

Through its full membership of the Health and Wellbeing Board through its role as the provider of Staffordshire's HealthWatch, ECS provides a powerful connection with the people of Staffordshire, ensuring that their voice is heard at every stage.

There is a raft of communication mechanisms in place locally that complement the countywide work of HealthWatch, in particular scrutiny through District and Borough Councils and the formal engagement activity undertaken during the summer of 2013 regarding the JHWS. This involved a significant number of members of the public and gathered clear evidence of support for the direction of travel set out in the JHWS.

Public, patient and service user engagement is also embedded in the process which is taking place to co-design service specifications, for example for re-procurement of key integrated service delivery areas of Long Term Conditions and Intermediate Care/reablement.

CCGs and SCC have well developed engagement mechanisms for all client groups.

Within learning disabilities, extensive engagement has been undertaken in developing the *Living My Life My Way* strategy through involving families and people with learning disabilities in shaping the direction of travel. Over 250 people have been involved in the consultation process to improve access to mainstream health services for people with learning disabilities.

HealthWatch has identified Carers Engagement as one of their key priority areas. HealthWatch has agreed to chair the newly established Staffordshire Carers Partnership as an independent voice.

Other robust examples of engagement include the Transforming Cancer and End of Life Programme, work with users on the mental health strategy, and a model of Experience Led Commissioning to fully involve people in the co-design of services for people with Long Term Conditions and Intermediate Care.

The next step in developing Staffordshire's patient, service user and public engagement is to develop ways to change the conversation from 'what can we do for you?' to 'what can you do for yourself?' and 'what can we do to support you to do this?'. This work has started in some areas as part of the Locality Commissioning developments (described in section 6).

b.) Service provider engagement

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

- NHS Foundation Trusts and NHS Trusts
- primary care providers
- social care and providers from the voluntary and community sector

Engagement with providers has been, and continues to be, undertaken at a number of different levels.

At the strategic level, the HWB has developed a strategy for provider engagement which addresses the complexity and scale of the provider market across the county, looking not only at the six large NHS Trusts within the county, but also the plethora of small and medium-sized independent and VCS providers across the range of social care and broader services highlighted in the Joint Health & Wellbeing Strategy (JHWS). This builds upon the foundations laid through the engagement process for the JHWS, which included a large event with providers in September 2013.

At the sector level, significant work has been done across specific local health and social care economies and with individual provider cohorts. Examples of this include:

- The Cross Economy Transformation Programme (CETP) work in North Staffordshire, which has been developed since January 2012 in regular and close consultation with providers
- There is a long standing transformation programme in the west of the County, more recently focussed on the Mid Staffordshire NHS FT Trust Special Administrator's input.
- A Health Economy Forum has been operating in the east of the County with the two CCGs, the acute, community and mental health providers and the County Council
- The Intermediate Care/Frail Elderly and Long Term Conditions market engagement activities which took place in December involving the South Staffordshire CCGs and the County Council
- The Lifestyles and Mental Wellbeing aspects of the Healthy Tamworth work.

Further details of consultation work can be found in our successful application to become an Integrated Care Pioneer for End of Life Care.

At individual provider level, engagement between commissioners and providers is active and on-going. The imperative for change is recognised in these on-going discussions. Properly modelled and evidenced delivery goals are being developed and the recently-announced work on Intensive Support for Planning will further support this.

We recognise there is currently a mismatch between commissioner and provider plans which needs to be bridged. A sustainable and transformed system requires sustainable commissioning and provider organisations.

The delivery of residential, nursing and domiciliary care, as well as voluntary sector support, carers support, housing and other areas of social care and support, is sourced from a diverse market with numerous smaller local provider organisations. For these sectors, there are a number of umbrella groups, which are providing the conduit for engagement.

District and Borough Councils are active participants in this process and are leading significant engagement with other key providers such as registered social landlords and the voluntary sector.

Very recently, the Area Team of NHS England had initiated work on an acute services review across the County. This work has now largely been superseded by coordinated whole systems analysis and strategic planning that will be externally conducted as part of the support that is being offered to Staffordshire as part of the Intensive Support for Planning tripartite offer from NHS England, the Trust Development Authority and Monitor.

Discussions are taking place through Health Education West Midlands (HEWM) and the Local Education and Training Board and Council (LETB/LETC) to address issues of workforce development required by the forthcoming Care Act, the JHWS and our local BCF plans.

Our ultimate goal is to have high quality, networked providers who focus on our citizens, ensuring appropriate care, efficient handovers and a culture of empowerment and independence on the part of service users.

c). Implications for Acute Providers

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

What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?

Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

This approach to improving support for people in the community will release a significant volume of presently overcommitted non-elective acute sector activity. The acute sector providers will benefit from a reduction in the volume of non-elective demand, allowing better use of bed capacity for more necessary and cost-effective provision. Over time this should also lead to closure of beds, enabling a flow of funds into preventative and community-based support.

In addition, improved and better coordinated community health and social care provision operating over the seven-day week will sustain more effective flow through the acute sector, and thereby reduce delays in discharge. More timely discharge brings significant benefits in terms of the experience and longer-term prospects of service users, while also releasing acute capacity.

The Staffordshire health and social care economy is very complex, with many separate organisations from statutory, private, voluntary and community contexts, working in the commissioning and provision of services.

In some areas of the county over the last two years, increasingly sophisticated modelling has underpinned the development of transformational work, and this work is beginning to take effect. It is the intention of the lead commissioning organisations of Staffordshire that the health and social care economy of the county be uniformly subject to the same level of modelling, and that such work will continue to establish the evidence base for commissioning of the future. This programme is in its inception phase.

In North Staffordshire, such modelling has taken place. The Cross Economy Transformation Programme will shift £12m-£20m of non-elective spend from being regularly committed to the acute sector and community hospitals to being spent on community-based services, as described above. This will release pressure on the presently overused acute facilities, and allow UHNS to use valuable bed space on more cost-effective specialist elective work. This plan is already modelled into the QIPP expectations for 2014/15 onwards, and is reflected in the contractual heads of terms that are presently being negotiated for the same period.

UHNS is the main acute provider in North Staffordshire and Stoke-on-Trent. There is direct consistency between the Stoke-on-Trent BCF and the North Staffordshire element of the

Staffordshire equivalent. As patients from Stafford and surrounds recourse to UHNS, strategic planning between that CCG and those in the north will become increasingly integrated.

The pan-Staffordshire plan is in early stages of development and as such, much of the work to quantify potential NHS savings and discussions with NHS partners remains work to be undertaken over the coming months.

Staffordshire providers are on the whole financially challenged. The Health and Wellbeing Board will actively work to drive the strategic review being undertaken as part of the national Intensive Support for Planning.

For South Staffordshire CCG, the savings to the NHS are estimated to be in the region of £15m p.a. from 2015/16 onwards. The work focuses on Long Term Conditions, Frail Elderly and improving the quality of services through re-ablement and carers support among other initiatives. Further work is required to model this in detail in all parts of the County.

An expansion of Flexicare homes in the County is expected to have a positive impact on GP visits, A&E visits, hospital admissions, outpatient attendances, and mental health episodes. The benefit to the NHS is estimated at £2,175 per apartment (average 1.5 people) p.a. There are risks inherent in this scheme in that sufficient funding may not be secured to make the housing developments viable, and the benefits to the acute sector would thereby be lost.

The integration of funding and delivery of major adaptations across the County is expected to result in improved service delivery and reduced delays, resulting in benefits to the NHS in the region of £0.5m p.a. on spend of £2.5m p.a. Risks apparent are the potential for delays in assessments or reductions in funding which would reduce the number of adaptations.

The county-wide scheme to facilitate LD supported living placements following discharge from hospitals is expected to save £700k p.a. in reduced delayed discharge.

We are in active discussions with mental health providers to shift resource from bed based to community based services, moving to a recovery model and reducing stigma by discharging users from specialist care wherever possible.

Hospital attendances and delayed discharges are expected to be reduced also from the Dementia programme, although this remains to be quantified.

A county-wide approach to Digital Health has just been launched as part of the BCF plan. This is expected to deliver savings to the NHS which will be quantified as part of the early stages of this work.

Discussions with the NHS providers to agree potential for savings in these areas have yet to take place, with the exception of the LD and mental health plans where on-going discussions are already taking place as part of regular contract and commissioning discussions.

The five year planning process is being used as a vehicle to model the impact, build the evidence base, establish more rigorous and integrated longer term transformation and financial strategies and to develop joint delivery plans with providers.

Part 1 – Annex 1: Detailed Scheme Description

See Appendix 1

Part 1 – Annex 2: Provider Commentary

See Appendix 2

This page is intentionally left blank

Staffordshire Better care Fund **Appendix 1**

DRAFT

Collection of Detailed Scheme Descriptions for each scheme/project included within the BCF

Ageing Well

Falls Prevention – Scheme ref no 1.1

ANNEX MISSING

Localities Commissioning – Scheme ref no. 1.2

ANNEX MISSING

Support to Live at Home

Disabled Facilities Grant – Scheme ref no. 2.1

Scheme ref no. 2.1
Scheme name **Disabled Facilities Grants**
What is the strategic objective of this scheme?
Adapting homes so that people with disabilities can remain living safely at home within their communities.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Disabled Facilities Grant (DFG) is a mandatory means tested grant funded by central and local government and administered by separate District Councils in order to help people who have been assessed as needing major adaptations to their property because of their disability, so that they can lead healthy, independent lives at home. DFGs are the statutory responsibility of district and borough councils Grants cover 'simple' large scale equipment such as stair lifts and hoists, and 'complex' adaptations involving surveyor/architectural drawings e.g. level access showers, ramping, or extensions. Ultimately the grant is one of the key services through which independence and wellbeing is promoted and maintained, reducing pressure on acute and community based services, preventing unplanned admissions and delayed discharges, delivering improved outcomes for customers and their carers. Similarly to integrated equipment services, the speed and efficiency of adaptation through DFGs is crucial.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The County Council has signed a participation agreement with all 8 District Councils to work together on improving the delivery of DFGs. A new county-wide Home Improvement Agency (HIA) contract will commence in October 2014, with Staffordshire Housing delivering a more efficient and consistent service, focussed on delivering outcomes for each service user.

A county-wide adaptations policy has been adopted and further joint working is planned for 2014/15 to improve joint working, develop protocols with housing providers and make better use of properties that have already been adapted.

The district councils retail the mandatory duty to award DFGs, and rely upon this funding to meet that duty.

The evidence base
Please reference the evidence base which you have drawn on

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

It is estimated that around one in five people in Staffordshire have a limiting long term condition which increases significantly with age.

There are 800 referrals per annum from Occupational Therapists for disabled people requiring adaptations to their home. Of these 640 results in a DFG to fund these adaptations at a total cost of approximately £4m. Of these 40.1% have a reduced reliance on social care, which equates to a saving to social care of approximately £4.75m annually.

Further analysis of social care records shows that people who have received a major adaptation and subsequently need residential care, on average enter residential care at the age of 81.5, compared to 70.1 years of age those who haven't. (can the saving for this be quantified?) Furthermore, those who haven't received a major adaptation stay in residential care for 6.5 years on average, compared to 2.4 years for those who have. This not only highlights a clear improvement in outcomes for people receiving major adaptations, but also demonstrates that a 4.1 year saving in care costs of nearly £50k. Using the proportion of older people currently living in residential care as a conservative benchmark would equate to an additional saving of around £270,000 annually.

For GPs and Clinical Commissioning Groups the service would have impacts, but particularly on:

- Reduced NHS expenditure as a result of reduced falls, infections and accidents in the home;
- Reduced delay to hospital discharge process,
- Reduced hospital acquired infections, and
- Improved quality of life for disabled people and their carers.

The savings attributed to these areas were considered as part of a Social Return on Investment study for a similar service in West Lothian. If the same methodology were applied to Staffordshire, this would equate to a saving of around £2.25m per year

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

Note DFG Funding as detailed in DOH notification of £3.804m

Cannock Chase	414
East Staffordshire	436

Lichfield	421
Newcastle-under-Lyme	654
South Staffordshire	431
Stafford	570
Staffordshire Moorlands	654
Tamworth	224

This funding allocation is based in part upon historic funding bids and does not necessarily reflect relative need or meet current demand. Work is being undertaken to establish the need for adaptations and consider the funding requirement and appropriate allocations.

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

DFGs provide a number of benefits which include the following.

- Provision of inclusive and supportive home living environment which promotes management of chronic illness and disability where possible and promotes ongoing potential for rehabilitation and improvement.
- Improved daily living skills and independence
- Potential to reduce care packages as independent living skills are enabled by home environments
- Promotion of quality of end of life care which can be enabled by adaptation/equipment and associated benefits to clients/families
- Reduction in 'revolving door' referrals into services as needs are more independently managed at home

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

The use of a bespoke Outcomes Star, incorporating 'housing needs, to asses need ensuring a holistic approach covering all aspects of a customer's well being which includes the following personal outcomes

- Reduced cost of their care
- Be more likely to live at home for longer
- Be less dependent on carers and/or social care services
- Be less likely to be admitted to hospital
- Be less dependent on health care services
- Be discharged form hospital quicker

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

Participation agreement and new HIA contract in place and delivery will be monitored by a multiagency steering group.
The steering group is also working on streamlining and standardising procedures across the County.

Adult Social Capital Grant – Scheme ref no. 2.2

ANNEX MISSING

Scheme ref no. 2.3

Scheme name

Technology Enabled Care Services (TECS) and Assistive Technology

What is the strategic objective of this scheme?

People living in Staffordshire will be supported to manage and improve their health and well-being through Technology Enabled Care Services

Overview of the scheme

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

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

A range of projects and interventions is currently being designed.

