Public Document Pack

Date of meeting **Wednesday, 2nd April, 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

1 **Apologies**

2 **DECLARATIONS OF INTEREST**

To receive declarations of interest from Members on items included in the agenda.

3 **MINUTES** **(Pages 3 - 6)**

To consider the minutes of the previous meeting.

4 **Better Care Fund** **(Pages 7 - 120)**

5 **Asset Management Strategy - Conservative Land Sale Proposals** **(Pages 121 - 122)**

6 **Discretionary Rate Relief** **(Pages 123 - 130)**

7 **Newcastle-under-Lyme Sports Council - Grant Aid 2014/15** **(Pages 131 - 134)**

8 **Short Term Hire of Refuse Collection Vehicles** **(Pages 135 - 138)**

9 **Review of Allotment Service** **(Pages 139 - 170)**

10 **Civil Parking Enforcement Review Initial Response** **(Pages 171 - 174)**

11 **Proposal For Selective Licensing** **(Pages 175 - 178)**

12 **URGENT BUSINESS**

To consider any business which is urgent within the meaning of Section 100B(4) of the Local Government Act 1972.

13 **Exclusion Resolution**

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

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 upon request.

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.

CABINET

Wednesday, 5th March, 2014

Present:- Councillor Gareth Snell – in the Chair

Councillors Mrs Beech, Kearon, Turner, Williams and Mrs Shenton

1. **APOLOGIES**

2. **DECLARATIONS OF INTEREST**

There were no declarations of interest stated.

3. **MINUTES**

Resolved:- That the minutes of the meeting held on 5 February, 2014 be agreed as a correct record.

4. **KEELE GOLF CENTRE**

Consideration was given to a report on the future use and/or development of the Keele Golf Course. Members were informed that only one complaint had been received with regard to its closure. The buildings had been secured and services had been cut off.

RMW Golf who had been selected to take a 25 year lease of the site were now unable to carry out the project and therefore medium to long term arrangements needed to be sought.

Members examined the long-list options analysis matrix and the areas that had been shortlisted. However, it was important not to rule out other community uses and leisure facilities and not to concentrate on another golfing facility. Further, the interim usage would have to take into consideration any future long term proposals in order not to damage the site to excess.

Resolved:-

a) That officers be authorised to engage with nearby/adjacent land owners with a view to jointly commissioning a comprehensive master-planning exercise, involving Borough Council owned land in the area in order to establish the most appropriate long term use for the Keele Golf Course site.
b) That officers report back on the outcome of the land owner engagement process and to seek approval for a two stage master planning exercise beginning with a scoping report to identify its physical parameters, with any budgetary approval being sought from Council as necessary.
c) That officers be authorised to undertake a limited maintenance regime on the basis described in the report until the outcome of the master planning exercise is known.
d) That officers be authorised to undertake security measures described in the report.
e) That officers be authorised to see expressions of interest in some form(s) of interim use for a period of up to three years.

f) That officers keep under review the holding costs attributed to the Keele Golf Course and take all appropriate steps to minimise the same.
g) That a wider, broader leisure use be kept in mind.

5. **LOCAL PLAN UPDATE**

A report on the proposed Newcastle-under-Lyme and Stoke on Trent Local Plan Programme was considered by Members. The Plan was in draft form and it was hoped to be signed off and published by the third quarter of 2016.

The list of the eight key stages of the Joint Local Plan were examined and Members were given an update on the formal stance of Stoke on Trent City Council.

A Joint Advisory Group would be created with an equal cross party membership and the relevant officers. Its purpose would be to ensure its delivery rather than the content of the Plan.

Councillor John Williams, portfolio holder for Planning and Assets, stressed that all political parties should be involved in this process with all Members examining the Plan in respect of their Ward. This would help to make the Plan a success for the future of the Borough.

Councillor Terry Turner, portfolio holder for Economic Regeneration, Business and Town Centres, congratulated the officers who had achieved the Local Plan in a short space of time.

Resolved:-

1) That Cabinet agree to the draft work programme for the production of the joint Local Plan, set out in the report.

2) That Cabinet agree to the creation of a Joint Advisory Group to support the delivery of the joint Local Plan and that in the interests of expediency the determination of the membership and terms of reference for the Joint Advisory Group be delegated to the Director of Regeneration and Development in consultation with the Cabinet Member for Planning and Assets.

3) That Cabinet agree to the preparation of a joint Statement of Community Involvement with Stoke-on-Trent City Council.

6. **RENEWAL OF MICROSOFT SOFTWARE LICENSING**

Consideration was given to a report seeking approval for the renewal of the Microsoft Agreement and Software Assurance contract which is due to expire in May, 2014.

The Microsoft Enterprise Agreement gives the Council the best overall pricing based on the size of the organisation.

Resolved:- That the Council renews its Microsoft Enterprise Agreement and Software Assurance for the supply of Microsoft products, licensing and software maintenance for a further three years, through the procurement and appointment of a certified Microsoft Reseller.

7. **CASE MANAGEMENT POLICY FOR COUNCILLORS - UNACCEPTABLE BEHAVIOUR & ACTIONS BY MEMBERS OF THE PUBLIC**

A Case Management Policy for Councillors – Unacceptable Behaviour and Actions by Members of the Public was presented to Members. A current Policy, approved in 2013 provided guidance for staff but did not specifically cover Councillors.

The Policy would provide guidance and support on how to deal with members of the public who display unacceptable behaviour and actions.

The document was welcomed by Members and a request was made to include the subject in the New Members Induction Programme.

Resolved:- That the Case Management Policy for Councillors be approved.

8. **COMMERCIAL WASTE (KEELE)**

Consideration was given to a report highlighting the opportunity for tendering for a medium sized recycling and waste management contract. It would enable Keele University to be offered a value for money service that fulfils their environmental requirements.

The contract would commence on 1 August, 2014 for a three year period and, subject to satisfactory performance as determined by the University, an option to extend for a further three years.

The success of this tender would assist in the rolling out of a borough-wide trade waste recycling service.

Resolved:-

1) That the Cabinet agrees with the submission of a tender and authorises Officers to enter into a contract if the Councils bid is successful.

2) That subject to the above, Cabinet delegates the authority to finalise the tender for the contract, agree the necessary up front funding requirements and enter into a contract with Keele University to the Executive Director (Operational Service) after consultation with the Executive Director (Resources and Support Services), the Monitoring Officer, Cabinet Portfolio Holder - Finance and

Resources and Cabinet Portfolio Holder - Environment and Recycling.

9. **IRRECOVERABLE ITEMS**

In the absence of Councillor Stubbs, portfolio holder for Finance and Budget Management, the Council's Executive Director for Resources and Support Services, Kelvin Turner introduced a report explaining how there were occasions when, following the issue of accounts for amounts due to the council, it was considered the debt was no longer able to be collected. This could be for a variety of reasons, normally following from the debtor having been subjected to insolvency proceedings or other legal processes in respect of their debts or even the death of a debtor. There was then no further redress to recover the outstanding amounts and it was necessary to write off the outstanding balances from the council's records.

Appendices were submitted setting out collection procedures and a list of recoverable items. It was reported that the appendices contained exempt information as defined in paragraphs 1 and 3 of Schedule 12A of Part I of the Local Government Act 1972, and were therefore not for publication. In the event of the discussion taking a course where it was likely that exempt information would be disclosed, it would be necessary for the Cabinet to exclude the press and public from the meeting.

It was noted that where limited companies which became insolvent, the law allowed those holding directorships and similar positions within them to start up similar businesses almost immediately, unencumbered by the debts of the previous organisation, and this was considered a legal loophole when efforts were made to recover the debts owed by those companies.

Resolved:- That the items set out in Appendix B to the report be considered irrecoverable for the reasons stated and be written off.

10. **Disclosure of Exempt Information**

COUNCILLOR GARETH SNELL
Chair

NEWCASTLE-UNDER-LYME BOROUGH COUNCIL

EXECUTIVE MANAGEMENT TEAM'S REPORT TO CABINET

Date 2nd April 2013

1. **REPORT TITLE** **Better Care Fund Submission**

Submitted by: **Head of Business Improvement, Central Services & Partnerships – Mark Bailey**

Portfolio: **Communication, Policy & Partnerships**

Ward(s) affected: **All**

Purpose of the Report

To inform Members of the proposals set out as part of the development of the Better Care Fund (BCF) across Staffordshire and within Newcastle. These proposals include the transfer of the Disabled Facilities Grant funding into the BCF from April 2015. The report asks Cabinet to approve the draft BCF plan for Staffordshire (submitted on 14th February 2014) and also to note that NULBC will have the opportunity to be part of a Partnership Agreement which will determine the future governance arrangements around the BCF and also take decisions over how the BCF will be invested. A final submission of the BCF Plan for Staffordshire will be made on 4th April 2014.

Recommendations

a) **That the Cabinet notes the contents of the report**

b) **That Cabinet endorses the draft Better Care Fund Plan submission up to the end of 2015/16 (see Appendix A), whilst reserving the right to review this endorsement at the end of 2015/16, pending a wholesale review of Disabled Facilities Grant (DFG) funding to NULBC after 2015/16**

c) **That Cabinet delegates authority to the Leader of the Council to agree and sign off the BCF submission on behalf of the Council**

Reasons

The Better Care Fund (BCF) aims to provide people with better integrated care and support in Staffordshire. The Fund has been created from a range of different existing budgets and from April 2015, the existing Disabled Facilities Grant (DFG) budget – which is currently provided directly to district/borough councils – will be allocated to the BCF, although the statutory duty will remain with district/borough councils.

The report requests that Cabinet endorse the Plan (Appendix A) and delegates the Leader of the Council to agree and sign the Plan on behalf of the Council. The BCF focuses on preventative work and that the scope of the BCF may expand over time, creating opportunities for district/borough councils in areas such as leisure/culture; housing; community safety; and environmental health.

Having said that, the present concern is obviously on ensuring that DFG funding is maintained and it has been confirmed that the DFG element of the BCF will be allocated back to district/borough councils for 2015/16. Agreement from NULBC to the BCF submission is predicated on the agreement that the funding position is reviewed before the end of 2015/16 with regard to DFG, and assurances sought on post-2015/16 funding for DFG from central government (Department of Health and Department for Communities and Local Government) and Staffordshire County Council and before NULBC commits to the BCF beyond 2015/16.

1. **Background**

1.1 The Better Care Fund (BCF) was previously known as the Integrated Transformation Fund and was announced nationally in June 2013 with the aim of providing people with better integrated care and support.

1.2 The Fund itself will be created from several existing budgets, with funding provided on behalf of district/borough councils from the Disabled Facilities Grant (DFG) (currently provided to district/borough councils in the form of a direct grant).

1.3 From April 2015, the DFG will be allocated to the BCF, although the statutory duty to provide DFGs will remain with district/borough councils.

1.4 It appears that NHS England will want these funds to be hosted by a Clinical Commissioning Group (North Staffordshire CCG in the case of Newcastle-under-Lyme) rather than by a local authority.

1.5 The allocation to Staffordshire from the national BCF pot will be £56.1m in 2015/16 (£3.8m of which will be the DFG component).

1.6 The BCF is focused on preventative work such as reablement, support for carers and services to allow disabled people to live independently. DFG, and the help it provides to people within the home, is a part of this.

1.7 The first draft of the Better Care Fund Plan for Staffordshire was submitted on 14th February 2014, following consultation with the Health and Well Being Board for Staffordshire and others. The Plan itself includes all district/borough councils as parties to the Plan; reflects the focus on prevention in the Staffordshire Health and Well Being Strategy (and also the local version of the Strategy in Newcastle under Lyme) around prevention; refers to the role of district/borough councils in engaging with providers and communities; and acknowledges the positive contribution of DFGs in preventing falls and other key areas of work.

2. **Issues and Areas for Consideration**

2.1 The BCF Plan is limited in terms of its references to the role of district/borough councils – there are few references to them beyond those listed above. Having said that, it seems likely that the scope of the funding channelled into the BCF nationally will expand over time and may provide opportunities for district/borough councils to promote the needs of the local communities in the borough and also input into the preventative agenda via a number of council services (e.g. leisure/culture; economic development; housing; community safety; and environmental health).

2.2 The issue of DFG funding is one of concern to councils such as NULBC (who will still have a legal duty to deliver adaptations where certain criteria are met). A letter was issued, therefore, in December 2013 from the Departments of Health and Communities and Local Government stating that the DFG element of BCF for 2015/16 must be allocated back to the relevant housing and strategic housing authorities. NULBC, in this report, is proposing to sign up to the BCF until the end of 2015/16 and will reserve the right to sign up to a longer term agreement based on a clear steer around future DFG funding beyond 2015/16. NULBC requests that a review is carried out around DFG funding during 2015/16 by a combination of the Departments of Health and Communities & Local Government with full involvement from Staffordshire CC and the district/borough councils in Staffordshire (including NULBC).

2.3 In terms of future working, it is likely that a Partnership Agreement (covering section 75 of the NHS Act allowing the NHS and local authorities to pool budgets) will be needed to underpin the governance and management of the BCF.

2.4 District/borough councils will not be obliged to sign up to the s75 Agreement and will be able to receive funding from the BCF without such an agreement in place, but not to do so could exclude NULBC from discussions on future allocations of funding and it may be difficult for additional funding to be invested from the BCF into NULBC work and also into the DFGs as a preventative activity.

2.5 The new s75 agreement will be developed during 2014 with a view to going live in April 2015 and a decision from NULBC is likely to be required sometime during the autumn of 2014.

2.6 The overall approach as articulated by the BCF process is to move resources away from acute services to preventative approaches by preventing crises and increasing peoples' independence and resilience. This is articulated in the 'Living Well in Staffordshire 2013-2018' document as produced by the Health and Well Being Board and also in the NULBC Health and Well Being Strategy.

3. **Options**

- Option A – that Cabinet support the proposals set out in this report, to endorse the BCF Plan (Appendix A) and delegate the Leader of the Council to agree and sign up to the Plan on behalf of the Council (Recommended)

- Option B – that Cabinet does not support the proposals in the report, thereby potentially losing the opportunity for NULBC to play an active role in terms of the Plan's current components (and thereby creating a risk around DFG funding) and also the future development of the BCF (Not recommended)

4. **Proposal**

4.1 It is proposed Cabinet consider the report and agree to the proposals set out to endorse the attached BCF Plan for Staffordshire.

4.2 Cabinet are also asked to delegate the Leader of the Council to agree and sign up to the submission on behalf of the Council.

4.3 The report also sets out some of the future issues around the BCF and Cabinet can be reassured that these developments will continue to be monitored closely by the Council.

5. **Reasons for Preferred Solution**

5.1 The BCF is a key part of the delivery of a wider preventative agenda across Staffordshire and, as such, ties in closely with the approach set out in the NULBC Health and Well Being Strategy. The BCF also allows for future development of opportunities for NULBC to play a key role in delivering health improvements and also easing the pressure on resources through the delivery of a number of its key services. The Plan also sets out the position currently with regard to DFG.

6. **Outcomes Linked to Sustainable Community Strategy and Corporate Priorities**

6.1 The Strategy has potential to help deliver key outcomes across all the priorities of the Borough Council.

7. **Legal and Statutory Implications**

7.1 NULBC is a party to the BCF Plan and is asked to sign the document to agree to its contents and ambitions. Future work will be required about the role of the Council in relation to s75 Agreements as part of the NHS Act.

8. **Equality Impact Assessment**

8.1 An Equality Impact Assessment will be developed, especially around the future of DFGs and also the potential for future NULBC input into the BCF. Any service redesign that may come about due to changes to DFGs or a focus on more preventative approaches would need to be subject to equality analysis.

9. **Financial and Resource Implications**

9.1 Under current arrangements, DFGs are funded through a combination of government grant received from DCLG and in house capital resources.

9.2 The 2014/15 budget for DFGs is £864,000, of which £514,000 is to be funded from external grant and £350,000 from Borough Council resources (New Homes Bonus). This is committed and demand for DFGs may be increasing as a consequence of demographic change.

9.3 From April 2015, funding for DFGs will be in part routed via the BCF. The amount allocated from the BCF for DFGs will be £654,000 to which the Council may decide to add further funds from the Housing Capital Programme, as it has done in previous years, should demand warrant this.

9.4 Given that district/borough councils will continue to have a statutory duty to deliver DFGs, it will be important that the DFG funding continues to be allocated to local housing authorities.

9.5 Special conditions will be added to the Conditions of Grant Usage (s31 of the Local Government Act 2003) which stipulate that upper tier local authorities/CCGs must ensure they cascade the DFG allocation to district/borough council level in a timely manner which can be spent within a year.

9.6 Having said that, there are no guarantees about the future level of funding that government makes available for DFGs. This report, therefore, requests that a review of the position regarding DFGs in Staffordshire is undertaken during 2015/16 and that this is done prior to any further sign off by councils such as NULBC. To this end, NULBC is proposing to sign up to the BCF up until the end of 2015/16 in the first instance.

9.7 Only government grant contribution to DFGs will be included in the BCF Plan, and the Plan makes no reference to or assumptions about the capital spend on DFGs which is funded by the in-house resources of each district/borough council. It is recognised that capital funding is under pressure and that the NULBC Housing Capital Programme is reviewed and revised annually.

10. **Major Risks**

10.1 The major risks within the proposal include: -

- Funding for DFGs reduce whilst the statutory duty is maintained – this position needs to be reviewed during 2015/16 as set out in this report
- Demand for DFGs continues to increase without commensurate increases in funding
- The future opportunities for NULBC and other districts/boroughs are not realised
- The expected outcomes and outputs from this work are not realised, including reductions in acute spend

Risk profiles have been developed for each of these risks, including control measures.

11. **Sustainability and Climate Change Implications**

11.1 Current levels of spending on health and social care are unsustainable and require a radical shift in investment to keep people living safely in their home as long as possible and ensure continued delivery of acute services to those really in need.

12. **Key Decision Information**

12.1 This item is included in the Forward Plan

13. **Earlier Cabinet/Committee Resolutions**

None

14. **List of Appendices**

Appendix A – Staffordshire Better Care Fund (First Draft Submission)

15. **Background Papers**

15.1 Held in the Business Improvement, Central Services and Partnerships offices and including Health & Well Being agendas; background papers on integrated commissioning and the Joint Strategic Needs Assessment (JSNA)

16. **Management Sign-Off**

Each of the designated boxes need to be signed off and dated before going to Executive Director/Corporate Service Manager for sign off.

	Signed	Dated
Financial Implications Discussed and Agreed ***Lead Officer – Dave Roberts***		
Risk Implications Discussed and Agreed ***Lead Officer –Mark Bailey***		
Legal Implications Discussed and Agreed ***Lead Officer – Mark Bailey***		
Equalities Implications Discussed and Agreed ***Lead Officer – Mark Bailey***		
Sustainability and Climate Change Implications Discussed and Agreed ***Lead Officer – Mike O'Connor***		
Report Agreed by: Executive Director/ Head of Service		

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Staffordshire Better Care Fund

Introduction

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

It represents a response to the opportunities and challenges presented by the Better Care Fund. Since submission of the draft document on 14th February 2014, work has progressed and this will be evident in this update.

Staffordshire has been identified as one of the eleven 'financially challenged' health economies - this is clear evidence that we are facing a steep challenge with a 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 Health and Wellbeing strategy.

The pooling of budgets with partners through the Better Care Fund affords an unparalleled opportunity to build on the progress we have made in focussing on prevention, early intervention and integrated care in the community.

The challenge that lies ahead is more than purely a financial one. It is about partners working together, changing behaviours and maximising the use of the public sector purse to deliver both greater community-based care and a wider health economy which is safe, strong and sustainable for the people of Staffordshire.

The Better Care Fund planning continues to be a work-in-progress which aligns locally with plans for a wider-scale integrated commissioning and 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 our citizens, voluntary and community sector, primary, acute and community health providers, and our social service teams.

Initial modelling work has been carried out using available LGA and NHS toolkits, these can provide a focus for further investigation into opportunities locally which may not yet have been considered. Plans for more detailed modelling based on local circumstances are in hand. 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.

The Better Care Fund has a focus on Older Adults at a national policy level however our local Staffordshire intention is to include mental health, learning disability and equipment services, where pooled or joint arrangements currently exist. 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.

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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 31st March 2014

Date submitted:

4th April 2014

Minimum required value of BCF pooled budget	2014/15	£16,000,000
	2015/16	£56,108,000

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Total proposed value of pooled budget	2014/15	£16,000,000
	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 *(insert signature here)*	Stafford and Surrounds CCG & Cannock Chase CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group *(insert signature here)*	East Staffordshire CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group *(insert signature here)*	South East Staffordshire & Seisdon Peninsula CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group *(insert signature here)*	North Staffordshire CCG
By	<Name of Signatory>

DRAFT

Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Staffordshire County Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Cannock Chase District Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	East Staffordshire Borough Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Lichfield District Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

DRAFT

Signed on behalf of the Council *(insert signature here)*	Newcastle-under-Lyme Borough Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	South Staffordshire District Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Stafford Borough Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Staffordshire Moorlands District Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Tamworth Borough Council
By	<Name of Signatory>

DRAFT

Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Staffordshire Health and Wellbeing Board
By Co- Chair of Health and Wellbeing Board	Johnny McMahon
Date	13 February 2014

13/2/14

Signed on behalf of the Health and Wellbeing Board	Staffordshire Health and Wellbeing Board
By Co- Chair of Health and Wellbeing Board	Robbie Marshall
Date	13 February 2014

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Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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, 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 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 ongoing. The imperative for change is the focal strategic context of these ongoing discussions, and properly modelled and evidenced delivery goals within the transformed service of the future are central to future contractual expectations. Examples include the engagement with University Hospital North Staffordshire (UHNS) as part of the Cross-Economy Transformation work in northern Staffordshire and with Mid-Staffordshire NHS Foundation Trust through the Trust Special Administrator (TSA) process.

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.

Ongoing engagement is taking place with providers, in recognition of the significance of their position in the system, the value they can bring, the need for transformational leadership and change, but also of the current structures that exist in parts of the county. It is only through this ongoing engagement that we will be able to transact change and transform the service approach for Staffordshire.

Very recently, the Area Team of NHS England has initiated work on an acute services review across the County, which will give a framework for discussions around the impact of delivering our ambitious strategy. This work will be further informed by coordinated whole systems analysis and strategic planning that will be externally conducted as part of the support that is being offered to Staffordshire due to its designation by NHS England as a 'distressed' health economy. . It is envisaged that significant ongoing engagement will be required to broker agreement on a programme of work and timescales to achieve reduced non-elective admissions and other reductions in activity in the acute sector.

A large proportion of the delivery of the Better Care Fund plan relies on a handful of large provider trusts with which engagement (led by the H&WBB) is taking place as set out above. However, 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.

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Discussions are taking place through Health Education West Midlands (HEWM), 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.

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

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 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 re-procurement of key integrated service delivery areas of Long Term Conditions and Intermediate Care/reablement.

The Transforming Cancer and End of Life Programme has embedded a structure of co-production with the local population. The programme has employed three non-executive board members who have full voting rights at board level and throughout the procurement process. They have worked with the programme team to lead and implement a structured patient engagement process and all outcomes and aspirations for the programme are based on experience from the local population.

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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.

Health Watch 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 chair.