The delivery chain

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

All of the health and social care commissioners across Staffordshire and Stoke-on-Trent, along with the NHS Trusts and major housing providers, have come together to establish a single coordinated programme, hosted by University Hospital of North Staffordshire (UHNS).

At present, there are approximately 2,000 clients receiving simple telecare in Staffordshire. In addition, about 12,000 have community alarms. The aim of this investment is to continue to improve the offer of simple telehealth and further embed use of telecare by all Living Independently Teams. The Assistive Technology funding will also continue to support the 'Live at Home' facilities, which allow people to try out assistive technology in mock homes and receive support in a community hub setting. In many cases, these facilities are jointly delivered with partner agencies, such as Staffordshire Fire and Rescue Service.

The evidence base

Please reference the evidence base which you have drawn on

-

The TECS programmes is currently collecting the necessary evidence base to direct its next steps.

Investment requirements

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

The contribution of the CCGs and County Council across Staffordshire, drawn from the BCF pool, will amount to £840k annually. In addition, £508k will continue to be devoted to Assistive Technology. Additional contributions, amounting to some £2m annually, will be made by the other partners.

Impact of scheme

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

- Reduced proportion of people who reach a point of crisis that requires emergency admission to hospital, admission to a care home, or GP call out.
- Increased ability to respond quickly to an emergency or react to deterioration in health at home.
- Increased opportunities for self-purchase by people who have concerns and want to take early action to monitor changes or protect their independence.
- Increased number of people living as independently as possible and carers feeling reassured.

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A TECS Programme Board has been established, bringing together all of the partners. This provides oversight of, and direction to, a series of project groups and is supported by five advisory groups, which ensure the approach is firmly based on perspectives from service users, clinicians, information management, workforce, and quality management.
What are the key success factors for implementation of this scheme?
The next steps of the programme are dependent upon the final success of a bid for national funding to enhance the local contributions.

Integrated Community Equipment Service (ICES) – Scheme ref no. 2.4

Scheme ref no. 2.4
Scheme name
Integrated Community Equipment Service (ICES)
What is the strategic objective of this scheme?
Providing aids and equipment so that people with disabilities or recovering from healthcare interventions can remain safely at home within their communities
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Health and social care prescribers across all acute and community providers have access to a catalogue of aids and equipment, from which they can draw down items suited to support the needs of people who are either finding it difficult to remain living independently at home or who are about to be discharged from hospital. Items may be provided on a permanent basis or for a limited time, to support rehabilitation. Once ordered by a prescriber, items are delivered to a set of agreed timescales to the user's home. Servicing, repair and maintenance, and replacement of consumables is undertaken while the equipment is in use. When no longer required, items above an agreed value are collected, cleaned and refurbished wherever possible, and recycled for further use.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
During 2012/13, all of the CCGs and both upper tier Local Authorities across Staffordshire and Stoke-on-Trent undertook an open procurement to bring together a range of separate services provided by different organisations into a single new service. The contract, secured by Medequip, came into operation on 1 April 2013. The service is commissioned by Staffordshire County Council, operating through a s75 agreement with the CCGs across the county, and a collaboration agreement with the s75 arrangements between the CCG and City Council in Stoke. The work is governed by a joint Board.
The evidence base Please reference the evidence base which you have drawn on -

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£4.809m
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reports indicate that the ICES is delivering more equipment more quickly to customers, resulting in: • greater user satisfaction, • reduced hospital & care home admission/readmission • earlier hospital discharge • reduced unit cost for items of equipment
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A full cost benefit realisation will be completed by the end of September 2014 to demonstrate the full impact. This will be considered by the ICES Board, which will agree actions to be taken by the commissioning team, hosted by the County Council.
What are the key success factors for implementation of this scheme?
S75 agreement across Staffordshire and Collaboration Agreement with Stoke, monitored by ICES Board.

Support to Live at Home Voluntary Sector Day Services (North Staffs) – Scheme number 2.5

Scheme ref no. 2.5
Scheme name
Support to Live at Home Voluntary Sector Day Services (North Staffs CCG), Approach & Moorlands Homelink
What is the strategic objective of this scheme?
To enable elderly people including those with dementia to remain in their own home and to live as independently as possible.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
These services support the cross economy transformation programme which aims to deliver comprehensive multi-agency community-based care and support for people with frailty, complex needs and/or long term physical and mental health conditions. **Approach** Approach provides specialist day care for older people with mental health needs or dementia. As part of a wider provision of day care in North Staffordshire, Approach is contracted to provide 15 places each week within its day care provision in the Newcastle area. Each group provides a structured programme and group sizes are kept small so that everyone has plenty of help and support. Approach aims to deliver services that focus on outcomes based on improving the quality of life of the

services user and their family, through the promotion of well-being (both physical and mentally) using individualised person centred care plans and support mechanisms

Moorlands Homelink

Moorlands Homelink supports older people of the Staffordshire Moorlands who are excluded through poor health, loneliness and isolation by providing opportunities for socialisation and inclusion which allow them to feel included and supported in their own communities while living at home.
The service provides information and advice enabling people to access appropriate services and benefits.
Day care is provided in a number of locations throughout the Moorlands for older people who are frail either mentally or physically to provide stimulation and carer relief.

Through these services, service users and their carers will have reduced feelings of isolation, be stimulated and motivated, encouraged to care for themselves and maintain independence and feel less anxious and depressed.

This will reduce dependence on health services and help prevent the need for admission to hospital.

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

The services are commissioned by North Staffordshire Clinical Commissioning Group and provided by 3rd sector organisations: Approach and Moorlands Homelink.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The following documents and locally commissioned reports have been used to develop the programme these are:

- Older People and Emergency Bed Use, The Kings Fund, 2012
- The Health and Social Care Act (2012) sets out an explicit focus on the importance of integrated care.
- EICST/Mott, Capita and ATOS overview of the urgent care and community service offers
- Fit for the Future Business Case
- Everyone Counts
- Public Health Indicators/demographic change
- Data developed through participation with the LTYC project
- No Health without Mental Health
- NHS Constitution
- Health and wellbeing profile North Staffordshire 2012
- Keogh Report
- Cross economy modelling overseen through the Cross Economy Leaders Group
- Dementia 2012: A National Challenge
- Alzheimers Society dementia hospital research
- The NHS Outcomes Framework 2014/15

Like most of the country, North Staffordshire is experiencing a continuing rapid increase in the proportion of older people in the population. This increasing proportion of older people in the population will make increasing demands on health and social care services. Positive, proactive approaches to service development providing individualised support can help ensure that psychical and mental health are sustained as long as possible, that people live at home as long as possible and that crises and unnecessary use of intensive services are minimised.

Approach adopts the Tom Kitwood social care model which forms the basis of a person centred approach to improving quality of life and the physical and mental well-being of people using our services

Moorlands Homelink have undertaken monitoring of client admissions to urgent care over a 6 month period which showed only 4 admissions from 438 clients. These people were able to return to the service post admission through discharge planning.

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

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

Contribution to BCF outcome metrics:

- More patients supported to remain in their home
- Reduced admissions to long term care
- Reduced non-elective admissions to acute care

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

Local service evaluation to measure the impact of this service on the key outcomes

Regular contract performance meetings.

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

1. More people supported to live at home.
2. The number of people admitted to long term care
3. Number of non-elective admisissions
4. People experience an improved quality of life.

Carers

Carers Services

Scheme ref no. 3

Scheme name

Carers (Inc. Carers Breaks, Mental Health Carers Support and Information for Carers) (need to include dementia carer cafes)

What is the strategic objective of this scheme?

The strategic objective of the Carers Scheme is to jointly commission improved outcomes for carers through a Whole Carers System Redesign, which includes the re-commissioning of Carers Breaks and wider universal carers support.

Staffordshire's JHWS Living Well in Staffordshire places an emphasis on working together to jointly support carers, "We also need to do more to support carers." The Health and Wellbeing Outcomes Framework within the Strategy identifies the following Specific aim and Indicator: Enhancing quality of life for people with long term health, care and support needs – Carer reported quality of life.

Improved outcomes for carers will have a positive impact on improved health and wellbeing outcomes for carers, which will have a positive impact on reduced non elective admissions, delayed transfer of care and admission to residential and nursing homes.

The **Staffordshire Carers Partnership (SCP)** was established February 2014 to provide strategic direction, governance and accountability for Carers outcomes in Staffordshire.

Healthwatch Staffordshire are currently leading independent Carers engagement activities on behalf of the SCP (see Appendix A – Support for Carers: Interim Report).

The SCP provides the strategic direction for the Staffordshire **'Carers Whole System Redesign'**, which is set out within the **SCP Framework** (see Appendix B – SCP Framework). The SCP Framework is not a static document and will evolve as the Partnership develops. The SCP Framework will replace the Joint Commissioning Strategy for Carers (2011-16) once formally agreed by SCC Cabinet and CCG Boards (September 2014)

The SCP is accountable to the Health and Wellbeing Board, and formally reports to the Integrated Commissioning Executive Group (ICEG). The SCP will also be the mechanism for reporting progress on the Carers Schedule within for Integrated Commissioning (IC).

The SCC Commissioning Manager for Carers and Wellbeing is jointly appointed across both People (Community Wellbeing Team) and Public Health to maximise on improved health and **wellbeing outcomes** for Carers, which is now a statutory of the **Carer Act**:

*"Local authorities **must promote wellbeing** when carrying out <u>any</u> of their care and support functions in respect of a person"*

Care Act Guidance (2014)

This also ensures links within the SCC Community Wellbeing Team, who are the commissioning leads for **Information, Advice and Guidance**, which is part of the Universal Carers Offer currently undergoing Whole System Redesign and also a statutory responsibility of the **Care Act:**

*"Local authorities **must** establish and maintain a service for providing people in its area with **information and advice** relating to care and support for adults and support for carers".*

Care Act Guidance (2014)

Dementia Carer Cafes are also made available to carers in order to achieve the following outcomes:

- Peer support
- Structured carer activities
- Cognitive stimulation therapies
- Contingency planning for carers (to avoid a crisis and possible admission to acute or long term care)
- Information for those either newly diagnosed or new carers

- Carer education, information & advice

The new services will improve outcomes for carers of people with dementia, and increase the number of carers supported – also making the service appropriate for young and older carers as well as those who are unable to attend cafes i.e. those who might benefit from telephone support. The contract value is also being used in order to generate methods of self-sustainability for the future – encouraging people to donate and contribute to the service costs. Carers accessing the service who are no longer in a caring role are encouraged to become volunteers to support the service and help it to grow.

Overview of the scheme

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

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

This Scheme is targeted at Carers, the census identifies that there are just under 100,000 carers across Staffordshire. However these figures are likely to be an underrepresentation of the true picture. Many individuals who care do not recognise themselves as carers and therefore remain under the radar of professionals. With the number of carers projected to increase over the next 30 years by 60% we need to work in partnership to identify more effective ways of improving outcomes for carers locally.

	Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
England	**5,430,016**	**3,452,636**	**721,143**	**1,256,237**
Staffordshire	**98,832**	**63,791**	**12,628**	**22,413**
Cannock Chase	11,817	6,947	1,736	3,134
East Staffordshire	11,467	7,492	1,443	2,532
Lichfield	11,569	7,662	1,359	2,548
Newcastle-under-Lyme	14,731	9,235	1,972	3,524
South Staffordshire	13,542	9,145	1,721	2,676
Stafford	15,040	10,208	1,709	3,123
Staffordshire Moorlands	12,551	8,308	1,545	2,698
Tamworth	8,115	4,794	1,143	2,178

Source: Census 2011

The Carers Scheme includes the re-commissioning of **Carers Breaks** and wider Universal Carers Support across Staffordshire through a **Carers Whole System Redesign.**

Existing **Carers Breaks** and wider Universal Carers Support is delivered via the voluntary and community sector, which is due to go out to open tender February 2015.

The **Carers Breaks** service in Staffordshire currently enables carers to access a break from their caring role for example through the purchase of alternative care or assistive technology. This service will be re-commissioned to develop more sustainable Carers Breaks options for example through peer/ volunteer support.

SCP aims to achieve a **Carers Whole System Redesign** which focuses on the following key areas:

- **Integrated Commissioning** (IC) for Carers health and wellbeing outcomes with **CCGs** through the **Better Care Fund** (BCF)
- Modernisation of the **Staffordshire Carers Journey** and **Carers Outcomes Framework**
- **Care Reform** (Care Act, Children & Families Act)
- Early Intervention, **Prevention** and Carer **Crisis Prevention**
- A **Locality** Approach to achieve improved outcomes for Carers at a community level;
- Building Community Assets, Community Capacity and Community Resilience to promote 'Individual and Community Autonomy'' (while recognising Carers as an asset who provide £1.825 billion of care in Staffordshire per year)
- **Co-production** and co-design with Carers, Market Providers and wider Stakeholders

Improved Outcomes for Carers in Staffordshire
The main aim of reshaping support for Staffordshire Carers is to improve outcomes for carers in Staffordshire.

Increased Value for Money – A more Power Investment
Commissioning improved outcomes for carers in Staffordshire will result in a more powerful investment in the way we commission support for carers in Staffordshire.

Joint Commissioning across Staffordshire and Stoke-on-Trent
Joint commissioning and procurement activities across Staffordshire and Stoke-on-Trent, between Staffordshire County Council, Stoke-on-Trent City Council, North and South Staffordshire CCGs, will ensure improved pathways and consistency in outcomes for carers.

A shift to a Whole Family Approach
The Whole Family Approach is supported through the Care Act with the intention for local authorities to take a holistic view of a person's needs, in the context of their wider support network. The approach will consider how carers, young carers and their support network or the wider community can contribute towards meeting the outcomes they want to achieve.

A Modernised 'Carers Hub Model'
A Carers Hub Model will provide one point of contact for carers to improve access to local support including 'Information Advice and Guidance', with a tried approach to Assessment, Care and Support (see figure 2.0). Feedback from engagement with local Carers supports the shift to a 'Carers Hub' approach.

A shift from a Deficits Approach to an Assets Based Approach
Reshaping support for Staffordshire carers will enable a shift from paternalistic support for carers, to a more personalised approach which will enable carers to become more independent and supported at an individual and community level. A 'person centred approach' will also promote 'Personal Autonomy' by empowering carers to build on existing networks of family, friends and community support.

Improved Staffordshire Carers Journey
Improved pathways for carers will increase identification, awareness, access and improve outcomes for carers in Staffordshire. Feedback from local carers identifies that a key concern is access to timely information, advice and guidance. We can commission for improved pathways through the development of a 'Carers 'Hub' approach, however much of the work in this area will be achieved through partnership working, influence and leadership through the SCP.

A Shift towards Universal / Community Level Prevention
Promoting sustainable, community level support for carers, which is coordinated through the Carers Hub approach. A shift to universal prevention will enable carers and communities to support each other. The development universal access points for carers, such as schools, GP Surgeries, and the workplace, with improved universal access to information advice and guidance, through a 'Carers Hub' approach.

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

Carers Breaks and wider Universal Carers Support is jointly commissioned by:

- Staffordshire County Council, SCC (delegated commissioning lead on behalf of CCGs)
- Stafford and Surrounds CCG
- Cannock Chase CCG
- East Staffordshire CCG
- South East Staffordshire CCG
- North Staffordshire CCG

Carers Breaks and wider Universal Carers Support is currently delivered by two main local carers voluntary and community sector organisations:

- North Staffs Carers Association (NSCA)
- Carers Association Southern Staffordshire (CASS)

The SCP works across two levels

- Governance and Strategic Direction (meets quarterly)
- Task and Finish / Project Groups / Work Streams

There are five core Work Streams that report the SCP Governance Group quarterly:

- Young Carers
- Engagement, Co-production and Insight
- Care Reform
- Health and Wellbeing / Life Outside of Caring
- Information, Advice and Guidance / Carer Awareness and Recognition

SCC and CCGs are members of the SCP and form a joint Carers Commissioner Steering group, who are leading the re-commissioning of Carers Breaks and wider Universal Carers Support across Staffordshire.

NSCA and CASS are also members of the SCP at the governance level and as the lead on the Carers Information, Advice and Guidance work stream.

Key Stakeholders who form the membership of the SCP at both levels include:

- Carers
- Heathwatch Staffordshire
- SCC Commissioning Managers
- CCG Commissioning Leads
- Stoke on Trent City Council Carers Commissioning Lead
- Voluntary and Community Sector Providers
- SSOTP
- Mental Health Trusts
- Independent Futures
- Families First
- Housing
- District Representatives
- Staffordshire Police
- Staffordshire Fire and Rescue
- Job Centre Plus
- Local Pharmacy Committees

The evidence base
Please reference the evidence base which you have drawn on

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

Permanent admissions of older people (aged 65 and over) to residential and nursing care

homes, per 100,000 population

- Carer-related reasons for admission to nursing or residential care are common, with carer stress the reason for admission in 38% of cases.**Error! Bookmark not defined.Error! Bookmark not defined.**
- **Commissioning breaks, training, information and emotional support for carers** could reduce the overall spending on care by local authorities by more than £1bn a year.
- Providing carers with **breaks, emotional support and access to training** can significantly delay the need for the person receiving care to go into residential care.**Error! Bookmark not defined.Error! Bookmark not defined.**
- A longitudinal study of 100 people with dementia found a 20-fold protective effect of having a co-resident carer when it comes to preventing or delaying residential care admissions. Further studies have confirmed that where there is no carer, the person receiving care is more likely to be admitted into residential care.**Error! Bookmark not defined.Error! Bookmark not defined.**

Delayed transfers of care from hospital per 100,000 population (average per month)

- Carers who do not feel prepared or sufficiently supported are one cause of delayed transfers of care which can cost the NHS £150m per year.**Error! Bookmark not defined.Error! Bookmark not defined.**
- In 2010, The Carers Trust published 'Out of Hospital' to make recommendations to help to reduce delayed transfer in care:
    - include identification, recording and referral of carers in hospital discharge policy;
    - collect clinical audit data on the numbers of carers identified and the impact of providing carer support on patients and hospital, e.g. improved patient experience of discharge, increased hospital efficiency;
    - health commissioners should agree carers' standards as part of the contract with hospital trusts;
    - health commissioners should actively participate in local strategic and developmental work on carers issues, e.g. local carers' strategy.

Non Elective Admissions

- Admission or readmission to hospital by a person with a long-term condition can be an indication that the carer is no longer able to care, often due to the strain of caring causing physical or mental ill health, or that discharge planning is poor and the carers is not involved as an expert partner in care. One study found that problems associated with the carer contributed to readmission in 62% of cases.**Error! Bookmark not defined.Error! Bookmark not defined.**

Carers UK National Carers Survey: The State of Caring (2014)
80% of carers report that caring has a negative impact on their health
69% of carers find it difficult to get a good night's **sleep** as a result of caring
73% of carers surveyed reporting increased **anxiety**
82% of carers have increased **stress** since taking on their caring role
50% stated they were affected by **depression** after taking on a caring role
http://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2014

Personal Social Services National Survey of Adult Carers in England – 2012/13
The Staffordshire questionnaires were sent to 1000 Carers. A random sample was generated applying the following criteria: carers of people aged 18 or over, and who were assessed between October 2011 and September 2012. The response rate was 48%. Of the respondents:

- Almost two thirds are female (64%).
- More than half (51%) are aged 55-74, while almost one in ten is aged 85 or above (8%).
- Almost a third of the people being cared for are aged between 75-84 (29%), while just over a third is 85 or above (35%).
- In respect of the range of physical and/or mental problems experienced by the cared for person, more than a third (37%) has a physical disability, including sight or hearing loss, while one in five has problems connected to ageing (20%).

Carers were asked if they had any physical, mental or long standing health conditions. Excluding

those reporting no health issues (38%), almost half (47%) have a physical impairment, including sight or hearing loss, while almost one third (32%) say they have a long term condition. Meanwhile, almost one in 10 (9%) said they have either a mental health condition or a learning disability.

In terms of the types of support used by the cared for person, more than a third (40%) use Equipment/Adaptations, while a third (33%) use traditional services such as home care/home help, Day Centre/Day activities, Lunch Club or meals. Fewer than one in five (17%) use a service which allows a break in caring, either in an emergency, from 1-24 hours, or 24 hours and above.

Qualitative feedback from carers identified the following feedback in terms of access to information advice and guidance:

Are asking for information and advice	**Found advice unhelpful or expressed a lack of resolution to their difficulties**	**Found information and advice provided helpful**	**Felt unable to obtain appropriate information, advice or services or don't know what's available**	**Thought the response was too slow**
Didn't know who to contact and/or found it confusing to access information, advice, support.	**Tried to contact a service but no one replied**	**Had contact with services but either no information, advice or support was given or it was unhelpful**	**Difficulty getting through to the right person**	**Found individual or service helpful**

Some of the key recommendations from the Staffordshire Carers Survey included:

- Building better links and signposting between partner agencies
- Improved access to information advice and guidance
- Increased access to carers breaks services

Carers Conversation - Carers Engagement

Independent Carers Engagement activities have been undertaken by Healthwatch Staffordshire on behalf of the SCP to inform our Commissioning Intentions, Carers Outcome Framework and Service Specifications. Common Themes identified by the engagement include:

- Access to breaks was valued by carers, who feel that it helps with their mental and physical wellbeing
- Timely access to information advice and guidance is important to carers
- To avoid confusion carers would like a single central body to contact for information, signposting and advice

Appendix A – Support for Carers: Interim Engagement Report
Appendix C – Healthwatch Staffordshire Carers Engagement Methodology
Appendix D – SCP Carers Engagement, Coproduction and Insight Framework

Investment requirements

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

	NS CCG	S&S CCG	CC CCG	ES CCG	SES&S CCG
Carers Breaks	£45,668	£91,584	£88,888	£101,570	£164,110
Mental Health Carers Support	£3,038	£11,763	£12,145	£14,289	£20,580

Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Vicky – We are in the process of developing a Carers Outcomes Framework (see table 1 / figure 1 below) But I'm not sure how we could directly evidence the financial impact of supporting Carers using the BCF metrics??
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Key Success Factors for the Carers Scheme include: - A Carers Whole System Redesign, through an 'Integrated Commissioning Approach' which includes the re-commissioning of Carers Breaks and wider Universal Carers Support across Staffordshire. - The alignment of the Carers Whole System Re-design with the Care Act, with a focus on improved Carers Pathways, Information Advice and Guidance, Wellbeing and Prevention. - A 'Co-production Approach' to Carers Commissioning, through ongoing engagement with Carers and Providers to inform the development of the Carers Outcomes Framework and Modernised Carers Service Specification. - A strong 'Partnership Approach' through the Staffordshire Carers Partnership (SCP) with buy in from all partners. Improved outcomes for carers will be achieved through re-commissioning and modernising Universal Carers Support in Staffordshire. However the SCP will enable the greater influence to improve links between partner agencies as well as aligned and improved carers pathways.

Frail Elderly

Social Care Transfers – Recurrent Funding (S256)

Discharge and reablement – scheme ref no. 4.1

Scheme ref no. 4.1
Scheme name:
Discharge and Reablement
What is the strategic objective of this scheme?
To support the delivery of the Joint Health and Wellbeing Strategy Vision for People in Staffordshire

and the County Council's Living Well Outcome Plan through a range of social care initiatives.
The overall objectives of the Living Well Outcome Plan are:

- Enable positive behaviour and supporting those who need it most.
- Improve the wider determinants of health to improve quality of life for all.
- Support independence at all ages and for those with disabilities and illness.
- Prepare for the later stages of life to ensure a high quality of years as well as increased life expectancy.

The impact for people within Staffordshire is to support people who have Long Term Conditions or who are frail older people and their families and carers to be:

- As independent as possible
- Have the knowledge to make informed decisions
- Have choice and be in control of decisions made about their care
- Be part of a community
- Receive support at the right time, not for a lifetime.

Overview of the scheme

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

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

The funding will be used to protect a range of services connected to respite, hospital discharge, and reablement:

- Hospital Discharge Teams - All areas have hospital discharge teams, but in order to boost capacity and support Urgent Care Plans there is a small investment. In addition, much work has been undertaken to streamline processes, e.g. dispensing with Sections 2s and 5s to support rapid flow and reduce bureaucracy.
- Hospital Discharge Service (Age Concern) - Additional capacity for domiciliary care, focusing on services for older people. The service ensures that people are well supported in their own homes, thus reducing the need for hospital or residential care.
- Integrated Community Intervention - Enhancing the core service to offer rapid intermediate care is key to the successful reablement of individuals. Evidence shows that getting clients, particularly those who are frail or suffer dementia home after hospitalisation is important in terms of their ability to recovery their independence. Often it is not health related issues which prevent hospital discharge but the fact there is no food in the fridge.
- Enablement Teams (LIS) - Specialist social work and therapy input to get people home and ensure they recover as much independence as possible
- Enablement Flats - This is payment towards rental and utility costs of some enablement flats in Newcastle. The enablement flats help people to become more independent thus avoiding longer-term support.
- Independent Sector Beds for Respite / Intermediate Care - Although the aim of the services is to shift spend to prevention in some cases we recognise there is a need to commission short term beds to support hospital discharge, carer respite and support winter planning.
- Great Wyrley CSU (Respite Beds) - This is an SCC run registered Care Home located in South Staffordshire currently used for respite only, for older people with a substantial or critical level need. Residential respite provides short-term care for mainly older people (65+) who normally live at home, often with relatives or someone else who cares for them. The main purpose is to provide a break for the carer to enable them to continue to undertake their role as carer and reduce the risk of hospital or care home admission

The delivery chain

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

These services are commissioned through the County Council, with the majority delivered through existing providers and contract arrangements reducing the need for time intensive procurement exercises and ensuring whole year performance benefit from the investment.

The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The schemes involved in this area have shown over an extended period that they make a significant contribution towards keeping people in their own homes and reducing the number and duration of non-elective hospital episodes. As one example, in 2013/14 the Great Wyrley CSU was used by 139 people for a total of 3,720 nights. The usage of the unit is split between Cannock CCG residents (70%), South East Staffs and Seisdon CCG residents (15%) and Stafford & Surrounds CCG (15%). SCC are currently completing a review of all in-house and external respite provision across the county and analysis of demand and supply to inform future provision, and are seeking to increase benefits through this review.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Hospital Discharge Teams - £1.854m Hospital Discharge Service (Age Concern) - £30k Integrated Community Intervention - £4.226m Enablement Teams (LIS) - £4.672m Enablement Flats - £22k Independent Sector Beds for Respite / Intermediate Care - £843k Great Wyrley CSU (Respite Beds) - £653k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
5. More people are safely supported to stay at home following an acute admission. 6. More people supported to live at home with reduced ongoing needs. 7. Reduction in referral to assessment completion timescales. 8. Reduction in the timescales from completed assessments to start new packages of care. 9. The number of people admitted into a residential or nursing home for the first time following and acute admission reduces 10. People experience an improved quality of life as a consequence of health and social care intervention 11.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
There are established mechanisms with our main delivery partner SSOTP, we will be using these mechanisms to monitor the achievement of outcomes and where delivery is through another provider this will be embedded within the contract arrangements. Staffordshire has a mature history of joint commissioning with our CCGs and we will embed the monitoring and evaluation of these initiatives within out joint working arrangements.
What are the key success factors for implementation of this scheme?
The key requirement for success is for all parties, commissioners, SSoTP and providers alike, to develop and adopt a new approach to ensuring individuals are able to remain living independently in the community. This will involve a shift of mindset away from a focus on determining the inputs of care – in terms of a certain number of visits per week, each lasting a given duration – towards an emphasis on outcomes – in terms of individuals facilitated to maintain the greatest possible level of independence.