Related Documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref.	Document	Synopsis & links
Doc1	"Living Well in Staffordshire" Health and Wellbeing Strategy 2013-2018	The Health and Wellbeing Strategy sets out the priorities and activities which the Health and Wellbeing Board will be pursuing between 2013-2018 across Staffordshire County Council and 5 CCGs.
Doc2	"Seven day services Transformational Improvement Programme"	Detailed planning document covering Northern Staffordshire with regard to implementation of 7-day services in the area. A similar plan is being developed for Southern Staffordshire.
Doc3	"Transforming cancer and end of life care", Pioneer Application, June 2013	Successful joint application between Macmillan, Staffordshire CCGs and the County Council, in partnership with patients and carers to develop a Principal Provider model for end of life care across Staffordshire, to help people achieve their desired place of care and type of support when faced with cancer, or at the end of their lives. Including innovative approach to integration through use of Principal Provider who has responsibility for patient and carer experience throughout the care pathway, requiring collaboration with Public Health, NHS, CCGs and LA; working with patients to co-design outcomes; using outcomes-based specifications.
Doc4	Stoke Health and Wellbeing Strategy	Stoke on Trent Health and Wellbeing Strategy http://www.moderngov.stoke.gov.uk/mgConvert2PDF.aspx?ID=52269
Doc5	Living My Life My Way	Strategy for Disabled People in Staffordshire 2013-2018
Doc6	Service Development Plan for Learning Disabilities	Service Plan for Specialist Health Adult Learning Disability Services, 2013 2016
Doc7	Metrics	Document setting out in more detail metrics and targets set
Doc8	Schemes	Spreadsheet showing schemes planned, current activity falling into each scheme, and Finance and Commissioning lead for

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		each scheme
Doc9	Digital health strategy for Staffordshire	Pan-Staffordshire (including Stoke-on-Trent) strategy for digital health, telehealth and assistive technology

2. Vision and Schemes

a) Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.
- What changes will have been delivered in the pattern and configuration of services over the next five years? - What difference will this make to patient and service user outcomes?

The vision for the health, social care and associated services of the future for Staffordshire are set out in the Health and Wellbeing Strategy (Doc2) "Living Well in Staffordshire" 2013-18. At the basis of the 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. It is estimated that preventative health and care services delivered in the community save £4 for every £1 spent.

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 ongoing social care services, such as residential care.

The vision is being delivered through an overarching set of principles, which is relayed into different approaches to service delivery for different delivery areas set out below, resulting in the main schemes which form part of this Better Care Fund plan, the links are indicated below:

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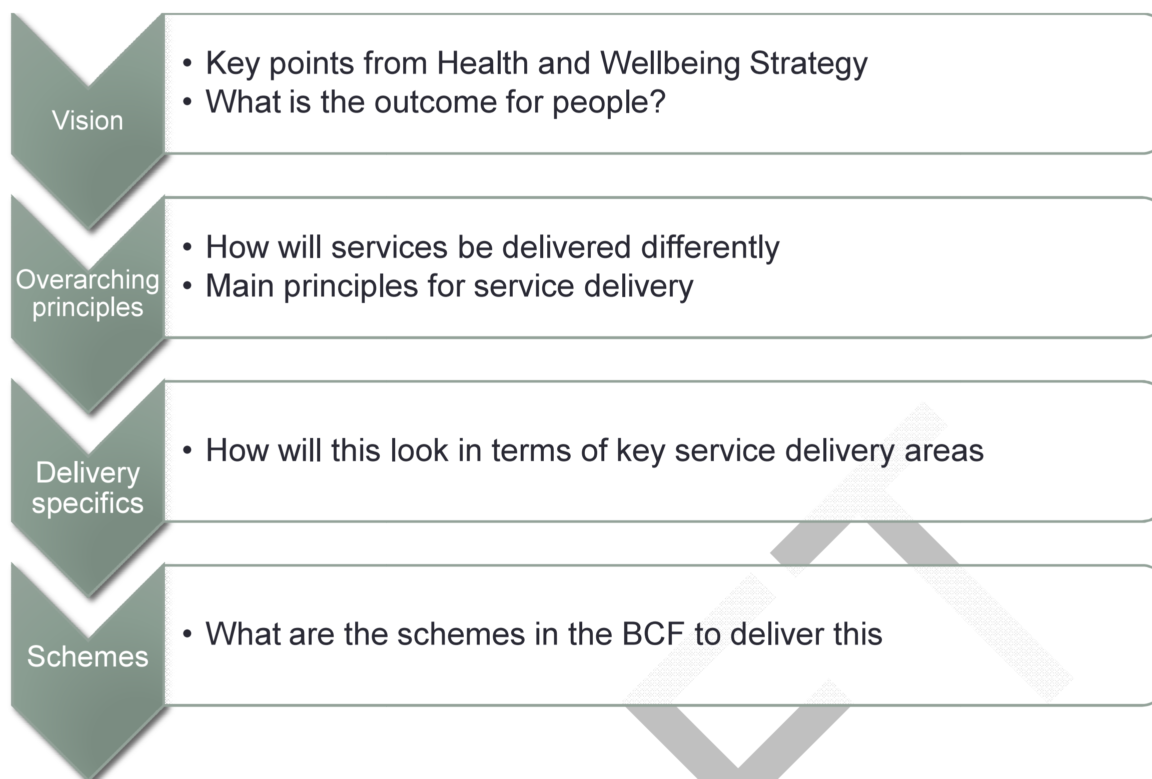

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Vision

The vision for people in Staffordshire is set out in the Joint Health and Wellbeing Strategy:

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.

Overarching principles

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

- There will be greater emphasis on preventing ill health and promoting independence in the provision of all NHS, social care and other associated services.
- 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, and delivering care and support where appropriate in peoples' homes.
- The delivery of community-based services will centre on General Practice, which will be the focal point of coordination and support.
- 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.
- Community-based services will be built upon, and will privilege the further development of the range of underpinning community assets fundamental to a healthy society.
- A significant amount of resource presently committed to non-elective urgent care services in the acute sector will shift to fund this community-based activity.
- Increasingly sophisticated processes of commissioning will be employed to incentivise community-based care and support, and to ensure joined up delivery of pathway-based services.
- People will be supported to take control of their health and wellbeing, and of the services that support them.
- Services will be commissioned where possible for outcomes rather than activity-based targets

This requires a major shift of resources from acute and secondary care, to community and primary services, including preventative approaches. Over the next five years we expect to see significant progress on this vision, with some schemes being developed at present, and more to be developed over the coming period, in collaboration with acute services locally.

Underpinning all of the principles is the concept of 'parity of esteem'. Parity of esteem relates to all services, but there is a particular issue around inequalities for people with mental health problems. Much of the investment for mental health is in the BCF and this will be expanded as we move to implement a joint strategy to transform mental health services. A decision has been made to fully integrate mental health commissioning in Staffordshire. Not only does the investment through BCF not constitute a risk to mental health services, it offers a positive opportunity to incorporate the implementation of a recovery based model, and an shift in investment from specialist to generalist services, equivalent to that described above.

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Work is already well underway in Staffordshire (aligned with strategic partners in Stoke-on-Trent) to address the above-noted issues in the context of the following areas of activity. These are the schemes which for the basis of this Better Care Fund submission.

1. Frailty/complex needs, long term physical and organic Mental Health
2. Support to live at home
3. Carers
4. Mental Health (not incl. dementia)
5. Learning Disabilities
6. End of Life Care/Cancer

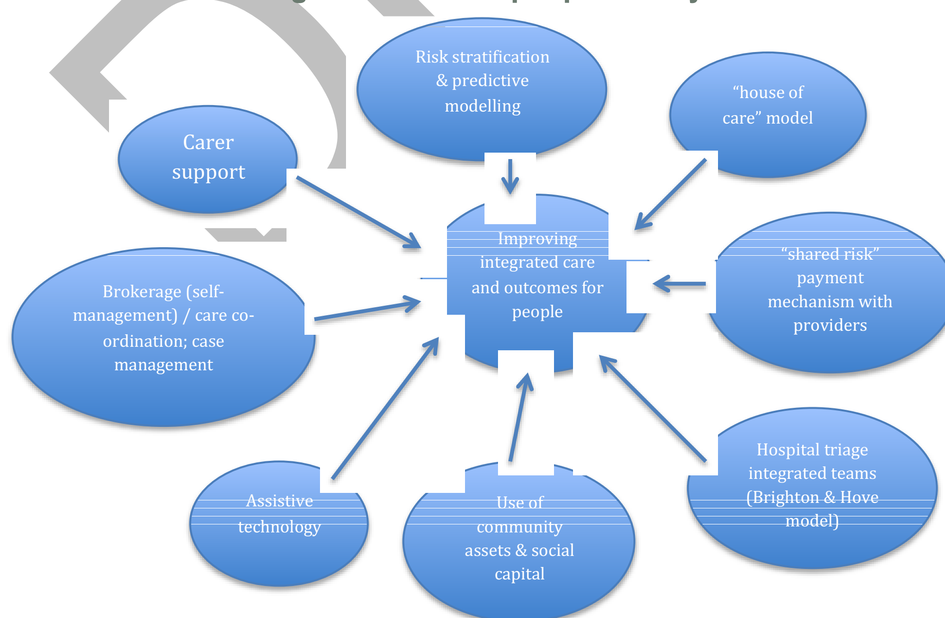
a.1 Better Care Fund Schemes

In practice the vision and overarching principles will translate into different approaches for different service delivery areas.

These approaches will need to be combined with the development of an approach to demand management and the changing of public behaviours which will centre on the development of a service offer that is preferable to the public, easier for them to understand and use. In Staffordshire, it is clear that this is a problem of service design and availability, and that the solution lies with those that commission and deliver services. The Brighton & Hove model is being explored in this context, although other approaches will also be considered.

We will also need to develop different solutions for different geographical areas, based on the risk profiles and local population needs of those areas. For this reason, as will be seen to some extent in this submission, variants on approaches are being developed for different localities within Staffordshire.

Enablers to achieving outcomes for people locally



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a.1.1 Frailty/complex needs/long term physical and organic mental health conditions

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. If people of this cohort are to be properly supported in the community, the same level of support needs to be available there

There are a number of elements which make up the vision for these patient/service user groups, in order to improve the support available in the community. These include the following:

A revised approach to **intermediate care / re-ablement / rehabilitation**. The Clinical Commissioning Groups and the County Council are co-designing and developing an Intermediate Care provision which acts to support patients in times of exacerbation and/or crisis. This support will be delivered either in the patient's own home or in a suitable bed based unit for a short period of reablement.

This approach aims to empower patients, families and carers to self-manage to prevent crisis, 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.

This work is being developed across a number of the partners within the BCF membership with the intention of a newly commissioned service being in place by April 2015.

Similarly, a revised approach is in development for people with **Long Term Conditions**. An innovative outcome-based service specification (co-produced with service users) is in development. Exploration of new ways of commissioning and delivering this ground-breaking long term conditions service is underway. A new model of LTC management will provide high quality clinical and social care interventions to empower patients, carers and families to maximise independent living. It 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.

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

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- 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.

Varying approaches to **Primary Care-led Services (Integrated Locality Teams)** are being developed across Staffordshire. These Primary Care-led Services based around GPs 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 manage patients where ever they live, including within care homes and be responsible for undertaking risk stratification of their vulnerable patient population and pro-active case management. These services will aim to increase patient and carer satisfaction and help reduce admissions to emergency services including readmissions.

This model is the Clinical Commissioning Groups' and County Councils opportunity to deliver an integrated and seamless service wrapped around the patient, ensuring that they only have to tell their story once and are supported by a range of highly skilled professionals who put the needs of the patient at the centre, rather than solely considering the person in the context of their diagnosed condition.

The exact service make-up differs from area to area, depending on the key needs of the local populations, but broadly speaking will incorporate a range of services including, medical, nursing support, practice pharmacy, social care, end of life specialists and Allied Health Professionals. This will be a system wide and complex programme of change which will take a number of months to define, commission and deliver.

Domiciliary care

Provision currently does not adequately meet local needs. Provision is fragmented and does not support easy and quick hospital discharge processes, creating system blockages. A radical overhaul of domiciliary care provision will take place under the Better Care Fund to deliver home and community support which is more closely integrated with health, and more flexible and responsive. The model being considered is based on the work of Wiltshire, and the Royal Borough of Windsor and Maidenhead, and will be commissioning for individual outcomes, rather than using a time and task-based model. The design of provision harnesses the use of community assets and social capital to deliver improved outcomes for

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individuals through encouraging self-reliance and improvement, working in partnership with health. Improving medication management will be explored as a part of this redesigned service, linking with GP multi-disciplinary teams and the Digital Technology programme.

Personal Health Budgets

These have been piloted nationally. The results are impressive, with an average of £169 savings from the Greater East Midlands CSU pilot per person per week (and greater savings elsewhere), and a better quality of life for those people who transfer to PHB's. Focusing on Continuing Healthcare patients (approx. 2,000 in Staffordshire), the pilot is aiming to become mainstreamed in 2014/15, with a staged implementation of up to 50 cases transferring, increasing to larger numbers in 2015/16. Year one will also focus on capturing other savings benefits, such as a reduced number of admissions to hospital, and of GP visits. The potential savings for Staffordshire are significant, estimated as being c.£17m savings if all CHC patients were to transfer to PHBs.

The right for people eligible for Continuing Healthcare and with Long Term Conditions to ask for and receive Personal Health Budgets is being strengthened over the coming year.

Staffordshire's work on Personal Health Budgets reflects the importance attached to delivering personalised services throughout all service delivery; most significantly in social care services.

a.1.2 Support to live at home

The Support to live at home scheme will include integrated prevention work (including falls prevention), digital technology (including medication management), housing, adaptations and community equipment.

Integrated Prevention

Staffordshire County Council, CCGs and District/Borough councils all provide different forms of grants to local organisations. It is anticipated that there is approximately £1 million currently available.

The desired outcomes for these grants include increase in physical activity levels, improved nutrition, improved sexual health, reduction in harm from alcohol, improved mental wellbeing (reduction in social isolation) and increase in self-care. These outcomes are important across the lifecourse.

There are various projects in process to review how these grants are delivered and what outcomes they aim to achieve. We are starting a project to propose how these funding sources can be integrated and a single approach to delivery adopted. Key principles behind this project are:

- Decision making shall be delegated to the district/locality partnerships. District/locality partnerships will include representation from Staffordshire County Council, the relevant CCG, the district/borough council and other relevant partners. The terms of reference for the district/locality partnerships will be formal line of sight to both the district/locality Local Strategic Partnership and the countywide Health and Wellbeing Board.

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- Funding should be distributed between the districts/localities based on need. The formula for this distribution will depend on the specific outcomes that the funding is intended for.
- Funding decisions should be based on addressing local need, utilising local assets and contributing towards the Joint Health and Wellbeing Strategy.

The projects funded by the Better Care Fund will contribute to preventing demand for the other priority areas identified through this Better Care Fund process. For example:

- Physical activity for older adults (particularly activity that promotes lower limb strength and balance) contributes to preventing falls.
- Interventions to support mental wellbeing in older adults (particularly those that promote opportunities to connect) will reduce social isolation and develop a wider community support network. This is important both for frail elderly and for carers.
- Interventions to support mental wellbeing can support recovery and independent living in people with mental health problems and learning disabilities.

The value of the integrated prevention fund at present is not sufficient to deliver prevention interventions on the scale that is necessary to have the desired impact. However, one of the principles behind the implementation of the Better Care Fund in Staffordshire is that the success of integrated commissioning targeting high need members of the population will release resources to increase the value of the integrated prevention fund over time.

Major housing adaptations (Disability Facilities Grant)

The Disabled Facilities Grant (DFG) is a mandatory means tested grant funded by the government and administered by 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.

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.

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

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 and delivering improved outcomes for customers. Similarly to integrated equipment services, the speed and efficiency of adaptation through DFGs is crucial.

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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 contract will commence in July 2014 to deliver a more efficient and consistent service, focussed on delivering outcomes for each service user.

Further joint working is planned for 2014/15 to adopt a county-wide adaptations policy, improve joint working, develop protocols with housing providers and make better use of properties that have already been adapted. The outcomes will be:

- Appropriate adaptations delivered in a timely manner
- Demand for adaptations moderated by better use of existing housing stock
- More people able to live independently in their own home leading to reductions in domiciliary care and care-home admissions.

For 15/16 the DFG allocation will be cascaded to district councils in a timely manner such that it can be spent within a year to ensure consistency of service and delivery across Staffordshire.

FlexiCare Housing

The model and philosophy of FlexiCare Housing is of an environment where residents own or rent their properties, and are able to access on-site care and support over a 24 hour period as they require it. FlexiCare Housing is not residential or nursing care, but it does allow a person with high-level care needs to maintain their living situation in the community. The philosophy supports a model of increasing independence and choice and by creating a mixed demographic of care (that is, a range of dependency levels), attempts to nurture an inclusive, supportive community amongst the people who live there.

Staffordshire currently has fourteen schemes which are labelled as FlexiCare Housing with six more currently in development, which in will in total give 1,325 units housing around 2,000 older people.

Ten further localities have been identified for future developments over the period 2015-2018 based on mapping of care needs. A tender for a framework of providers will be completed by April 2014 with, with new schemes set to start on site from April 2015. Consultants have been engaged to identify further sites outside the ownership of the County Council. The intention is to commission a minimum of ten new schemes, with the potential to accelerate delivery if further sites become available.

Plans are in place and being implemented to deliver a consistent vision and model of care across all FlexiCare schemes – based on an integrated service developed in consultation with residents, where people with care-needs have choice and control over how their needs are met. The housing provider will be responsible for providing/facilitating all services on site as part of a turn-key solution, replacing the current artificial split between care, support and housing.

Along with other forms of specialist housing for older people, FlexiCare housing is generally seen to deliver a number of beneficial outcomes. There is emerging evidence to suggest that it can make a considerable improvements in the health and wellbeing of residents, as well as achieving care efficiencies, pre-empting and preventing hospitalisation and where admission is unavoidable reducing the duration of an individual’s stay in hospital.

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The provision of new FlexiCare and the remodelling and re-provision of existing schemes will deliver benefits to customers and to health and social care partners achieved through a reduction in demand on acute and long term residential and nursing care.

Community equipment

Staffordshire and Stoke-on-Trent have set up a joint commissioning partnership for the delivery of an integrated community equipment service (ICES). An effective community equipment service is an essential element of any system of care and support, and through the consolidation of commissioning power the intention is that this arrangement will deliver both cost benefits through economies of scale, and also improve the speed and efficiency of the service. This will have positive benefits for those that use the service.

From 2015/16, the ICES will be funded through the Better Care Fund.

Delivering Digital Technology at Scale

Staffordshire has a proven track record in developing groundbreaking technological innovations and complementary service approaches to make the most of the support and stability that can be gained from astute use of assistive technology solutions. This will continue to be prioritised, and embedded in the strategic thinking that underpins the work of the Better Care Fund. Staffordshire has recently formed the Staffordshire Digital Programme Board to support implementation of Technology Enabled Care Services (TECS) (previously known as 3MillionLives).

Each stakeholder cannot plan or deliver TECS without considering the implications upon others, in terms of what is possible and what staff and service users want and need.

We are all agreed that as technology becomes increasingly available, the challenge is to secure the necessary evidence to support particular technology for specific groups, whether that be staff or service users.

There is acknowledgement that IM&T infrastructure is a given. Partners in Staffordshire will work together to ensure interoperability, connectivity and sharing of data for the greater good of staff and patients.

a.1.3 Carers

Carers are the largest providers of care and support in the UK, providing £119bn of care per year. There is strong evidence to suggest that effective integrated commissioning for improved outcomes for carers can have significant impacts on health and social care services. Staffordshire aims to improve outcomes for carers through the development of a co-produced service re-design for delivery from April 2015. Improved outcomes for carers in Staffordshire will be driven through the 'Staffordshire Carers Partnership' which aims to provide governance, strategic direction, meaningful engagement and co-production with stakeholders including carers, providers, social care and health.

Staffordshire will shape a future where the contributions carers make is recognised and supported, a place where carers will be treated as 'Expert Care Partners'.

By April 2015 we will be working towards increased early identification of carers across the county, we will be providing a range of information, advice and guidance for carers, and we shall be supporting carers to take a break and receive support to access emotional support.

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Working with practices we shall be identifying and supporting carers to recognise the importance of their own health, which is often forgotten when caring for another, and Carers will be supported with return to work pathways and will have equal access to services.

We recognise that early identification, provision of information advice and guidance and support for carers is key in terms of the prevention agenda for the health and wellbeing of both carers and the person they care for. There is evidence to suggest that the commissioning of information and advice services, breaks and emotional support for carers can reduce overall spending on care and their need to access mental health services. Effective integrated commissioning for carers can therefore have a significant impact on financial savings for health and social care and will: reduce admissions to hospital and residential care; reduce the costs of delays in transfers of care; reduce carers' need to access primary care as a result of their caring role and reduce overall spending on care. Evidence to support integrated commissioning for carers has identified that 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.

Key outcomes identified for carers in Staffordshire include improved health and wellbeing through increased access to information and support and opportunities to have a break from the caring role, these services will be provided through the re-design of services which is currently taking place.

a.1.4 Mental Health (excluding dementia)

As noted above, the concept of 'parity of esteem', especially for those with issues of mental ill-health, underpins all of the work towards this Better Care Fund submission for Staffordshire. The partners in Staffordshire recognise that the disjoint between 'mainstream' health and social care services and 'specialist' services that support people with mental health needs is a major and increasing problem, especially when considering the growing cohort of people with multiple long term conditions requiring coordinated and coherent community-based support. The inclusion of specialist mental health activity and the development of generic mental health capability in all services will be a key priority of this developing agenda for integration.

There has been a gradual shift over time in clinical delivery of mental health care, in that there has been a move from delivering mental health care in acute care settings to delivering care in the community. The clinical case for this is well researched and has led to a reduction in the number of admissions and the length of stay of people admitted. However. there is a significant and increasing proportion of individuals with complex and multiple needs now being supported within the community that requires packages of care to support them to remain there and avoid the need for contact with acute care settings.

As commissioners, we are committed to leading the health and social care agenda to ensure that local people with mental health problems have the opportunity to prosper, be healthy and happy.

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We will be building on the benefits of integrating care not only across the boundaries of health and social care but taking into account the growing support for better integrated healthcare. Achieving parity between mental health, physical health and social care is an essential feature of our intentions going forward as part of a system that expects to reduce inequality and provide the best possible support to individuals.

We have set out our intention to work with all of our providers to deliver a model of care provision that closes the gaps between services, we intend to work in a more integrated way to remodel existing support with a greater focus on early intervention, service integration, personalisation and recovery, seeing recovery as a journey rather than a destination – this will require new and innovative ways of working to deliver the outcomes we have identified.

We are fully engaged with local providers in the discussion around services taking a problem solving, rather than a criteria led approach.

We are now setting out our agenda with other public services including those within the wider areas of the Local Authority, as well as with the Police and other public services, to ensure that mental health is embedded in everyone's agenda. We will have a specific goal around eliminating the detention of people subject to a section 136 being detained in police custody.

a.1.5 Learning Disabilities

The commissioning of learning disability services has been reappraised in consideration of the findings of the National Development Team for inclusion (NDTi), commissioned in 2011 by NHS and local government commissioners for Stoke-on-Trent and Staffordshire to review specialist Adult Learning Disability health services across the two areas, and the DH review of the Winterbourne View Hospital in December 2012. The intention is that, as a product of these reviews, learning disabilities services will be commissioned in partnership on a Staffordshire and Stoke on Trent basis.