Market Development and Domiciliary Care - scheme ref no. 4.2

Scheme ref no. 4.2

Scheme name

Market Development of Domiciliary Care

What is the strategic objective of this scheme?

To support the delivery of the Joint Health and Wellbeing Strategy Vision for People in Staffordshire and the County Council's Living Well Outcome Plan through a range of social care initiatives.
The overall objectives of the Living Well Outcome Plan are:

- Enable positive behaviour and supporting those who need it most.
- Improve the wider determinants of health to improve quality of life for all.
- Support independence at all ages and for those with disabilities and illness.
- Prepare for the later stages of life to ensure a high quality of years as well as increased life expectancy.

The impact for people within Staffordshire is to support people who have Long Term Conditions or who are frail older people and their families and carers to be:

- As independent as possible
- Have the knowledge to make informed decisions
- Have choice and be in control of decisions made about their care
- Be part of a community
- Receive support at the right time, not for a lifetime.

Overview of the scheme

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

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

Quality of and access to domiciliary care is variable across Staffordshire, with concerns expressed by all partners on the ability of these services to deliver positive outcomes and avoid Delayed Transfers of Care and hospital admissions.
Work has begun to review current domiciliary care provision, and a longer-term vision has been agreed by all partners.
Investment will ensure ongoing stability of the domiciliary care provision by maintaining increased payments to providers in areas where provision was previously failing. The joint project team is working to transform service delivery to focus on outcomes, rather than just task and time, and in the meantime to secure short-term solutions to maintain stability of the market.

The delivery chain

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

Domiciliary services are commissioned by Staffordshire County Council, through its s75 arrangement with SSoTP. Under this arrangement, SSoTP holds the budget for all placements and either calls off care from contracts held by the County Council or secures care directly through its own contracting functions. In order to avoid conflicts of interest, it has been agreed that SSoTP will not provide domiciliary care, other than where the level of acuity is such as make full integration of the health and social care aspects essential.
Domiciliary care is provided through a large number (up to 100) of independent and third sector organisations, operating across the full spectrum of size and scope. In accordance with the principles of choice and control encapsulated in the Care Act, the County Council is seeking to promote and develop this market, to support the availability of a wide range of providers able to offer responsive and high quality services to Staffordshire people, in ways that accord with the specific needs and wants of individuals.

The evidence base

Please reference the evidence base which you have drawn on

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

Current interventions to support the domiciliary market are based on analysis of the ability of the market to meet demand, complemented by extensive engagement with service providers and with SSoTP as the micro-commissioner. In addition, approaches and experience is being drawn from national exemplars and programmes, as well as from other Local Authorities directly.

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£1.8m in additional funding to enable care providers to support packages that involve relatively short visits.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The domiciliary care market will remain viable, with fewer providers failing financially, better quality of care available, and service users placed more easily with providers, thereby facilitating early discharge from hospital and reductions in the number of crises that might require non-elective admission.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A joint project group, bringing together key staff from the County Council and SSoTP has been formed and is actively reviewing the position and is engaging with providers and other partners to identify options for the future and the impact of actions taken.
What are the key success factors for implementation of this scheme?
The key requirement for success is for all parties, commissioners, SSoTP and providers alike, to develop and adopt a new approach to ensuring individuals are able to remain living independently in the community. This will involve a shift of mindset away from a focus on determining the inputs of care – in terms of a certain number of visits per week, each lasting a given duration – towards an emphasis on outcomes – in terms of individuals facilitated to maintain the greatest possible level of independence.

Implementation of the Care Act - scheme ref no. 4.3

Scheme ref no. 4.3

Scheme name:

Care Act Implementation Funding (Revenue)

What is the strategic objective of this scheme?

1. **To support the delivery of the Joint Health and Wellbeing Strategy Vision for People in Staffordshire band SCC Living Well Outcome Plan.**
2.
3. Cabinet and SLT has expressed through the Business Plan how the County Council will deliver a commissioning authority and meet the priority outcomes for Staffordshire People and communities:

    - *Be able to access more good jobs and feel the benefits of economic growth*
    - *Be Healthier and More Independent*
    - *Feel safer, happier and more supported in and by their community*

The overall objectives of the Living Well Outcome Plan are

- **Enable positive behaviour and supporting those who need it most.**
- **Improve the wider determinants of health to improve quality of life for all.**
- **Support independence at all ages and for those with disabilities and illness.**
- **Prepare for the later stages of life to ensure a high quality of years as well as increased life expectancy.**

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

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

The Care Act is huge piece of legislation that consolidates existing legislation, amends others and in limited cases introduces new statuary conditions. The Act reflects the Government's intention to create a more sustainable and integrated care system that ensures a clear pathway for service users moving through the health and care systems. The act also creates a statuary footing for wellbeing and preventative measures, the provision of Information and Guidance and the development of new finance mechanisms to fund care.

In terms of expenditure, the Social Care and Health represent the largest spend for the Local Authority. The Care Act will be a key factor in the successful delivery of the 'Living Well Agenda' and the priority objectives of ensuring people are 'Healthier and more independent'.

The implementation funding will be utilised across both the County Council and it's providers of assessment and care management to prepare for implementation and to ensure that appropriate resources and systems are in place by April 2016.

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

The lead Commissioner is the Commissioner for Care within Staffordshire County Council and the County Commissioner for Older People and Market Development.

There is an established Care Act Programme which includes the following work streams.

Work stream	Members	Deliverables
Regulation, Policy and Comms	Ben Odams (Lead), Claudia Brown, Mark Sproston, Andrew Errington, Lee Pardy-McLaughlin and Legal Representative	1. Briefing on the regulations 2. Respond to the Government's consultation 3. Update all of the policies • Contributions and charging • Ordinary residence and continuity of care (needs to include extra care housing) • Prisons and continuity • Eligibility criteria inc carers • Assessment pathway and advocacy (inc tiers of assessment) inc carers • Financial advice • Deferred payments • Prevention • Provider failure • Refresh of direct payments and personal budgets approach

		• Practice manual • Transitions 4. Review of Delegation 5. Develop a Prevention Strategy 6. A Guide to the Care Act (for County Council Staff, Providers, Service Users etc)
Assessment, Eligibility and Support Planning	Helen Trousdale(Lead),, Jeanette Knapper, Denise Tolsen, Julie Forrest-Davies, Plus Representatives from SSOTP, Mental Health (Mark Cardwell, Andy Oakes) and Independent Futures (Jeanette Knapper)	1. Refresh the Practice Manual 2. Approach to Personalisation 3. Self funders, Carers and Walk in 4. Prisoners and Veterans 5. Embed Prevention 6. Transition 7. Deficit Capacity Plan
Insight and Care Markets	Bev Jocelyn (Lead), Shirley Way, Enrique Centeno, Lucy Heath, Esther Jones, Corporate Insight Representative, Other Commissioners.	1. Scope additional demand 2. Risk analysis around Care Markets 3. Refresh the Market Position Statement 4. Engage with the Care Market 5. Use the ELSA data to undertaken a 'map and gap' exercise 6. Deficit Capacity Plan
Finance	Sara Pitt (Lead), Lee Assiter, Chris Aldritt, Julie Edwards-Thompson	1. Complete necessary Financial modelling to support analysis 2. Charging 3. Welfare Reform 4. Modelling Deferred Payments Deficit Capacity Plan
Safeguarding and Quality	Sarah Hollingshead-Bland (Lead), Laura Johnston, Donna Colgrave, Jim Ellam, Commissioning Quality Lead, Plus	1. Review current Safeguarding practice against provisions in the act 2. Make Recommendations for Practice and Market quality including

	Representatives from SSOTP, Mental Health and Independent Futures	How we will monitor quality 3. Deficit Capacity Plan
Workforce: It was agreed that this work stream relies on the work of others so this will be set up later on in the project.	Shirley Way (Lead) Plus Representatives from SSOTP, Mental Health, Independent Futures, Families First, Finance and Legal	1. Training for Provider workforce on Assessment 2. Wider workforce training 3. Organisational Development 4. Capacity Planning a. Care Assessments b. Legal c. Financial Services d. Market Workforce 5. Culture and Practice – New ways of working
Prevention and IAG	Nichola Glover-Edge (Lead)	1. Independent Financial Advice 2. Updating Staffordshire Cares 3. Making sure Frontline (inc. Voluntary Sector) know how to use the IAG 4. Tiers of Assessment including Self Assessment
ICT	Jan Cartman Frost (Lead)	1. Care Director 2. Interface with NHS systems for integrated providers.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Care Act is a new piece of statutory Legislation and the changes required will apply to anyone either in receipt of adult social care support or requesting support from 1.4.2015 (phase 1) and 1.4.2016 (full implementation)
The implementation is being managed as a transformation project and has a full risk analysis.

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

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

Have we got specific outcomes for the project which are separate to the Living Well Outcomes?
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The project plan identifies a number of key milestones and critical success factors. The delivery to agreed milestones of both the project and any associated work streams will be monitored through SCC governance routes. DH is monitoring LAs readiness and implementation through Stock-take submissions and has appointed regional leads through ADASS who are providing guidance and support.
What are the key success factors for implementation of this scheme?
Success Factors 1. **Implementation of Mandatory requirements of the Care Act within required timescales to ensure the council meets go live date of 1.4.15 and 1.04.16.** 2. **That the council is not able to be successfully judicially reviewed for non compliance.**

Frail Elderly - Admission avoidance and delayed discharges & SSoTP Community Frail Elderly (Stafford & Cannock CCG) - scheme ref no. 4.4

Scheme ref no: 4.4

Scheme name
Frail Elderly - Admission avoidance and delayed discharges 'Stemming the flow' – Cannock Chase and Stafford and Surrounds CCGs (South West) 'Partnering working for LTCs'
What is the strategic objective of this scheme?
The majority of users of NHS and social care services are older people, many experiencing frailty, often with complex needs and multiple long-term conditions. Present service configurations and their focus on specific health conditions do not always serve these people well, and they can become stuck in high-level services for want of a more coordinated approach to addressing their needs. Often, the experience of services for this cohort of users can be negative and disempowering. However, acute sector services do offer a level of safety and certainty to people with complex needs who are in crisis. Across Staffordshire the pattern of services for the Frail Elderly is currently unsustainable, with a model that leads to an inappropriate high use of acute hospital services. A transformative model of service provision is required to reduce avoidable acute hospital admissions and reduce excess hospital length of stay. Informed by patients and the public innovative service models are being developed, these will see the provision of an anticipatory care service at scale and pace. For patients this will mean that they will have greater control of their own treatment and care and access to appropriate and timely support from professionals in the community. This approach will offer patients a new and different approach to the current service models. This approach aims to empower patients, families and carers to self-manage to prevent crisis and maintain personal independence, it aims to improve the experience of timely hospital discharge and improve after care support to enable people to recover and live life to the full. For the South West of the county, the Stemming the Flow scheme provides a model for Out

of Hospital Care that can enable the safe and sustainable reduction of bed capacity and provide the assurance required by acute providers to down size their operating capacity as per the recommendations of the Trust Special Administrator (TSA).

Similarly, a revised approach is in development for people with **Long Term Conditions**. In the south of the county, innovative outcome-based service specifications (co-produced with service users) are in development. New models of LTC management will provide high quality clinical and social care interventions to empower patients, carers and families to maximise independent living. They will provide individual choice and control, actively support individuals to maintain optimal levels of functioning, self-care, adopt healthier lifestyles, adapt to disease progression and manage any decline in health/ independence.

Overview of the scheme

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

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

The disaggregation of Mid Staffordshire Foundation Hospital Trust provides a unique opportunity to transform the provision of community services and in particular for the Frail Elderly. A new service model has been developed to support the necessary transformation of the local health economy and take forward the integrated provision of care across the primary care, community and acute sector. The provision primarily related to the over 75 years who may now or in the future require access to a health and social care system, it will deliver a systematic, tiered approach to out of hospital services, including a range of discrete but interdependent elements, which together will have the capacity and capability to manage large number of patients out of hospital in the community setting either through self-care or supported management. Drawing on the work of the Kings Fund (ref) the service includes the use of risk stratification to support the identification of the needs of patients, the development of individual care plans, care coordination through primary care and escalation. The provision of services are mapped to the level of support / needs of the patient and will be delivered via multi-professional teams including the third and voluntary sector, working across integrated patient pathways.

The scope of this scheme relates to the over 75 years population resident in the localities of Stafford and Cannock who may now, or in the future, require access to a health and social care system. The case presents a systematic, three dimensional model for Out of Hospital Services, including a range of discrete but interdependent elements, which together have the capability to manage large numbers of adult patients out of hospital in community settings, either through self-care and / or supported management.

There are a cohort of service users below the age of 75 who would also benefit from level 3 and 4 care. However, the numbers are significantly smaller and their case management needs will be met by general practice with support from community health and social care teams. There is a much more significant cohort in level 2 in the under 75 year old category. This requires a more detailed consideration on preventative services for long term conditions and is being considered separately from this scheme.