The main priorities of this joint commissioning approach adhere to the strategic principles outlined above, but in addition by 2015/16, the approach to both specialised and generalist support for people with learning disabilities and complex needs will privilege inclusion, the enabling of the full rights of citizenship, and parity of treatment of people with learning disabilities in mainstream NHS, social care and associated services.

Through this integrated commissioning approach and the use of the Better Care Fund mechanism, the increasingly integrated delivery of learning disabilities services will benefit from more sophisticated and outcome based specifications, more rigorous monitoring of delivery, and vastly improved outcomes for people with learning disabilities. Working in a collaborative and integrated manner allows us to provide a whole system approach and the most effective pathways to support people by offering a seamless service to the individual making the best use of resources in the system.

The strengthening of social services and the increased focus upon personalisation is being further improved by the development of a new 'all ages' assessment and person centred planning service: 'Independent Futures'. The next stages in this programme of work will be closer integration across health and social care.

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Based on the aims and objectives of the BCF, Learning Disabilities should be included as a priority for Phase 2 . In line with the national models regarding Local Authority leads for learning disabilities, Staffordshire County Council (as agreed by the Health and Wellbeing Board) shall be the host for the integrated commissioning of Learning Disabilities services. Further discussion and decision will be needed around the delegated powers of the pooled budget manager in relation to Learning Disabilities.

The respective parties are keen to include in the BCF as a starting point all the Learning Disabilities Health related budgets, this amounts to just under £16m per year across the North and South of the County. Further discussion and agreement is needed in respect of the County Council Adult Social Care budget for Learning Disability which amounts to around £80m.

A due diligence exercise will need to be completed in respect of the health related budgets. This validation exercise needs to include (without limitation) agreed definitive costs, contracts included, services involved and numbers attached to each budget. It is imperative that such validation is undertaken and signed off by the appropriate leads within each organisation. In addition, due consideration needs to be made in respect of how arrangements such as Independent Futures (Staffordshire County Council Learning Disabilities Assessment and Care Management teams) fit into such an integrated arrangement.

There are a number of financial issues that will need to be discussed and agreed between the respective finance arms of the partner organisations once broad agreement has been reached on what is and out of the BCF, this will include issues such as charging policies, etc.

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a.1.6 End of Life Care/Cancer

The Staffordshire Transforming Cancer and End of Life Care Programme is one of fourteen national Integration Pioneers. The aim of the Transforming Cancer and End of Life Care Programme is to support NHS and social care commissioners to shift the focus of practice from providers and individual interventions to one that encompasses the whole patient journey, both for cancer care (prevention through to survivorship) and for end of life care (for advanced progressive incurable illness). To achieve this, the CCGs will tender for a prime provider for each pathway (relating to cancer services for four tumour sites initially – lung, breast, bladder and prostate), and one for end of life care who will be held accountable for the whole patient journey and will have all the individual contracts for that journey assigned to it.

There are three core components to the programme.

- Co-designing the best outcome-based integrated health and social care pathways, based on patient/carer need, for end of life care for all long term conditions.
- Changing the way both cancer and end of life care services are commissioned with the move, by April 2015, to prime provider models. It will be up to each prime provider to determine the best pathway, based on outcomes, and appoint thereafter subcontractors to deliver the pathway.
- Supporting the prime provider from 2015-2025 to manage change within the contracts to ensure that outcomes are achieved and that the project becomes self-funding within the

first two years, and innovation and system change are achieved for whole scale integrated working.

This integrated approach will enable the development of care and support that is more qualitative, and that is tailored to the needs and preferences of the people receiving the services. The individual outcomes that people experience will be significantly improved.

a.2 How will we deliver this?

a.2.1 Programme Management

The delivery of whole-system transformational change will only be achieved if a range of coordinated developmental programmes is 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.

The Better Care Fund for Staffordshire is an integral part of the developing CCG-led two-year operational and five-year strategic plans for the county, all of which have their strategic basis in the Joint Health and Wellbeing Strategy. As noted above, the BCF embraces and works to coordinate a range of theme-specific areas of strategic development. A simple and coherent set of plans will be delivered through this coordination, and help to render the complex strategic agendas of the NHS, local authority and key partners more understandable.

Risks on a per scheme basis will be developed during 14/15 as part of the development of individual projects which will sit within each scheme. 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.

2.2 Improved strategic commissioning

Central to this transformational vision is the imperative of joined up and coordinated strategic commissioning. If the NHS, local authorities and other contributors are to continue to provide high quality, safe and effective services to those that need them in the face of the financial and demographic challenges of the future, there will need to be diligent attention paid to the use of resources, the avoidance of duplication, and ensuring that activity properly addresses

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defined need. In addition, as noted above, the present arrangement of services does not provide the right kind of support to the growing swathe of people who are living longer with long term conditions, frailty and complex needs.

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.

Commissioning partnerships must be pragmatic, and feature the best membership to address the particular areas of need. In Staffordshire, the Better Care Fund is immediately welcome in the context of the range of activity outlined above. 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.

a.2.3 Organisational development and the workforce of the future

Pan-Staffordshire cross-economy consideration is required to address the questions of workforce that these challenging new agendas raise. If a significant amount of higher-level planned and non-elective activity is to take place within communities, focussed upon GP practices, then consideration of the competencies required is essential, and reconsideration and redesign of the community workforce is inevitable.

Amongst the existing areas of community activity, General Practice and domiciliary care present some of the starkest workforce challenges. For example, for very different reasons, both areas present major recruitment challenges in some areas of Staffordshire. Any conceivable reimagining of community approaches to care and support will entail reconsideration of the roles and activities of GPs and other health disciplines, domiciliary care and other areas of delivery. This reconsideration must be done 'whole-system', as no single organisation will be able to address the global nature of the challenges.

Partners working on the Staffordshire BCF, in the context of broader system-wide strategic work, will engage the support of the HEWM, the LETB, LETC and Area Team to further this element of the enabling programme.

Whilst consideration of the existing workforce, roles and competencies is essential, it is also necessary to pursue alternative and innovative ways of working in communities in order to fully address the spectrum of individual needs that vulnerable people may present. As service approaches become increasingly preventative, lower-level issues that prevent the exacerbation of situations and recourse to high-level non-elective solutions to need will be routinely addressed as part of joined-up and person-centred case management. This will inevitably entail consideration of work delivered outside standard NHS and social care disciplines, and will require recognition and privileging of existing and new community assets best placed to support people to confidently self-care and retain their independence for longer.

a.2.4 Modelling

Initial work on modelling potential areas for further exploration has taken place, using the Anytown and LGA Value Case examples. These indicate that significant benefits could be

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achieved, however, they need to be treated with a high degree of caution as the detail of the value cases against which they are based in a number of cases reflect existing structures and services locally which are already in place.

Specifications have been agreed for future modelling tools to be developed during 14/15 which will enable regular checks against progress and analysis of future service development.

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a.3 Case studies

In practice the vision can be shown through individual stories that reflect some of the people in Staffordshire and their needs (the stories profiled are not real people):

Dorothy's story - Frail Elderly

Dorothy is 70 years old and lives at home with her husband David for whom she has been his main carer for over 15 years, following a stroke, which left him paralysed down one side.

Dorothy isn't known to her GP as a Carer, but she often visits her practice, to bring her husband in for regular check- ups and blood tests for his warfarin.

Dorothy struggles to have the time to think about her own health, as she is always busy looking after her husband's care needs, and she rarely gets the chance to have time to herself and do the things she enjoys.

Dorothy is worried about the future and what will happen if she gets ill and is no longer able to care for her husband. Dorothy is diabetic and has to attend regular check-ups at the practice.

There is no plan in place to prepare in case of an emergency and when professionals do visit the house, they can often be brief visits.

But in the new world, it will be a different story to tell…..

Dorothy has been supported throughout her life to make healthy decisions and access services to support those decisions should she need them.

Dorothy is known to her GP as a Carer and is supported in her caring role. She has had a full assessment by her local social worker who has developed a plan to support her continue in her caring role, including ensuring that she has a break every 6-8 weeks when a professional carer comes into the home, and sits with her husband ensuring that he is safe and supported whilst she is able to access her community. Dorothy is a very active member of her local Church and this respite often gives her the time for herself to meet with her friends.

Dorothy is able to monitor her blood pressure at home through a machine and send the results through to her practice for checking. If Dorothy's blood pressure is a concern, her GP is able to make arrangements for her to visit the practice and review her medication.

If Dorothy's health deteriorates she is fully supported by her Integrated Local Care Team based at her practice who are able to put in place the necessary actions to delay or prevent an exacerbation of a condition.

Should Dorothy develop a long term condition, she will be known by her local integrated team who will assess and support Dorothy to remain well for as long as possible. Dorothy is provided with the relevant information to understand and manage this condition, and is part of shared decision making, understands the risks and is supported with decisions. Dorothy

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feels like she has choices and is in control. Should her condition deteriorate she has access to specialist care should she require it.

Should Dorothy become acutely unwell she is supported to stay at home, and her care is co-ordinated by relevant professionals (ie, Nurses, therapists, social workers). Information about Dorothy is held as one central record which can be accessed by a range of professionals including ambulance crews. This will includes an Emergency Plan around her husband should Dorothy be admitted into a hospital.

If Dorothy has to be admitted into a hospital she will only need to stay for a short length of time and she is supported to come home as soon as she is medically stable. She is treated with dignity and respect by the staff who care for her and she receives short term intensive support to regain her independence as soon as possible.

Whilst Dorothy is regaining her independence, her husband is assessed by the Integrated Local Care Team who will ensure that both his physical and emotional needs are met.

As Dorothy approaches the end of life she has the time and opportunity to discuss how she feels about this and her wishes. She is supported to die with dignity in a place of her choosing and with the knowledge that husband will be supported after her death.

Dorothy is empowered to manage the development of any long term condition, she is treated as a ‘person’ with individual needs and wishes and she is given the confidence that the staff who look after her, care about her.

Sarah’s story - Learning Disabilities

Sarah has learning disabilities and is in her mid 40’s with a long history of self-injurious behaviour which has led to increasing physical health needs. She originally had a placement in a long stay hospital and then left to move to a private care provider. This was not a good experience and in the late 1980’s moved into the NHS ‘campus’ type accommodation.

Under our new vision, Sarah has moved into a new care provider. She now lives in her own flat with an individual care package for 1:1 support and assistive technology provided. The carers have helped Sarah to learn to cook so she can manage her own meals, and have trained her in using public transport so she can get around by herself. The technology allows her to feel safe cooking for herself (fire & smoke alarms) and accessing public transport (GPS solution), in the knowledge that she can call her carer should she get lost. Sarah is much happier in her own flat, and can choose what she does when, her social network is expanding. Her family are delighted at the change in her independence levels.

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b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

As noted in the previous section, the integrated work that will take place under the auspices of the Better Care Fund will adhere to some high-level strategic principles which will determine the way that future services are developed. Some of these pertain directly to existing activity in development, and the success of this activity will be measured in the following ways.

- **There will be greater emphasis on preventing ill health and promoting independence in the provision of all community-based NHS, social care and associated services.**
- **Community-based services will centre on General Practice, which will be the focal point of coordination and support.**

- The ongoing development of the supportive network of NHS, social care and associated services (Integrated Care Teams (ICTs)) will become increasingly preventative in approach, and improved and better-coordinated support will **help people to stay well and independent** for as long as possible.
- ICTs will centre on the **GP Practice,** which will be the focal point of the 'community hub' and co-ordinate the individual's care, working with an extended team of specialist services

By 2015/16, x-number of people using ICTs will report that their wellbeing and experience of care has improved since they were using the service. (Local measure to be established / range of qualitative measures to make up this % from new outcomes framework.)