The model deploys multi-professional teams working across integrated patient pathways which harness the collective strengths of health, social care and third sector providers. The roles and contributions of all providers, not least the third sector, will be fundamental to the success of the model; as will be the new ways of working (systems, structures and behaviours) of a reinvigorated approach to partnering.

For LTCs, drawing on the Kaiser Permanente triangular model of care, the LTC service will

incorporate the following elements:

- risk profiling
- individual care plans where the patient contributes and takes ownership of their goals
- integrated teams including multidisciplinary and multi-agency (health, social care and voluntary sector) management
- delivery of ongoing patient education and behaviour change programmes
- case management
- remote monitoring
- self-management tools including the use of health coaching and telehealth technologies
- proactive planned care
- personal health budgets/ Direct Payments
- rigid quality criteria (ref Francis report)

This will require significant development of a range of service user inspired options to provide the required solutions. Service users and their carers will be supported by effective communication technologies (assistive technology, self-monitoring, remote monitoring etc.) to enable them to maintain maximum control of their care and independence in their lives.

In the north of the county, North Staffordshire CCG (in partnership with Stoke-on-Trent CCG) has already carried out modelling of LTCs through the national Long Term Conditions Year of Care programme, and through the Cross Economy Transformation Programme. A range of services to manage LTCs in the community has been commissioned and contracted.

Given the disaggregation of Mid Staffordshire NHS Foundation Trust, the South West of the County will work in collaboration with partners to deliver an LTC model of care that aligns to the LTC strategy written and approved by the Cannock and Stafford CCGs.

Across Staffordshire, community NHS and social services are provided through an integrated health and social care trust: the Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP). Across all partners throughout the system, there exists a commitment to support people to live independently in their own homes with the minimum of external input through the development of **Integrated Care Teams** (ICTs), which will offer coordinated care and support to people with long term conditions (including dementia), frailty, and complex needs. Whilst these ICTs are at different stages of development in the separate CCG areas and are named differently, there are many common principles that they share.

These primary care led services will offer not only an assessment and diagnosis for the patient, but will support the patient with the management of their long term condition/s through to their end of life.

These services will support patients wherever they live, including within care homes and be responsible for identifying vulnerable patients and pro-actively applying joined up case management.

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

For the South West, Cannock Chase and Stafford and Surrounds CCGs are the commissioners for the Stemming the Flow transformational project.

The delivery of an integrated pathway of care requires a significant level of partnership working, a supportive infrastructure and shared outcomes to achieve significant improvements in quality and efficiency. The provider consortium that will deliver the project consist of three main Provider organisations; Staffordshire and Stoke on Trent Partnership NHS Trust, GP First and British Red Cross.

The evidence base

Please reference the evidence base which you have drawn on

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

The scheme aims to achieve a step change in the way adult patients are managed; and realise key step changes and associated quantifiable outcomes:

Step Changes	Outcomes (Measurable benefits)
▪ Increased self-care / self-management in the primary care setting ▪ Increased range and improved emergency ambulatory care condition pathways ▪ Robust frailty pathways across the entire health and social care continuum	▪ Reduced number of non-elective attendances to MSFT, Wolverhampton and UHNS Emergency Departments by Stafford and Cannock registered patients ▪ Reduced number of non-elective admissions ▪ Reduced social care demand

There is evidence nationally that integrated approaches can yield substantial benefits including reduced duplication of services; more proactive care models resulting in improved outcomes and reduced hospitalisation; easier access to specialist input / advice and diagnostic services; as well as financial benefits accruing from more appropriate use of resources.

Locally, the **integrated service hub**[1] in North Staffordshire offers learning about the potential of an out of hospital HUB based model for organising access to community based services as an effective alternative to reactive acute care; it evidences quantifiable benefits including:

- a rapid shift in referrals by GPs away from hospital to alternative community services, with an average of 25-30 referrals per day to the local Hub;
- around 20 referrals /day from the West Midlands Ambulance Service to the local Hub that would previously have been conveyed to A&E;
- that in the week commencing 12 May 2014, of the 332 referrals to the Hub by general practice and ambulance service, 258 have been confirmed as avoided attendances at A&E with the service user needs being met by an alternative community response; There remains considerable scope to increase diversion as more GPs use the Hub as a referral route;
- for self-referred patients, the integrated service Hub can facilitate rapid access from A&E to community packages, including community step up beds, as an alternative to acute admission.

Collaboration and more formal partnering arrangements are becoming more organised. Nationally and locally there is a drive towards more collaborative, integrated solutions to enhance out of hospital care services and reduce pressures on acute services.

[1] Reference about North Staffs Hub model see SSOTP

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
By definition outcomes will be measurable and set within contracts with providers. Agreed targets and timescales will be monitored, issues arising will be escalated and a collaborative approach will be used to develop remedial action plans.
What are the key success factors for implementation of this scheme?
Patient safety and good quality care is the top priority of all work streams. Non-Elective Admissions are an indicator that highlight system failure to manage patients effectively in their community. Therefore the key success factor for the Frail Elderly and LTC programmes of work would be a reduction in Non-Elective Admissions. Each programme has set objective which aim to contribute to the overall success factor. The key objectives specific to the Frail Elderly and LTC schemes are detailed below: The main benefits (outcomes) from implementation of the "Stemming the Flow" model are: ▪ The holistic needs of the patients are met; ▪ Safe and effective, integrated services, with improved quality and productivity; ▪ Sustainable and appropriate alternative care provision for patients who historically went to Mid-Staffordshire Foundation Trust (MSFT); ▪ Enhanced effective working relationships between frontline staff across all disciplines; ▪ The best care for the population served; ▪ Cost savings; ▪ Evidence based outcomes. The outcomes of the partnering working for LTCs will be split into four key components: • Patients are enabled and empowered to manage their long term condition; • Clinical measures, detailing how the health outcomes of our population are improving, proving that the model is delivering effective care and support; • Support to carers and families, acknowledging the key role carers and families provide to patients; • Communication, to ensure that providers work collaboratively and maximise the opportunities of integration.

Frail Complex – Intermediate Care (South East & Seisdon CCG) - scheme ref no. 4.5

Scheme ref no. 4.5
Scheme name

Frail Complex – Intermediate care, South East Staffordshire & Seisdon Peninsula CCG

The following definition of Intermediate Care is used for this service:

'A range of integrated health and social care services which aim to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long term residential care, that supports timely discharge from hospital and maximises independent living'

What is the strategic objective of this scheme?

This scheme is in relation to the commissioning and procurement of a new Intermediate Care Service for the registered population of South East Staffordshire & Seisdon Peninsula Clinical Commissioning Group.

The **aim** of the service is to treat and support people in times of health or social care crisis to avoid hospital admission, and to support people following an inpatient stay.

This service is currently out to tender.

The **Strategic Objectives** of the Service shall include:

- Delivery of responsive care to meet individual needs;
- Ensuring where appropriate individuals are safely supported in their usual place of residence during acute illness/crisis
- Ensuring individuals are supported to maximise their independence
- Supporting individuals to return to their optimal level of functioning
- Supporting individuals to self-care
- Support individuals to adapt to disease progression and decline in health/ independence.
- Ensure individuals and their families/carer feel part of the care process.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The Service shall deliver a multi-disciplinary, multi-agency approach to delivering the following levels of provision:

Level 1 – Fast Track Comprehensive Geriatric Assessment - A specialist medical assessment of frail older people that supports prevention of future hospital admissions.
Level 2 – Intermediate Care Step Up – A range of personal care, clinical and therapy assessment, diagnosis and treatment either in the service users' usual place of residence or a bed based facility to prevent hospital admission.
Level 3 – Hospital Discharge Planning - A clinical review and facilitation of service users' discharge, as soon as they are medically stable. This includes service users in either Emergency Departments or Hospital Wards.
Level 4 – Intermediate Care Step Down - A range of personal care, clinical and therapy assessment, treatment, rehabilitation and reablement, either in the service users' usual place of residence, or a bed based facility. This will support acute hospital discharge,

recovery from illness and increase independent living.

The Service shall support individuals aged 19 years and over.

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

The Commissioner is South East Staffordshire & Seisdon Peninsula CCG, although there are opportunities for Staffordshire County Council to join the procurement at a later stage.

Whilst the service is currently out to procurement, there is no named provider involved in this activity.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National evidence suggests that acutely ill older people are being poorly serviced by a lack of speedy access to appropriate assessment and treatment and a lack of generalist skills and expertise. Current patterns of care for older people are unsustainable. There is an ageing population and the increasing complexity of patients requiring urgent care are major challenges for the healthcare system. This national evidence base supports the design of our Intermediate Care Service.

Locally an Experienced Led Commissioning Programme was commissioned to focus on the following question – *"what needs to happen so that people and families needing intensive support feel empowered and supported to quickly regain and maintain control and live their lives to the full."*

This question was asked because when those needing intensive help feel supported in control and confident about recovering and managing their condition, they will keep well and more quickly return to independence.

This Experienced Led Commissioning Programme provided evidence to inform the outcomes included within the Intermediate Care Specification.

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

The potential value of the scheme will depend on the extent to which (if at all) the County Council participates in the procurement and/ or its services. Finances detailed in Part 2 relate purely to the Health investment.

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

Local anticipated outcomes:

- Reduction of Emergency Department attendances for individuals classified with ambulatory care sensitive conditions under the age of 70 years.

- Reduction admissions for individuals classified with ambulatory care sensitive conditions under the age of 70 years.
- Reduction of All admissions for service users over the age of 70 years.
- Reduction of readmissions for the same clinical condition within 30 days.
- Reduction of individuals placed in permanent placement in care homes from acute care.
- Reduction of excess bed days in the following specialities: Trauma and Orthopaedics, Long Term Conditions or those related to Frailty Conditions.

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

Outcomes for this scheme will be measured via working together with the successful provider, acute trusts and County Council to ensure delivery of key service outcomes.

This will be done through contract monitoring, performance reviews and listening to the views of our patients/carers in receipt of the service.

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

- Successful award of contract
- Smooth transition to new service
- Commencement of new service
- Successful delivery of key local outcomes defined above.

Frail Elderly – Cross Economy Transformation Programme "Big Tickets" (North Staffs CCG) - scheme ref no. 4.6

Scheme ref no. 4.6

Scheme name
Cross Economy Transformation Programme "Big Tickets"

What is the strategic objective of this scheme?

At the core of this approach is **comprehensive multi-agency community-based care and support** for people with frailty, complex needs and/or long term physical and mental health conditions. This care and support will feature community health, adult social care and associated services in one coherent offer. It will be delivered under the leadership of General Practice, will be premised upon case management, which will coordinate a range of inputs to provide greater stability to people who may otherwise become overwhelmed by their circumstances, and recourse to acute sector/urgent care services.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The CEPT programme has 3 key work streams these are:

1. Integrated Locality Care Teams (ILCTs) and Intermediate Care

ILTCs are fundamental to this care and support. In 2014/15, 2,400 people within North Staffs will be being actively case managed through ILCTs.

This supportive community service will be complemented by Intermediate Care. Joined-up Intermediate Care services are a key service component to ensure people stay healthy and independent for longer, and prevent them from being unnecessarily admitted to, or becoming 'stuck' in inappropriate acute sector services for want of the right community solutions.
In 2013/14 North Staffordshire CCG (in conjunction with Stoke on Trent CCG invested in the consolidation of, and staffing of Intermediate Care services.
Social care reablement is at the heart of a programme of modernisation and redesign with a shift in focus from bed to community based provision. A more effective approach to review and better integration with the NHS intermediate care service has led to greater efficiency and improved outcomes for the customer. Overall numbers through the service have increased, the customer journey has reduced and outcomes have improved with greater numbers of people leaving the service with no need for ongoing care and the majority, in the main, leaving with a reduction in care required.
Phase two (2014/15+) will see the alignment of social care Intermediate Care/reablement services with the NHS activity under the Better Care Fund, and the consequent development of a single admission avoidance/discharge hastening pathway. This will continue to shift the community service emphasis from being on discharge, to being on admission avoidance.

2. Frail and complex

The CETP model specifies a multi-agency specialist frail and complex MDT and 'directorate' that works across acute, community and primary care, delivering continuity of care throughout the patient journey. This frail and complex approach will work in conjunction with the ILCTs and Intermediate Care service and provide support to GPs and community services from consultant geriatricians and specialist workers.
The fully-fledged Frail Complex capacity will be mobilised in 2014/15. The support will

- Be available to nursing care homes where it is safe and appropriate to manage a sick patient in the home
- Ensure that people who are frail and become sick are managed at home with intensive community services
- Provide step down services to enable people to be discharged to their home as soon as possible after an acute hospital admission

3. **System coordination / capacity 'hub'** –

This is the central point of entry and exit into/out of the urgent care system, with the emphasis upon the coordination of a range of services. Optimal system performance is secured through this active management of the 'flow', and the system is much more effective in circumstances of higher demand. The hub is clinically-led, and is overseeing the development of regularised cross-economy assessment and decision-making methods that will ensure people receive the right care delivered in the right place at the right time.

The CETP will deliver a reduction in non-elective admissions across the Northern Staffordshire local health economy of 4,300 in 2014/15, increasing to 11,900 in 2015/16. Based on 40 % of this, the reduction for North Staffordshire CCG will be 1720 in 14/15 increasing to 4760 in 2015/16.