- **Higher-level and better coordinated treatment, care and support will be available for people in their communities, and delivered where possible in peoples' homes.**
- **There will be 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.**

In 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 Staffordshire, there exists a commitment to support people to live independently in their own homes 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

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development in the separate CCG areas and are named differently, there are many common principles that they share.

- In Staffordshire, we will be **supporting people to live independently in their own homes** 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.
- ICTs will utilise a **risk profiling** tool to identify their practice population most at risk of emergency admissions, and adopt a **case management approach**, through which a named practitioner will take responsibility for coordinating the range of formal and informal services and supports, enabling the individual to lead a healthy and independent life.
- ICTs, in conjunction with improved Intermediate Care services and the increase of community capability, will ensure that people with needs of a higher level of acuity will be supported at home, thus **minimising unnecessary admissions to acute sector and community hospital beds, and into residential and nursing care homes**.

By 2015/16, an estimated 24,000 people across Staffordshire and Stoke on Trent will have an active care plan supported by ICTs.

By 2015/16, there will be a x% reduction in the number of people permanently admitted to residential/nursing homes (indicator subject to change).

By 2015/16, there will have been a sustained low number of delayed discharges from acute sector hospital to the community (indicator subject to change).

- **A significant amount of resource presently committed to non-elective urgent care services in the acute sector will shift to fund this community-based activity.**

- The approach to improving support for people in the community will release a significant volume of presently overcommitted non-elective acute sector activity, thus making it possible to **give people the best support when they need it most.**
- In Staffordshire, 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.
- 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 reduce delays in discharge**.

By 2015/16, 4,760 fewer non-elective admissions will be made to UHNS from the population of North Staffordshire. The equivalent goals for the Southern Staffordshire CCGs and their key acute sector providers is c.2,000 (South CCGs currently benchmark well for emergency admissions).

By 2015/16, there will be a x% increase in the number of people benefiting from rehabilitation / reablement services (indicator subject to change).

- **Increasingly sophisticated processes of commissioning will be employed to incentivise community-based care and support, and to ensure joined up delivery of pathway-based services.**

- Increasingly, commissioners will be working together to produce evidence-based integrated strategies and specifications that will ensure that **providers work better**

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together for the people who they serve, and use the available resources to maximum benefit.

- **A pan-Staffordshire financial strategy** is being developed, to gain a fuller appreciation of the range of interrelated existing and emergent financial and operational challenges for the county
- Pan-Staffordshire approaches to **IT, patient data management and risk stratification** will be implemented.
- Whole-system approaches **to seven-day working** will complement individual organisational performance improvement to guarantee optimum system efficiency.

Through the use of ICT, patients and carers will be empowered to develop the knowledge, skills and confidence to care for themselves and their condition effectively, in order that they can retain their independence and quality of life.

A selection of the following population-wide measures of health gain will be employed to demonstrate the success of this integrated approach.

- Increase healthy life expectancy
- Reduce gap in life expectancy between defined areas reflecting health inequalities
- Reduce premature deaths from respiratory conditions, CVD, and other defined LTCs
- Reduce inappropriate admissions for defined cohorts of people with LTCs, frailty and complex conditions
- Improve health related quality of life for people with LTC's
- Reduce inappropriate admissions for people with dementia
- Reduce inappropriate length of stay for people with dementia
- Improve patient experience
- Demonstrable transition from 'reactive' to 'proactive' care approach
- Ensure people feel supported to manage their condition
- Enhance quality of life for carers
- Better control over symptoms
- Reduced days off work

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c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

The Joint Staffordshire Health and Wellbeing (JHWS) strategy sets out the following five priority areas, three of which are directly relevant to the presenting issues of challenge.

- **Starting Well**: Giving children the best start. The highest priority in the Marmot Review was the aim to give every child the best start possible as this is crucial to reducing health

inequalities across the course of someone's life. Key areas for action are (1) parenting, (2) school readiness;

- **Growing Well**: Maximising potential and ability. Children, young people and adults who are supported to reach their potential can have greater control over their lives and their health and wellbeing. Key areas for action are (3) Improving educational attainment; (4) Reducing NEETs (5) Children in care;
- **Living Well**: Enabling good lifestyle choices means that people in Staffordshire can lead long and healthy lives. Key areas for action are (6) & (7) reducing harm from alcohol and drugs (8) Promoting healthy lifestyles and mental wellbeing;
- **Ageing Well**: By helping people to live independently and be in control of their lives, we can support older people to be health and well. Key areas for action are (9) Dementia (10) Falls prevention; (11) Frail Elderly with Long Term Conditions – providing good quality personalised care;
- **Ending Well**: Ensuring good quality care and support at the end of someone's life. Key areas for action are (12) ensuring someone is well cared for and where possible in a place of their own choice at the end of their life.

Key success factors for the delivery of all activity which forms part of the BCF plan will be that the outcomes reflect positively against those set out in the JHWS, and deliver the outcomes and priorities stated above.

We recognise that achieving our vision will mean delivering a radical shift in how our resources are spent. We intend to focus on early help and prevention rather than reaction at a point of crisis. But reducing demand on the acute hospital system, so that expenditure can be reduced, while maintaining the quality of care, will require a significant reshaping of that system. We recognise the challenges involved in this. The CCGs and local authority commissioners who make up Staffordshire County are committed to working together to create a marketplace, and effect the required behavioural and attitudinal change in the acute sector to ensure that this happens. There must be a balanced mix of investments to protect current services, identify those at most risk and target services appropriately, while redirecting resources longer term to preventative and early intervention activity.

Using the growing wealth of information available in the Joint Strategic Needs Assessment for the area, locality mapping has taken place in North Staffordshire as part of the strategy to create a locality-based and focussed approach to community service delivery. Each locality has benefited from a detailed breakdown of its presenting health needs, demographic characteristics, level of deprivation and related information. Through these, future commissioning activity at the locality level will be locality-specific, in order to ensure the style and scope of community services meet the presenting needs of the population.

A similar approach is taking place in southern Staffordshire, using the HWB to strengthen learning and shared action across the whole system, taking into account the work in Stoke-on-Trent and North Staffordshire.

There has been much recent work to engage both the people in receipt of, and those delivering, the services of the local health economy in Staffordshire. The aim has been to discuss with people what they think about local health, social care and associated services. Some of the key summary outcome themes coming from these engagement processes are listed below.

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- More avoidance of crisis/improved planning ahead – proactive/preventive
- Better focus on all of the individuals' needs
- Services should value and support Carers
- Single coordinator of care/case management
- More support for those who can and want to self manage
- Improved quality of domiciliary care provision (care, timing and reliability)
- Improved timeliness of and access to services – improved accessibility of community services
- Better access to GPs
- Improved working between all agencies
- Better continuity of care
- Improved hospital discharge process
- Improve the sharing of patient data to support the patients/Carers

These outcome themes have been incorporated into the overarching principles for the future vision for health, social care and associated services in Staffordshire as set out in section 2 a) above.

Across Staffordshire, the vision set out for the BCF plan will be delivered against the following timeframes:

Scheme	14/15 activity	15/16 activity	Benefits
Frailty/complex needs/long term physical and organic MH	• Continuing co-design with providers to deliver our vision of integrated services, focusing on Long Term Conditions, Frail Elderly and Intermediate care and Rehabilitation, Dementia and Telecare / Telehealth • Dementia care, reviewing current service delivery to assess where more integrated services could be implemented working with 3rd sector and NHS providers to co-design delivery models. • Phase 2 of the Stoke on Trent and North Staffordshire Intermediate Care pilot programme will see the alignment of social care Intermediate Care/reablement services with the NHS activity, and the consequent development of a single admission avoidance/discharge hastening pathway which will continue to shift the community service emphasis from being on discharge to being on admission avoidance. •	• Locality teams in place in all areas • Long Term Conditions Year of Care pilot started across Northern Staffordshire • Consolidated NHS intermediate care and social care reablement services covering Staffordshire using locally determined commissioning specifications • Long Term Conditions primarily managed in communities by GPs and Integrated Locality Teams with specialist input from acute sector consultants • Domiciliary Care full Staffordshire & Stoke review taken place • Appraisal of workforce and workforce map showing competencies required to deliver vision of community-based services • Support for people with dementia embedded in community service offer – development of lifetime pathway	£12-20m North Staffordshire programme (£15m for South Staffordshire in 16/17 onwards) Patients feel more empowered, in control, more knowledgeable about the nature of their condition
Support to live at home	• Falls prevention programme developed and	• All District Council areas have a consolidated local plan for	More frail elderly people supported

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	agreed with Districts
	• Staffordshire Digital programme board established to drive the adoption of technology to improve outcomes, transform services and create efficiencies at "scale and pace", it will encompass all modalities of digital health, this includes:-
	  ○ Tele-care (reminders and devices to support independence)
	  ○ Tele-health (remote monitoring of health parameters)
	  ○ Mobile Apps and online self management support (patient facing support for tele-care & tele-health)
	  ○ Clinical video conferencing & Tele-diagnostics (near patient testing, remote diagnostics and video conferencing)
	• Expansion of Flexi-care homes, offering better choice of appropriate accommodation for people.
	• Integration at County level of housing adaptations, leading to more consistent approaches, improved service delivery and reduced delays.
		supporting frail elderly people to stay safely and well supported at home including housing solutions, DFGs, equipment etc.	to live safely and well at home
			
			More generalist support for people with long term conditions
			
			Improve health and wellbeing for local populations.
			
			People supported to feel safe and secure in their own homes, actively participating in their local communities

Carers	• Carers support programme in place across Staffordshire, providing respite breaks, and leisure and learning activities to support carers to achieve and maintain good health and wellbeing	• Integrated locality teams support identification of and support delivered to Carers	Carers better supported to continue in their caring role
Mental Health	• Rehabilitation and recovery services for people with complex mental health needs mapped and reviewed, for gap analysis. These services are aimed at reducing the time people need to spend in ward-based services, and improving the support within the community.	• Rehabilitation and recovery services for people with complex mental health needs – pathway and services in place. • Work underway to put in place recovery focused services	

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Learning Disabilities	• Learning Difficulties programme to expand the use of community-based services, reducing impact on acute care through a specialist team offering intensive support services.	• Specialist and generalist support will priviledge inclusion, enabling full rights of citizenship, and parity of treatment.
		• By end March 2015, an integrated approach in place to deliver the following outcomes:
		  ○ reduce dependency on high cost out of area placements and independent hospitals
		  ○ reduced demand on specialist and acute services, including hospital admissions and re-admissions, residential and nursing care
		  ○ enable a more flexible use of resources and whole system approach to deliver the right solutions locally
		  ○ enable the joint commissioning of an appropriate range of services including the development of an integrated Intensive Support service in the community to support people with complex needs and challenging behaviour avoiding unnecessary admissions to hospitals
		  ○ Support the continued development of the market to offer more personalised services
		  ○ Enable the commissioning of integrated community learning disability teams with health and social care
		  ○ Ensure the continued inclusion of people within their local communities
		•
			All service users have personalised care plans

End of Life/Cancer	• End of Life Care Integration Pioneer programme working with Macmillan in Staffordshire is established and developing a range of innovative approaches to provide Principal Provider approach working with patients, carers, providers & commissioners to co-design outcomes-based services for the next 10 years.	• Prime provider in place, outcomes for local people starting to be delivered, with whole patient journey for cancer care and end of life care in place.	
Programme Management	• Manage the implementation and benefits tracking for live	• Further development and implementation of the next wave of pilots and programmes to deliver	

	integrated services and developing the next stage of joint commissioning plans in line with local needs, JSNA and the HWS. • Modelling tool developed • Agreement on programmes of work to deliver outcomes between finance, commissioners • Programme management structure and governance in place and reporting monthly on progress	our vision for integrated care, taking heed of pilot and programme outcomes from 2014/15 and prior.	

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County Council Strategy – work is being undertaken to identify priority outcomes and a plan to deliver a fundamental shift in public expectations over a generation. This will frame the delivery plan in terms of our ambition to support people to take more control of their lives.

CCG Five Year strategies – the CCGs collectively are in the process of articulating their five year vision and delivery strategy. The work to support this will include detailed modelling of the impact of changes which will underpin more detailed plans for the BCF.

Strategic Service Review – We recognise there is a disconnect between commissioner plans and provider plans in term of sustainability. A strategic review has just begun to clearly identify and address inconsistency in commissioner and provider assumptions.

Through current governance and programme management mechanisms now being put in place, activity in the County will be carefully managed to ensure alignment between the JHWS, JSNA and CCG and Local Authority commissioning plans. There is a long history of joint commissioning, through a previously established Joint Commissioning Unit. This arrangement has been replaced recently with a clear governance structure around integrated commissioning, linking directly to the Health and Wellbeing Board.

The JSNA informs the JHWS, and supports the identification of priority areas for action. The JHWS is a five year strategy but is reviewed on an annual basis in the light of new data to check the priorities remain appropriate.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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. Whilst there is very little that is systematic about the economy at present, the strategic impetus behind the BCF and related activity requires a more rigorously derived and robust evidence base upon which to premise future development. 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.

However, there is a clear desire to focus on early intervention as expressed in the Staffordshire Health and Wellbeing Strategy (Doc1), while at the same time, Staffordshire hospitals are suffering from increasing budgetary constraints. These levers and pressures mean that finding ways to reduce demand on the NHS through the development of community and social care services is a priority across the health and social care economy. Targeting BCF activity on areas which will have most impact on reducing hospital admissions, length of stay and delayed discharge is a given, and the next step will be to work this plan through in more detail with NHS partners..

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

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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.

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 ongoing 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 engage with providers more effectively.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes.

Current arrangements are that the HWB has overarching responsibility for the achievement of the BCF plan, with executive responsibility delegated to the Staffordshire Senior Officers 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, governance may be reviewed with some changes to the existing structure as set out below:

The Senior Officers Group (SOG) will act as the collaborative management committee with executive responsibility for the Better Care Fund, making recommendations to the Health and Wellbeing Board and local commissioning and finance committees/board where appropriate for agreement.

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.

The SOG (or separate partnership board if required) will: -

- Identify services, funding and strategic objectives where a PAN CCG/county approach or a locally specific CCG approach is required as appropriate

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- Oversee the implementation of the projects for review and redesign within geographical areas as appropriate
- Oversee the co-ordination of appropriate engagement with local patients, clinicians and commissioning networks
- Ensure quality patient/user care and the best value for services
- Monitor the performance (agreed outputs, outcomes) and financial aspects at a local/county level
- Review the effectiveness of the collaboration
- Establish working groups as appropriateThe 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.

3. NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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 and budgetary pressures. We will maintain current eligibility criteria and focus on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are 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.

Please explain how local social care services will be protected within your plans

Funding currently allocated under the s256 transfers from NHS England to County Council has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained. New requirements to be placed on services which will have financial impacts will be around delivery of seven day services and the new Care Bill which requires additional assessments to be undertaken for people who did not previously access Social Services. Since the additional costs of these developments have already been factored into the baseline grant provided by DCLG, implying significant reductions in core funding available for existing

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social care services, the County Council will be reliant on re-focusing of funding either from within the BCF or from DH to meet these requirements. ADASS have calculated that the allocation for Staffordshire within the BCF meant to cover the cost of the Care Bill is £6.9m however work has yet to be completed to establish more accurate estimates of Care Bill costs for the County.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and 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.

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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 confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

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.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

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.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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.

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Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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.

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- 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 Newcastle approx. 124 individuals are subject to active case management and 121 individuals in Moorlands.

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.

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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.

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4. RISKS

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

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. As the BCF 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. 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.

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Risk	Risk rating	Mitigating Actions
CCGs are unable to make the 3% savings required	Medium	Focus activity planned on approaches which are most likely to deliver financial benefits as well as population outcomes. Review good practice from elsewhere, including LGA value cases and outcomes of Anytown modelling to identify opportunities for greater impact.
CCGs are unable to reduce hospital intake leading to inability of partners to make savings intended through the plan	High	Gradual transformation with staged approach to investing in preventative options. Negotiation on new contracts with Hospitals agreeing caps on intake numbers and shared risk with Hospitals on overspends
Money going into BCF already tied up in mainstream services, therefore cannot fund additional activity	Low	Plans already in place for re-commissioning of services at lower cost which will fund expansion of preventative / community investment
County Council social care budget being cut, therefore funding may have to be used to protect existing services	Medium	As above
Potential impact of Mid-Staffordshire NHS Foundation Trust changes where redesign is focused on maintaining financial viability of Hospital rather than supporting changes	High	Gradual transformation with staged approach to investing in preventative options.

set out in BCF		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 may prevent signatory partners gaining sufficient assurance to approve plans. • Arrangements for (S75) budget pooling. • Establishment of reasonable local improvement trajectories and targets. • Mechanism for determining 'failure', apportioning responsibility, and withholding resource.	High	LAT to accept 'work in progress' commitments within Feb 14th submission, to lobby nationally for answers to key questions, and to support the development of locally relevant trajectories/targets where applicable.
National benchmarks/baselines upon which performance is to be premised may present unrealisable trajectories/targets for local health economy/CCG areas. BCF will not be approved by H+WBB if this is the case. (See appended metrics document)	High	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.	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.

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Better Care Fund - Current Activity/Expenditure aligned to new Schemes as at 11th March 2014

BCF Scheme	Lead Officers	Existing Activity (14/15)	Existing Expenditure (14/15)									Future Activity
			DCs/BCs	SCC	Stoke	NS CCG	S&S CCG	CC CCG	ES CCG	SES&SP CCG	Total	
1) Frailty/complex needs, long term physical and organic MH	Finance: Wendy Kerr (CFO ESCCG) Commissioning: Jenny Watson (Snr Commissioning Manager SES&SP CCG)	Reablement,Enablement,Intermediate Care Admission avoidance and delayed discharge Service Review Frailty, complex needs, LTC, OP	0	0	491,203	16,237,000	3,220,694	2,628,848	4,590,886	7,183,966	34,352,597	- Intermediate Care, Reablement, Rehabilitation - Long Term Conditions - Integrated Locality teams - Domiciliary Care (whole system review) - Personal Health Budgets for LTCs/CHC - Dementia
2) Support to live at home	Finance: Sarah Pitt (SCC) Commissioning: Helen Trousdale (tbc) (SCC)	Disability Facilities Grant ASC Capital Grant Community Equipment Flexicare Homes Assistive Technology/Telehealth	3,804,000	5,502,259	0	596,000	304,675	385,737	253,676	436,342	11,282,689	- Falls Prevention - Medication Management - Housing - 'flexicare' homes (District input reqd) - Adaptations - DFGs etc (District input reqd) - Community Equipment - Digital technology
3) Carers	Finance: Sarah Pitt (SCC) Commissioning: Shelley Brough (SCC)	Carers	0	0	49,800	78,868	136,813	126,281	115,859	184,690	692,311	- Carers - Staffordshire Carers Strategy (April 15)
4) Mental Health	Finance: Colin Thomas (CFO - SES&SP CCG) Commissioning: Dawn Jennens (SCC)	Mental Health (incl Dementia)	0	919,881	0	0	9,435,340	8,143,623	7,815,202	13,254,794	39,568,840	- Mental Health Strategy (to be developed)
5) Learning Disabilities	Finance: Sarah Pitt (SCC) Commissioning: Christine Adams (SCC)	Learning Disabilities (incl Autism)	0	0	0	0	864,173	893,218	795,794	1,243,154	3,796,339	- Learning Disabilities re-commissioning for Staffordshire (2015)
6) End of Life/Cancer	Finance: Tony Matthews (CFO NS/SoT CCG) (SnrCommissioning Manager, S&S & CC CCG)	End of Life Cancer Palliative Care	0	0	0	0	953,521	806,395	510,190	1,011,170	3,281,276	- End of Life/Cancer specialist provision development (integration Pioneer)
			3,804,000	6,422,140	541,003	16,911,868	14,915,216	12,984,102	14,081,607	23,314,116	92,974,052	

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Better Care Fund

as at 17/03/14

Business Objectives	Corporate Risks	Risk Identified	Potential Consequences	Impact	Likelihood	Risk Rating	Control Measure	Final Impact	Final Likelihood	Final Risk Rating	Further Action Required	Owner	Target Date
Better Care Fund													Risk Count: 6
		Inefficient partnership working between key stakeholders	Reputational damage to the council. Improved outcomes for the borough's residents not realised. Dissatisfied stakeholders. Lack of partnership working.	3	2	6	The statutory duty to provide disabled facilities grants will remain with the borough council. The Better Care Fund Plan identifies Newcastle Borough Council as a party to the Plan	3	2	6	Cabinet approval of Better Care Fund report	Bailey, Mark (Head of Business Improvement & Partnerships)	02/04/14
		Demand for disabled facilities grants increases without an increase in funding	Inability to provide the required service to residents. Increased number of complaints against the council. Stakeholder dissatisfaction. Increased costs to the council.	3	2	6	The 2014/15 budget for disabled facilities grants is £864,000, of which £514,000 will be funded from external grant and The disabled facilities grant element of the Better Care Fund will be allocated back to the Council for 2015/16 The allocation to Staffordshire from the national Better Care Fund pot will be £56.1m in 2015/16 The allocation to Staffordshire from the national Better Care Fund pot will be at least £16m in 2014/15	3	2	6			
		Future funding for disabled facilities grants reduces	Increased costs to the council. Inability to provide the required service to residents. Resident's dissatisfaction.	3	2	6	The 2014/15 budget for disabled facilities grants is £864,000, of which £514,000 will be funded from external grant and The allocation to Staffordshire from the national Better Care Fund pot will be £56.1m in 2015/16 The allocation to Staffordshire from the national Better Care Fund pot will be at least £16m in 2014/15	3	2	6			

Business Objectives	Corporate Risks	Risk Identified	Potential Consequences	Impact	Likelihood	Risk Rating	Control Measure	Final Impact	Final Likelihood	Final Risk Rating	Further Action Required	Owner	Target Date
Better Care Fund													Risk Count: 6
		Better Care Fund aims and objectives are not realised	Improved outcomes for the borough's residents not realised. Dissatisfied stakeholders. Reputational damage to the council. Inefficient partnership working. Income potential for the borough not maximised.	3	2	6	Corporate Governance arrangements for the fund, Including Performance Management, have been identified and agreed The statutory duty to provide disabled facilities grants will remain with the borough council.	3	2	6			
		The council is not involved in the future development of the Better Care Fund project	Increased costs to the council. Improved outcomes for the borough's residents not realised. Dissatisfied stakeholders. Reputational damage to the council. Inefficient partnership working.	3	2	6	The Better Care Fund Plan identifies Newcastle Borough Council as a party to the Plan A system of electronic signatures has been agreed and Mark Bailey is Newcastle Borough Council's representative.	3	2	6	Cabinet approval of Better Care Fund report	Bailey, Mark (Head of Business Improvement & Partnerships)	02/04/14
		The Better Care Fund Plan for Staffordshire, including Newcastle under Lyme, is not agreed by NHS England	Loss of income to the council. Improved outcomes for the borough's residents not realised. Stakeholder dissatisfaction.	3	2	6	A first draft of the Better Care Fund Plan has been submitted to NHS England A final version of the Better Care Fund Plan is currently out for consultation amongst stakeholders	2	2	5			

Staffordshire Better Care Fund

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.