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

Commissioners
Cross Economy Transformation Programme is commissioned locally via North Staffs and Stoke CCGs

Lead Providers of the relevant services are listed below:

ILCT – SSOTP
Intermediate Care and Re-ablement – Provided by SSOTP & Staffordshire County Council
Frail & Complex – SSOTP
Capacity Hub - SSOTP

The evidence base

Please reference the evidence base which you have drawn on

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

The following documents and locally commissioned reports have been used to develop the programme these are:

- Intermediate Care - Halfway Home
- National Audit of Intermediate Care
- Older People and Emergency Bed Use, The Kings Fund, 2012
- The Health and Social Care Act (2012) sets out an explicit focus on the importance of integrated care.
- Integrated care for patients and populations: Improving outcomes by working together. A report to the Department of Health and the NHS Future Forum, Kings Fund, 2012
- EICST/Mott, Capita and ATOS overview of the urgent care and community service offers
- Fit for the Future Business Case
- District Nurse Review
- Everyone Counts
- West Midlands Quality Review – LTC
- Francis Report
- Public Health Indicators/demographic change
- Data developed through participation with the LTYC project
- No Health without Mental Health
- NHS Constitution
- The Operating Framework for the NHS in England 2012/13
- Health and wellbeing profile North Staffordshire 2012
- Pilot results -ILCTs 2012
- Keogh Report
- Cross economy modelling overseen through the Cross Economy Leaders Group

Investment requirements

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

Impact of scheme

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

Contribution to BCF outcome metrics:

- Reduce numbers of acute and sub-acute hospital admissions by increasing the number of patients cared for in a home-based intermediate care setting
- More patients safely supported to stay at home during acute illness/crisis.
- More patients supported to remain in their home following an intervention
- Reduced admissions to long term care
- Shorter lengths of stay within the acute and community trust setting, thereby contributing to reducing delayed transfers of care
- Reduced numbers of re-admissions within 30 days for patients

Feedback loop

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

A framework of KPIs and outcome measures to be measured by both Provider and Commissioner has been developed.

Acute Trust SUS data and Social Care nationally reported indicators will be used to monitor some of the LHE desired outcomes.

Local service evaluation and audits will be completed to measure the impact of this service on the key outcomes listed above.

The programme of work is supported by the Cross Economy Transformation Team. There are weekly meetings to monitor progress on the Big Tickets and the impact on activity. This feeds in to monthly contract performance meetings.

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

The Vision for the CETP programme is within three years we will be:
• Supporting people to live independently in their own homes
• Giving people the best support when they need it most
• Helping people to stay well
• Working better together for the people who we serve
• Using our resources to maximum benefit

The ambition for the Northern Staffordshire LHE is to achieve a system which will see:

- 3,500 people per year leave the acute hospital earlier
- Improved step-down to community (requires 3,266 additional intermediate care places)
- 11,900 Non-elective admissions to acute hospital avoided
- 25% of NEL admissions avoided amongst the 20 to 69 age group
- 30% of NEL admission avoided amongst the 70+ age group
- Pro-active management of 50,000 people with LTCs
- Improved flow of patients to the right place at the right time through a combination of simplified systems/services, reduced occupancy levels and a capacity hub function.

.
NB. The modelling excludes patients outside of Stoke-on-Trent and North Staffordshire.

Reablement Services (North Staffs) - scheme ref no. 4.7

Scheme ref no. 4.7

Scheme name

Reablement and support for Older People(North Staffs CCG)

What is the strategic objective of this scheme?

The funding and investment is considered a *unique and excellent opportunity to forge better integrated working between health and social care systems, for the benefit of patients, service users and carers.* Key to achieving this are Joint working arrangements and these will ensure appropriate development of re-ablement capacity in councils, health services, and the independent and voluntary sector

Co-ordinated Services will deliver care closer to home, support to recovery and self-help and prevention

This scheme supports flow through the system by facilitating hospital discharge, reduced length of stay and delayed discharges..

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?

- Which patient cohorts are being targeted?

This scheme supports the cross economy transformation programme which aims to deliver comprehensive multi-agency community-based care and support for people with frailty, complex needs and/or long term physical and mental health conditions.

The main elements of this scheme are:

Support for hospital discharge

Additional social care assessors ensure that assessments can be undertaken in a timely fashion contributing to reduced length of stay and reduction in delayed discharges. This capacity is required to cope with the increased throughput. Referrals have increased by an average of 15 per week in Q1, although it is planned that the assessors will become more proactive, working from the point of admission rather than waiting for referrals.

Transition / step down beds

It is recognised that there is the need for some transitional support for people who no longer need to be in hospital but cannot yet manage in their own home. 12 beds are commissioned to provide a further period of 24hr nursing support so that patients can be discharged from hospital but still receive further assessment if required and a period of rehabilitation to maximise independence and support return to home if possible.
The key aims of the transitional support is to support flow across the local health economy, reduce length of stay in acute, provide a better environment for the multidisciplinary assessment of patients and to enable patients to achieve optimal functioning after a period of rehabilitation.

The beds are supported by a wrap-around team including OT, social work, rehab support worker and physiotherapy.

The expectation is that patients will be discharged from the transition beds within 4 weeks.

Stay at Home Scheme

This team supports people with dementia to secure timely discharge from acute and community hospitals and to return home from residential and nursing care settings. A full screening assessment is undertaken enabling the team to suggest solutions which will enable people to leave hospital quicker and to support rehabilitation in the community.

The scheme can help prevent inappropriate admissions to residential care, provides care closer to home and increases independence. The team make use of assistive technology to reduce 24 hr care through lifestyle monitoring such as “Just Checking”

Brighton House

Brighton House provides a range of rehabilitation services for up to 26 people including enablement, assessment and respite. The service is available to people over 50yrs who are medically stable and can be maintained in the community, those who are deemed to be at risk of admission to long term care and people who may benefit from a short term programme of enablement. The service is supported by the Community Intervention Service (CIS). Therapeutic activities and assistive technologies are used to support people with their progress.
In 2013/14:
94% of admissions were from hospital
13% were re-admitted to hospital
66% returned home
21% admitted to long term care

Community Services for Older People

- to develop and maintain community services for older people
- to enable older people to regain and maintain daily living skills and optimise their independence, dignity, health and well being
- to contribute to the improvement of throughput and capacity across a range of older peoples services; namely domiciliary care, in house rehabilitation / re-ablement and specialist provision for older people with dementia

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

Social care assessors and wrap around care -commissioned by North Staffs CCG provided by SSOTP
Transition beds are commissioned by North Staffs CCG provided by the independent sector.
Stay at Home is jointly commissioned by North Staffs CCG and Staffs County Council and provided by SSOTP
Brighton House is jointly commissioned by North Staffs CCG and Staffs County Council and provided by SSOTP
Community Services for Older People are commissioned by Staffordshire County Council from SSOTP, voluntary sector and private sector organisations.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The following documents and locally commissioned reports have been used to develop the programme these are:

- Older People and Emergency Bed Use, The Kings Fund, 2012
  - The Health and Social Care Act (2012) sets out an explicit focus on the importance of integrated care.
  - EICST/Mott, Capita and ATOS overview of the urgent care and community service offers
  - Fit for the Future Business Case
  - District Nurse Review
  - Everyone Counts
  - Francis Report
  - Public Health Indicators/demographic change
  - Data developed through participation with the LTYC project
  - No Health without Mental Health
  - NHS Constitution
- Health and wellbeing profile North Staffordshire 2012
- Keogh Report
- Cross economy modelling overseen through the Cross Economy Leaders Group
- Dementia 2012: A National Challenge
- Alzheimers Society dementia hospital research

Local evaluation has shown:
65% of patients in transition beds stay less than 4 weeks
61% of patients were discharges home
Of the 91 people supported by the stay at home scheme over a 12 month period, only 3 were admitted to long term care.

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

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribution to BCF outcome metrics: • More patients supported to remain in their home following an intervention • Reduced admissions to long term care • Shorter lengths of stay within the acute and community trust setting. A specific target is difficult to set as trim points and long stay payments vary according to speciality. Targets will need to align with current and future Cross Economy Transformation plans for length of stay • Delayed transfers of care Delayed transfers of care per 100,000 of the population aged 65 and over will be maintained at or below 3.5%. A further percentage reduction in delayed transfers of care is critical to accommodate reduction in acute capacity and the aim is to work proactively in reducing delayed transfers of care to <1% • Reduced numbers of re-admissions within 30 days for patients
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Local service evaluation and audits will be completed to measure the impact of this service on the key outcomes Monthly contract performance meetings.
What are the key success factors for implementation of this scheme?
12. More people are safely supported to return home following an acute admission. 13. More people supported to live at home with reduced ongoing needs. 14. Reduction in referral to assessment completion timescales. 15. Reduction in the timescales from completed assessments to start new packages of care. 16. The number of people admitted into a residential or nursing home for the first time following and acute admission reduces People experience an improved quality of life as a consequence of health and social care intervention

Frail Elderly – General Practice Plus (South East & Seisdon CCG) - scheme ref no. 4.8

Scheme ref no. 4.8
Scheme name
General Practice Plus- South East Staffordshire & Seisdon Peninsula CCG
What is the strategic objective of this scheme?
The vision of South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group is to transform general practice to become the centre of local healthcare. To build community services into the practice team so that there is seamless care for patients and clear lines of accountability.

The objectives that contribute to this vision include:-

- To provide as much care as is safely possible close to home;
- To support fast track access to medical services where required
- To support GPs to develop clinical specialisms to support cohorts of patients in the local community eg ENT, paediatrics, .
- To ensure support for patients and the public to build confidence to manage their own condition.
- One clinical record for a patient so all clinicians, and the patient, understand the plans.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The South East Staffordshire & Seisdon Peninsula CCG vision for General Practice Plus incorporates five key functions. These include:

1. Supportive Care for the whole family from cradle to grave

2. Advice, support and guidance to help people prevent or delay the onset of long term conditions and/or illness

3. A focus on the Proactive Management of Long term conditions(LTCs)

4. An urgent response in times of patient's perceived need

5. A key co-ordination role in the care of frail older people

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

The CCG and membership will develop and deliver the General Practice Plus vision.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Over the past few years, the NHS has seen unprecedented change, not least in general practice. Demand on the NHS is growing with the local population ageing at a greater rate than the national average. This increase in demand is coupled with an increase in the populations' expectations, with patients wanting more holistic, coordinated care with faster access to both routine and urgent care. Whilst general practice has often been sited as the 'answer' to these challenges, the ability for general practice to increase capacity is limited within current arrangements, with year on year funding decreases and significant workforce challenges for both nursing and

medical staff (Deloites 2013).

Local clinicians and the community have highlighted the need to respond to these challenges and develop a much more sustainable solution with its heart in primary care. Multiple stakeholders have suggested that this solution should closely align (or integrate) with community services which will wrap around the practice wherever appropriate and possible. This change will see a corresponding shift in resources from acute settings. This solution has been defined as 'General Practice Plus' (GPP).

Call to Action: Improving Primary Care and the local drafted Primary Care Strategy both support a transformational change in primary care, which our General Practice Plus vision starts to articulate.

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

See Expenditure Plan.

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

Local anticipated outcomes:

- Coordinated proactive care for patients with long term conditions and frailty leading to a reduction in:-
  - ✓ Hospital admissions
  - ✓ Reduction in outpatient attendances in hospital settings
- Increased integration of services and support with GPP- including third sector leading to an increase in:-
  - ✓ Team approach to care- the right person to deliver the care.
  - ✓ Community support
- People taking more control over their own health
- Sharing of good practice and skills within localities.
- Transfer of resources to primary care from secondary care

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

Patient & Carer feedback
Provider Contract monitoring
Measurement of the success of the cross economy frail elderly strategy.

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

- Successful delivery of the General Practice Plus Strategy.

Scheme ref no. 4.9

Scheme name

Frail Complex – End of Life Care, South East Staffordshire & Seisdon Peninsula CCG

What is the strategic objective of this scheme?

There are currently a number of services which provide end of life care to the registered population of South East Staffordshire & Seisdon Peninsula CCG. These services are subject to a review and will be considered as part of the overall model of care for the CCG.

The **Strategic Objectives** for End of Life Care include:

- Increased identification of patients at end of life;
- Improved Care Planning and Recording of Preferred Place of Death;
- Reduction in Emergency Admissions;
- Rapid discharge from Hospital;
- Improving the quality and experience for end of life care;
- Delivering Communication, Education and Training

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Our End of Life Strategy 2014-2016 represents our vision as a Clinical Commissioning Group to develop a model of support for individuals at end of life which ensures that they feel **cared for**, **confident** and **listened to**. It will offer the individual a **personalised care plan**, which addresses not only the **medical** needs but the **social** and **psychological needs** of the individual at end of life.

The strategy aims to improve the offer of integrated care, so that a patient at End of Life is identified early and **offered personalised support right the way through to their end of life**. The service delivery model to realise our vision is through the development of a '**General Practice Plus'**

Our model of care will include the commissioning of generalist End of Life care beds and the provision of support for General Practice around the pro-active management of Long Term Conditions patients through to End of Life.

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

The End of Life Strategy was approved at the CCG Board and is being mobilised through an Accountable Care Partnership arrangement. This covers both South East Staffordshire and

Seisdon Peninsula localities and includes local hospice representation, acute hospitals, Staffordshire & Stoke on Trent Partnership NHS Trust and the CCG.

The evidence base

Please reference the evidence base which you have drawn on

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

A series of engagement events in the form of world cafes (a simple process which engages people in conversations that matter) alongside an online survey, asking the question ***' what is important to you or a loved one at end of life'*** have provided the Clinical Commissioning Group with the views of patients and carers to inform the development of the strategy.

The engagement has highlighted that it is important to individuals to be **listened** to at end of life and for professionals to recognise that everybody has difference preferences over where they choose to die. Being **comfortable**, **pain free** and treated with **dignity** and **respect** were key themes throughout the feedback along with being provided with **honest conversations**, **experienced and knowledgeable professional carers** who have the time to spend with patients and families to provide **on-going/regular support**.

Further evidence is within the National End of Life Strategy and the Gold Standards Framework.

Investment requirements

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

See Expenditure Plan.

Impact of scheme

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

Local anticipated outcomes:

- Reduction in hospital deaths
- Increased number of Advanced Care Plans
- Transferable DNAR
- Reduction in A&E admissions for End of Life Patients
- Increased number of Emergency Care Plans uploaded as Special Patient Notes
- Reduction in Length of Stay for patients in their last year of life
- Cross fertilisation of End of Life Skills within general practice

Feedback loop

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

Outcomes for this scheme will be measured via the Accountable Care Partnership arrangement.

This will also be reported through contract monitoring, performance reviews and listening to the views of our patients/carers in receipt of the service.

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

- Successful delivery of the End of Life Strategy

Dementia Care Services - scheme ref no. 4.10

Scheme ref no. 4.10

Scheme name

Dementia Services (Memory Assessment & Diagnostic Service, Community Mental Health Teams, Care Home Education Support Service & Dementia Day Care)

What is the strategic objective of this scheme?

These schemes form a significant part of the existing dementia care pathway across Southern Staffordshire and enables people to access a team of mental health specialists in order to access an assessment and diagnosis as well as ongoing care in the community. The overall objective for these services is to enable people to get the right support when they need it, feel supported to live at home and remain out of hospital. The services were designed and commissioned in order to meet the outcomes set within the National Dementia Strategy, the Prime Ministers Dementia Challenge and NICE Guidelines.

Overview of the scheme

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

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

These services are aimed at adults and older people with a suspected dementia or a formal dementia diagnosis. The model of care for these services aims to enable patients to receive an integrated and co-ordinated pathway of care which helps them to achieve the right diagnosis, receive the right support in the community and have a single point of contact in a crisis situation or when support is needed. Specialist support within residential care is also important due to roughly 1/3 of people living with dementia are expected to be in some form of residential care.

South East & Seisdon CCG are looking in particular at developing existing services into a new multi-disciplinary dementia service which has close links with GP services but supports the person from diagnosis through to end of life, providing outreach into the community.

The delivery chain

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

Commissioners are as follows (with support from Staffordshire County Council):

- East Staffordshire CCG
- South East & Seisdon Peninsula CCG
- Stafford and Surrounds CCG
- Cannock Chase CCG

The provider of these services is Shropshire & South Staffordshire NHS Foundation Trust (SSSFT) which also provides a range of mental health services across the region, all of which are managed using traditional contract management arrangements. Performance and activity reports are provided to commissioners on a monthly basis and discussed during contract meetings and Care Quality Review Meetings.

The evidence base

Please reference the evidence base which you have drawn on

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

Best practice in mental health and dementia care provision is well evidenced and is supported in the following documents:

- DOH 2005, Mental Capacity Act, Department of Health, London
- DOH 1983 (amended 2007), Mental Health Act, Department of Health, London
- DOH 2009, Living Well with Dementia, A National Strategy, Department of Health, London
- DOH 2011, No Health without Mental Health: A cross government mental health outcomes strategy for all ages, Department of Health, London
- The NHS Outcomes Framework 2014/15
- Prime Ministers Dementia Challenge, 2012
- NICE Commissioning guide

Investment requirements

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

Impact of scheme

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

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

Our aim for these services is that they will enhance people's quality of life for those living with long term conditions (NHS Outcomes Framework) by providing specialist services which can support people living with dementia, as well as the following outcomes:

- Enable people to receive an early and accurate diagnosis
- Enable people to feel supported and informed
- Be supported to live as independently as possible
- Have a point of contact for access to information, advice & guidance
- Provide support to the carer/family
- Provide support to care home staff

Feedback loop

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

Activity and outcome measures will be formulated and fed back to commissioners via contract monitoring mechanisms and outcomes reporting.

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

- A network of memory clinics in a variety of settings across all commissioners with home visits being offered, if deemed appropriate.
- A NICE Compliant Dementia Assessment, Diagnosis and Review Service that includes:
- The provision of an initial assessment and diagnosis, that includes approved screening tools such as BASDEC.
- Facilitate onward referral and access to dementia advisory service for those with a diagnosis of dementia
- Improved service integration with other provision within the provider, (Dementia Teams East & West, Care Home Education Support Service) CHESS team and the providers community mental health teams.

Scheme ref no. 4.11

Scheme name

Implementation of the Care Act

What is the strategic objective of this scheme?

The Care Act 2014 represents the most significant change in the legislative basis of adult social care since the modern system was established in 1948. While many of the principles enshrined in the legislation simply put onto a statutory footing services and approaches that have long been in place within the County Council, there are many changes to the detail of these, while there are also many new requirements, such as the introduction of Care Accounts.

Effective implementation of the Care Act will enable adult social care services across the county to be more focused on prevention and on reducing the need for care through adopting an approach based on empowering the service user. Success here will reduced demand for non-elective hospital services and facilitate faster and more effective discharge from hospital.

Overview of the scheme

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

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

The Care Act touches almost every aspect of the delivery of adult social care. This will require all policies to be reviewed, with many being significantly amended, while operational staff will need to be trained in their new / revised functions, supported by updated IT systems, and service users, their carers and advocates will need to be informed of the changes and their enhanced responsibilities.

The delivery chain

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

Adult social care services are commissioned by Staffordshire County Council from four separate providers:

- Through a s75 arrangement with SSoTP, for Older People and people with Physical Disability / Sight Impairment
- Through s75 agreements with SSSFT and CHC, for people with Mental Health issues
- Through an SLA with Independent Futures, the County Council's in-house all-age service for people with lifelong disability

Under these arrangements, SSoTP and IF hold the budgets for all placements and either call off care from contracts held by the County Council or secure care directly through their own contracting functions. The two Mental Health Trusts either provide care directly or use their own contracts. Frontline staff in all of these organisations, as well as the County Council itself, will require training and support to deliver their new / revised duties.
In addition, there are several hundred independent and third sector organisations that provide care to Staffordshire people. While less directly affected by the changes in the Care Act, these will have significant impacts upon the way in which they operate. In particular, because the Act brings self-funders more closely into the statutory system, providers serving that part of the market may experience particular implications.

The evidence base

Please reference the evidence base which you have drawn on

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

The Care Act draws from nationally identified best practice. In implementing the legislation locally, significant efforts will be maintained to draw from national and regional guidance and to adapt this to the specific local context of Staffordshire.

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£2.179k of revenue costs for one-off transition £700k of capital costs for IT system changes
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Effective implementation of the Care Act will ensure that the adult social care system is fit for purposes, based on a philosophy of prevention, empowerment and a person-centred approach. This will facilitate the availability of services that reduce demand for hospital and long-term residential care, while enabling rapid discharge from hospital with the minimum of ongoing care needs.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A project group, addressing the full range of strands affected by the Care Act and bringing together key staff from the County Council and all of the providers, especially SSoTP, has been formed and is actively reviewing the position. Each strand is engaging with providers and other partners to identify options for the future and the impact of actions taken.
What are the key success factors for implementation of this scheme?
The key requirement for success is for all parties, commissioners, micro-commissioners (SSoTP, SSSFT, CHC, and IF) and providers alike, to develop and adopt a new approach to ensuring individuals are able to remain living independently in the community. This will involve a shift of mindset away from a focus on determining the inputs of care – in terms of a certain number of visits per week, each lasting a given duration – towards an emphasis on outcomes – in terms of individuals facilitated to maintain the greatest possible level of independence.

End of Life

Macmillan End of Life (Stafford & Cannock) – Scheme Ref no. 5.1

Scheme ref no. 5.1
Scheme name
End of Life/Cancer/Palliative Care (Stafford and Cannock)
What is the strategic objective of this scheme?
In relation to End of Life Care Services there are three key aspects for the Programme within the Region: • To improve the identification of people approaching the end of their lives to ensure they receive the care and support they need; • To improve the patient experience and quality of care for patients at end of life, their families and carers; • To improve patient choice at end of life • To reduce the fragmentation of care provision so that there is seamless, integrated and personalised care, when and where people need it, so that no patient or carer will get lost in a complex system.

Overview of the scheme

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

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

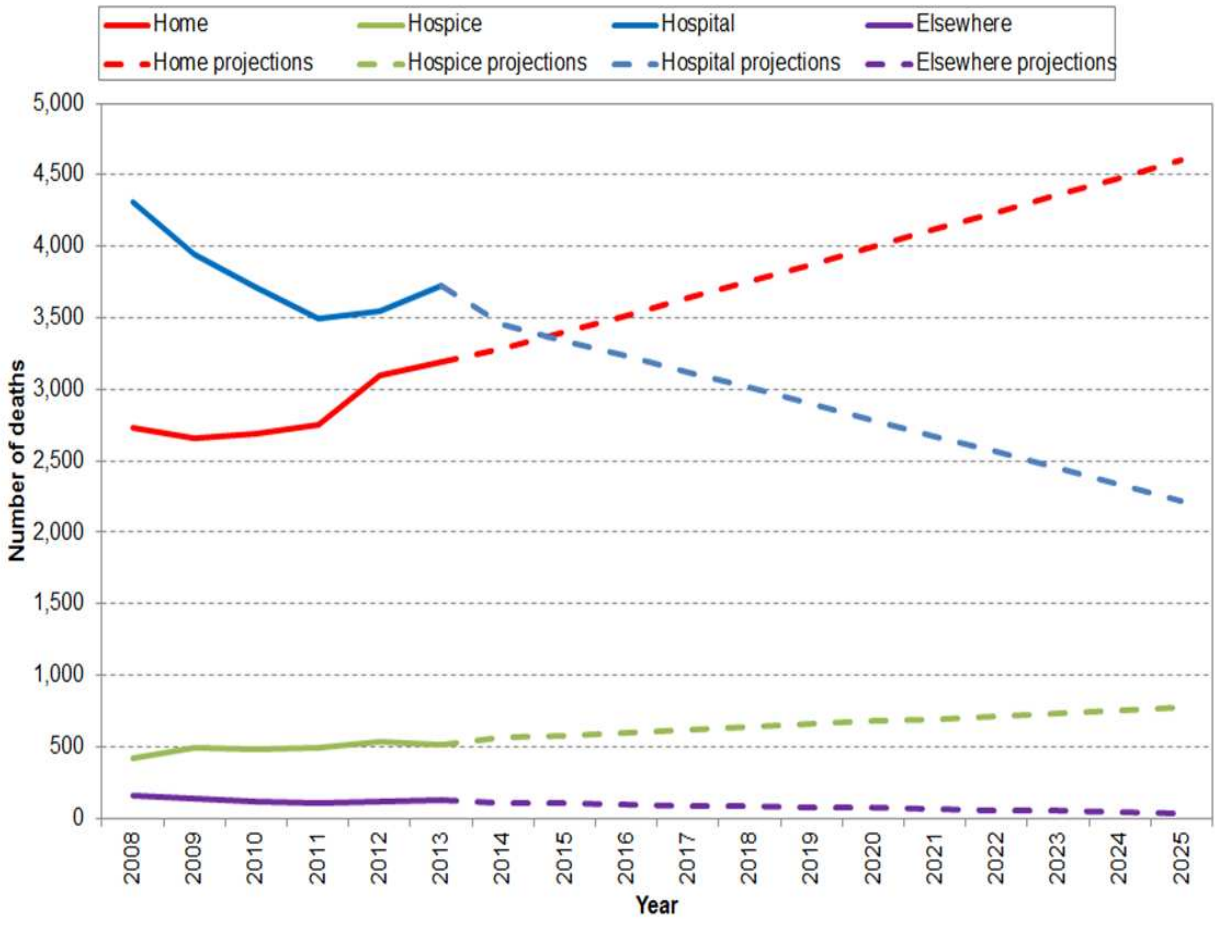
N.B. Cannock Chase CCG and Stafford and Surrounds CCG are the only two CCGs that are placing this scheme under the BCF. In addition, the only financial element of the Cancer/End of Life programme that is being attributed to the BCF pot is the funding attributed to local hospices and Marie Curie. In so doing the CCGs recognise that by co-ordinating the palliative care / hospices element of end of life care, health and social services can work more effectively to ensure patients nearing the end of their life are supported in their choice of preferred place of death. In so doing the number of patients being supported to dye at home will increase, this in turn will have an impact on the proportion on non-elective admissions being experienced by patients in their final weeks. .
The National End of Life Care Programme (*what we know now 2013*), tells us that

- nationally across England people average around 2.1 hospital admissions in the last 12 months of life
- Approximately 78% of people will be admitted to hospital at least once in their last year of life.
- People from most deprived quintiles are more likely to die in hospital. 61% of people in most deprived quintile die in hospital compared with 54% of people in least deprived quintile (2007-2009)
- Hospital was the least preferred place of death in all regions except for the North East, where care homes are the least preferred.
- People think that dying in the preferred place of death is an important priority. Across the country, ranking 'Dying in preferred place' as the number one care-related priority' varied by region from 29% to 43%.
- There is variation between people's preferred place of death and actual place of death.
- The gap between a preference for a hospice death and actual deaths in a hospice is highest for older people accounting for on average 30 bed days.
- Admission rates are highest in young age groups

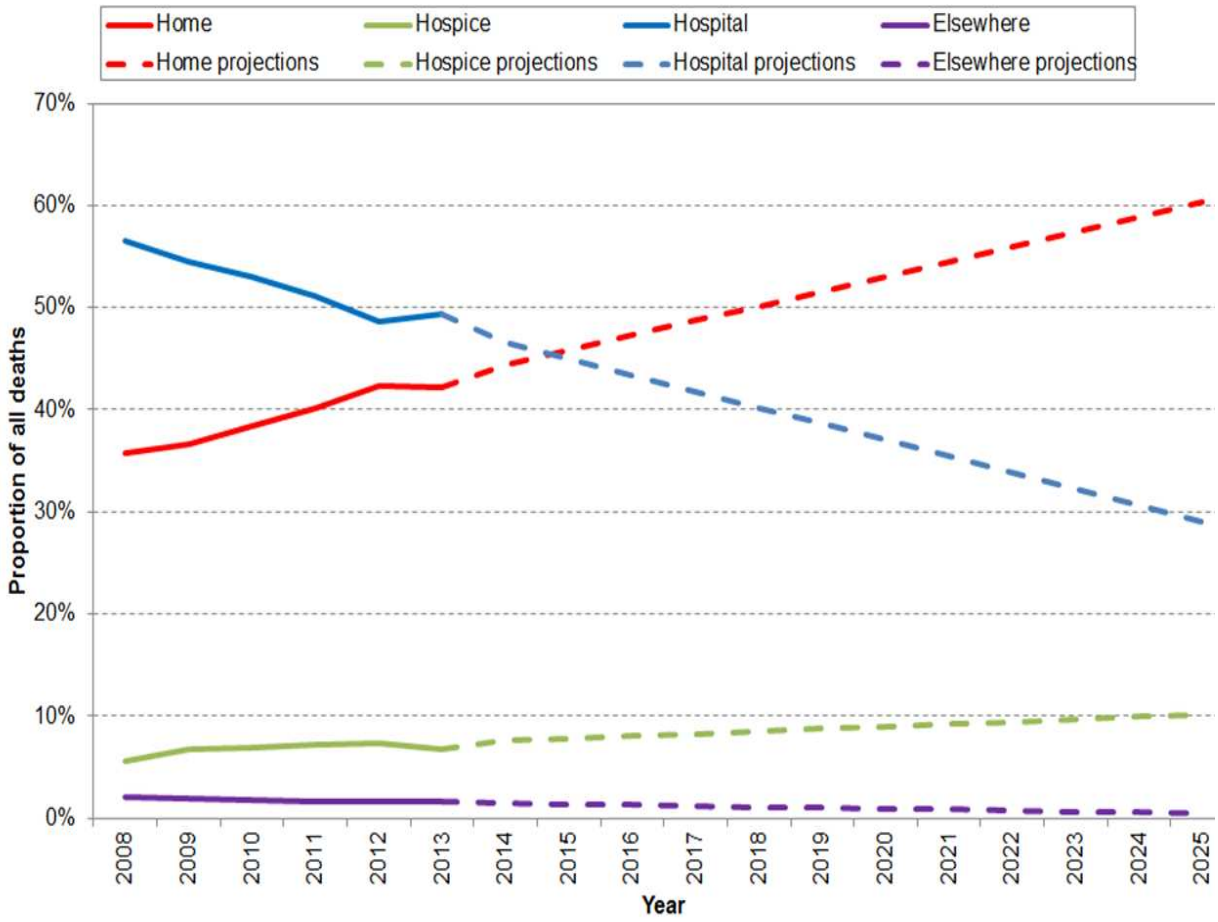
Locally, our patients are telling us that if they could, they would prefer to die at home with their family around them.
Evidence shows us that this is not happening:
Local Picture – Place of death
Cannock Chase, Stafford & Surrounds, North Staffs, Stoke on Trent

	2012 actual	2013 provisional	2015	2020	2025	Percentage change between 2013 and 2025
Number of deaths						
Home	3,092	3,186	3,399	3,996	4,605	45%
Hospice	539	514	581	677	774	51%
Hospital	3,543	3,728	3,340	2,786	2,214	-41%
Elsewhere	118	125	102	70	38	-70%
All deaths	**7,292**	**7,553**	**7,421**	**7,529**	**7,631**	**1%**
Proportion of all deaths						
Home	42%	42%	46%	53%	60%	43%
Hospice	7%	7%	8%	9%	10%	49%
Hospital	49%	49%	45%	37%	29%	-41%
Elsewhere	2%	2%	1%	1%	0%	-70%
All deaths	**100%**	**100%**	**100%**	**100%**	**100%**	**0%**

Local projections on place of death:
Trends and projected number of deaths by location



Trends and projections of proportion of deaths by location



About the project

North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups jointly and on behalf of themselves, and with the support of NHS England, Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England launched the End of Life Care Programme in April 2013.

The Programme is one of the fourteen Department of Health National Integrated Health and Social Pioneer initiatives.

The Commissioners see the appointment of a Prime Provider for End of Life Care Services as an opportunity to modernise and target services that best meet the needs of the local population. Recent engagement sessions with the local population have made it clear that the public want responsive services that are person centred and developed in partnership with the patient, family and carers, delivered in a holistic manner.

The aim of the Programme is to support health and social care commissioners to shift the focus of practice from commissioning acute based care and individual interventions to one that encompasses the whole patient journey, is fully integrated, and puts the patients' needs at the centre of End of Life Care Services across all providers of care.

The vision for the Programme is aligned with and underpinned by the principles outlined in the five-year plan for Staffordshire and Stoke-on-Trent (2014-2019), the Commissioning

intentions of all partners, and the local Health and Wellbeing Strategies. Namely, a vision for an integrated health and social care system which is centred on individual needs more personalised community-based care and support, and one which recognises the wider determinants of health.

Innovation and having a responsive health and social care system across the locality which meets patient and carer expectations is fundamental. The attributes of such a system would be that it:

- is co-designed by the public, personalised to their needs and preferences;
- provides access to services 24/7;
- reflects a modern model of integrated, co-ordinated care between providers and sectors;
- reflects a high quality, innovative and flexible care market resulting in service models designed to deliver outcomes not outputs underpinned by a high quality and a stable workforce;
- results in exemplary end of life care for patients and carers, enabling independence, choice and control;
- exemplifies integrated systems and pathways reflected by the quality of experience of recipients of care; and
- ensures seamless transitions through health and social care systems and improved cross-boundary and partnership working with an infrastructure in place to enable this to happen.

In addition to meeting national requirements for end of life care, there is the expectation that the appointment of a Prime Provider through a long term contract will deliver the following outcomes:

- all patients at end of life have an excellent and equitable experience of care and support, with care organised around them, provided by a skilled and able workforce;
- all patients at end of life receive appropriate and timely care, support (24/7) and access to NHS funding to enable them to live the best possible life and to support people to die in their place of choice;
- integrated care that is centred around the patient with timely access to local services that provide continuity of care where appropriate;
- reduced inequalities and improved early identification of people with progressive illness in order to support their individual needs and wishes;
- increased choice and personalised care and support based on the holistic needs of patients;
- treatment and care for people in a safe environment and protection from avoidable harm;
- where clinically appropriate, the ability for patients at end of life to self-manage or to receive supported management of their condition at home; and
- a single point of contact for all care and support needs, with services that are co-ordinated and responsive to the specific situation.

The patient cohort

Research by the End of Life Care Intelligence Network (now Public Health England) suggests that on average around 25% of deaths are unexpected. This means that around 75% of people dying should have their end of life needs recognised and provided for in the last year of life and should be on palliative care QOF registers (which record the number of patients who are expected to die within the next six to 12 months).

Locally, there is a great deal of work to accomplish improvement in the recognition of people at end of life:

	2008/09	2009/10	2010/11	2011/12	2012/13	Number an percentag point differe between 200 and 2012/1
Cannock Chase	146 (0.1%)	211 (0.2%)	277 (0.2%)	286 (0.2%)	364 (0.3%)	218 (0.2%)
East Staffordshire	92 (0.1%)	118 (0.1%)	131 (0.1%)	149 (0.1%)	188 (0.1%)	96 (0.1%)
North Staffordshire	186 (0.1%)	295 (0.1%)	421 (0.2%)	509 (0.2%)	533 (0.2%)	347 (0.2%)
Stafford and Surrounds	132 (0.1%)	195 (0.1%)	217 (0.1%)	240 (0.2%)	255 (0.2%)	123 (0.1%)
Stoke-on-Trent	302 (0.1%)	403 (0.1%)	500 (0.2%)	636 (0.2%)	609 (0.2%)	307 (0.1%)
Staffordshire and Stoke-on-Trent CCGs	**858 (0.1%)**	**1,222 (0.1%)**	**1,546 (0.2%)**	**1,820 (0.2%)**	**1,949 (0.2%)**	**1,091 (0.1%)**
West Midlands	**5,489 (0.1%)**	**8,287 (0.1%)**	**10,440 (0.2%)**	**12,705 (0.2%)**	**13,542 (0.2%)**	**8,053 (0.1%)**
England	**53,857 (0.1%)**	**74,907 (0.1%)**	**92,870 (0.2%)**	**113,105 (0.2%)**	**130,233 (0.2%)**	**76,376 (0.1%)**

Source: Quality Management and Analysis System (QMAS) database - data as at end of July, Copyright, The Health and Social Care Information Centre, Prescribing and Primary Care Services.

End of Life Care Services are defined as services for those people "approaching the end of life" where they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

• advanced, progressive, incurable conditions;

• general frailty and co-existing conditions that mean patients are expected to die within 12 months;

• existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and

• life-threatening acute conditions caused by sudden catastrophic events

Definition used by the GMC and NICE End of Life Care Working Group1

Prisons

Nationally, As of March 2010, 85,184 people were being held in prisons across the UK

- Up to 30% of prisoners have learning disabilities
- 48% of prisoners are at or below the reading age of an 11 year old

- 82% of prisoners are at or below the writing age of an 11 year old
- Once offenders have been in prison for 4 or more years, they age twice as quickly as the general population
- People over 60 yrs of age have been identified as the fastest growing group within the prison estate
- Of the prisoners across the UK, 95% are male and proportionately more prisoners are from an ethnic minority
-

Staffordshire has a high prison population with a total of over 4,000 prisoners.
Across Staffordshire & Stoke on Trent there are 9 Prisons:

- Drake Hall (Womens prison)
- Swinfen Hall (Young Offenders – male)
- Werrington Prison (Young Offenders – male)
- Brinsford (Young adult)
- Featherstone (Adult cat C)
- Stafford Prison (Adult male cat C)
- Oakwood Prison (Adult male cat C)
- Dovegate (Adult male cat B)
- Stoke Heath Prison (Adult & young adult male closed cat C)
-

Palliative Care & End of Life provision across the West Midlands comprises of:
1 palliative care cell with 24 hour nursing at Hewell Prison in Worcester
2 palliative care cells with 24 hour nursing at Birmingham Prison (Winson Green) Patients at end of life will use normal inpatient facility if palliative care beds occupied.
Out of hours GP cover provided to all prisons by current out of hours provider
ISSUES: Shortage of 24 hour specialist nursing and palliative care provision

Commissioning partners will work to address the issues around end of life care for our prison population.

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

North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups jointly and on behalf of themselves, and with the support of NHS England, Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England launched the Transforming Cancer and End of Life Care Programme in April 2013.

The providers of adult hospice / Palliative care for Cannock and Stafford are:
Marie Curie
Staffordshire and Stoke and Trent Partnership Trust
St. Giles Hospice
Katherine House Hospice

Douglas McMillan Hospice
Compton House Hospice

The evidence base
Please reference the evidence base which you have drawn on

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

Building the evidence of such an approach, as well as scope for the programme has been

organic from extensive public and clinician engagement over the course of a two year period. An external organisation has been commissioned to work with the commissioners to evaluate the Programme in real-time, to enable learning to be applied. The first stage of the work carried out was an insights piece which looked at the range of commissioning models and the risks and benefits for each. As a Pioneer site commissioners are committed to being a part of more of an impact evaluation. Macmillan, as the key strategic partner has committed to commissioning a longitudinal evaluation and impact assessment of the Programme for the lifetime of the contract (10 years).

Evidence that a shift to a more 'Hospice at home based approach to End of Life care' could provide the following efficiencies and improvements in quality of care:
Palliative and end-of-life care can be provided in a range of settings,
including hospitals, hospices, outpatient or community services, and at home. Studies have suggested that palliative and end-of-life care can allow more people to die at home, improve quality of life, reduce pain and other symptoms, and lower the demand for unplanned hospital care
(*Alonso-Babarro and others, 2011; 2012; Barbera and others, 2010; Brumley and others, 2007; Gomes and Higginson, 2006; Gómez- Batiste and others, 2012; Lorenz and others, 2008; Serra-Prat and others, 2001; Shepperd and others, 2011; Tamir and others, 2007; Temel and others, 2010).*

A recent review of funding for palliative care estimated that around 75% of the 470,000 people who die each year in England would benefit from palliative care, while around 90,000 people die each year without access to palliative care
(Hughes-Hallett and others, 2011).

The evaluation of the Marie Curie Nursing Service by the Nuffield Trust showed:
Across all types of hospital activity, people who received MCNS care used significantly less hospital care than matched controls.

People who received MCNS care were much more likely to die at home, less likely to require hospital care and incurred significantly lower hospital costs.

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

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

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

Feedback will be through the End of Life Programme Board and the EoL Programme Implementation Team (Commissioners). An EoL outcomes framework has been developed and will be finalised as part of the process to award the EoL prime Provider contract.

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

By co-ordinating the hospices element of end of life care, health and social services can work more effectively to ensure patients at the end of their journey experience in a planned, coordinated way individuals will be able to choose their preferred place of dying. Patient consultation has demonstrated that there will be a shift away from the current default of the

acute hospital setting to the home or hospice provision reducing the number of non-elective admissions for this patient group in the latter stages of death.