It represents a response to the opportunities and challenges presented by the Better Care Fund. Since submission of the draft document on 14th February 2014, work has progressed and this will be evident in this update.

Staffordshire has been identified as one of the eleven ‘financially challenged’ health economies - this is clear evidence that we are facing a steep challenge with a 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.

The pooling of budgets with partners through the Better Care Fund affords an unparalleled opportunity to build on the progress we have made in focussing on prevention, early intervention and integrated care in the community.

The challenge that lies ahead is more than purely a financial one. It is about partners working together, changing behaviours in order to strengthen our population’s capacity and desire for personal responsibility, independence, choice and control. This will be supported by measures designed to maximise the effectiveness of the public sector purse to deliver both greater community-based care and a wider health economy which is safe, strong and sustainable for the people of Staffordshire.

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 our citizens, voluntary and community sector, primary, acute and community health providers, and our social service teams.

Initial modelling work has been carried out using the available LGA and NHS toolkits, these can provide a focus for further investigation into opportunities locally which may not yet have been considered. Plans for more detailed modelling based on local circumstances are in hand. 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, however our local Staffordshire intention is to include learning disability and equipment services, where pooled or joint arrangements currently exist. In addition, in the southern CCGs, joint commissioning of mental health services will also be included. 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.

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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:

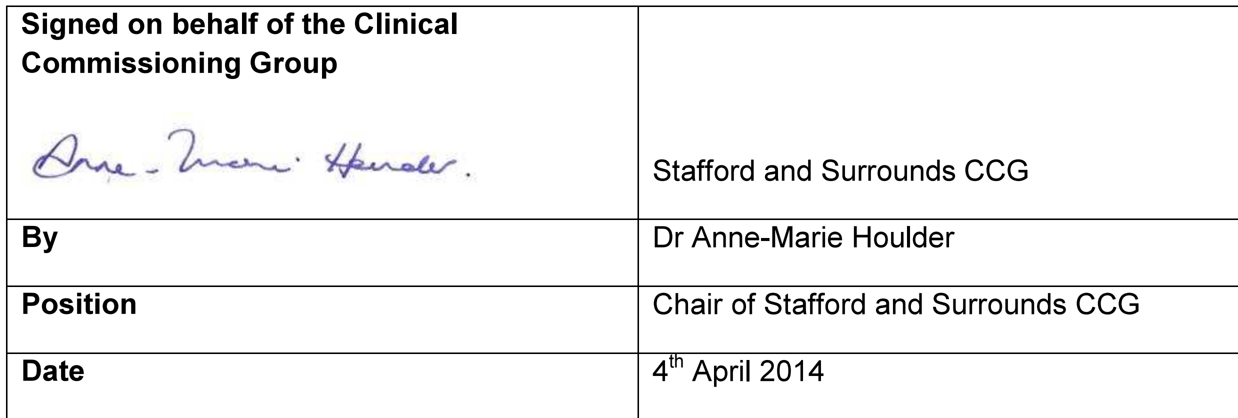
Final sign-off 31st March 2014

Date submitted:

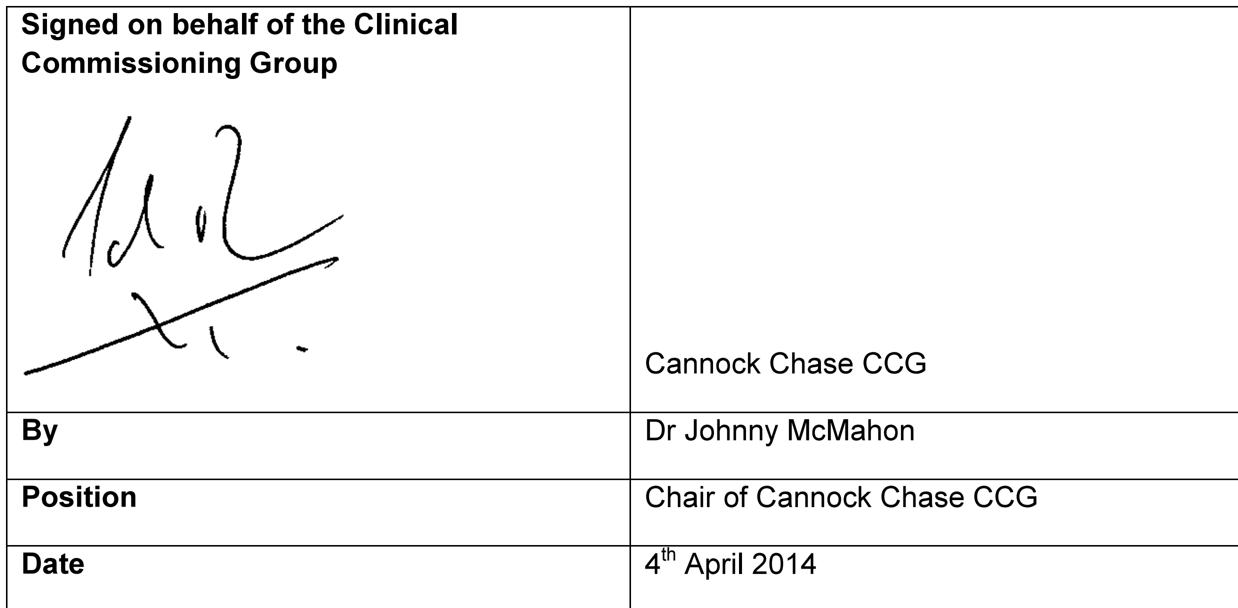
4th April 2014

Minimum required value of BCF pooled budget	2014/15	£16,000,000
	2015/16	£56,108,000
Total proposed value of pooled budget	2014/15	£16,000,000
	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	4th April 2014



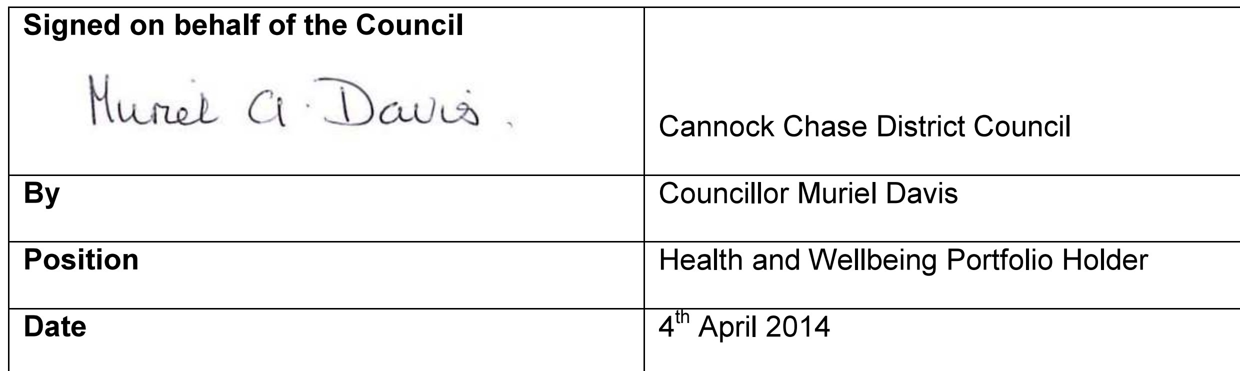
Signed on behalf of the Clinical Commissioning Group	Cannock Chase CCG
By	Dr Johnny McMahon
Position	Chair of Cannock Chase CCG
Date	4th April 2014

Signed on behalf of the Clinical Commissioning Group *(insert signature here)*	East Staffordshire CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

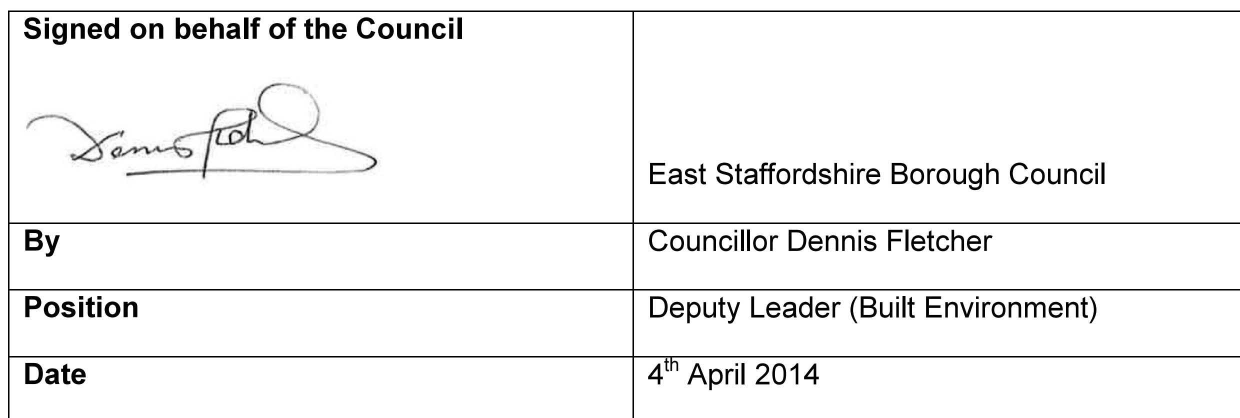
Signed on behalf of the Clinical Commissioning Group *(insert signature here)*	South East Staffordshire & Seisdon Peninsula CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group *(insert signature here)*	North Staffordshire CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council *(insert signature here)*	Staffordshire County Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>



Signed on behalf of the Council	Cannock Chase District Council
By	Councillor Muriel Davis
Position	Health and Wellbeing Portfolio Holder
Date	4th April 2014



Signed on behalf of the Council	East Staffordshire Borough Council
By	Councillor Dennis Fletcher
Position	Deputy Leader (Built Environment)
Date	4th April 2014

Signed on behalf of the Council	Lichfield District Council
By	Councillor Colin Greatorex
Position	Cabinet Member for Community, Housing and Health
Date	4th April 2014

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

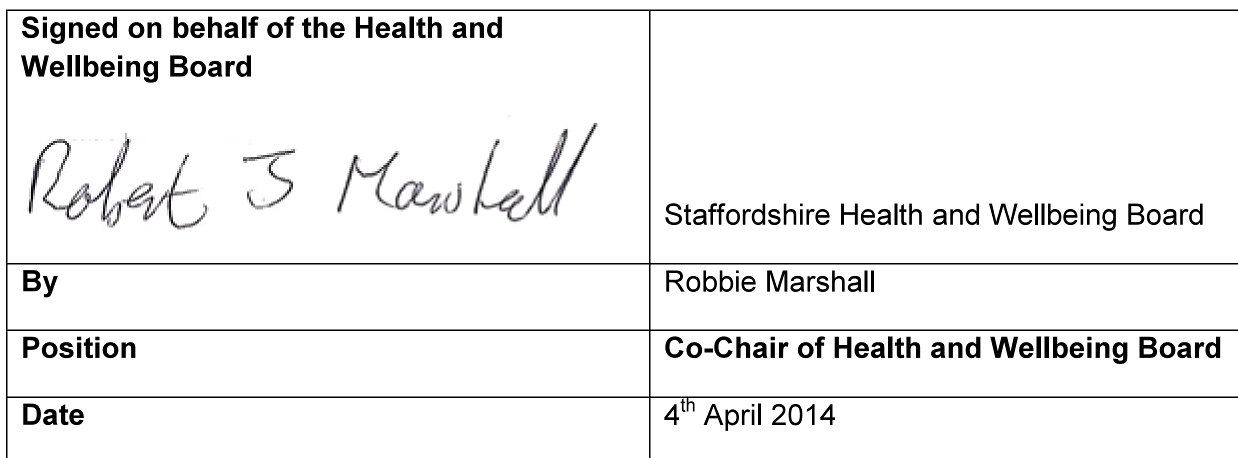
Position	Leader
Date	4th April 2014

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	4th April 2014

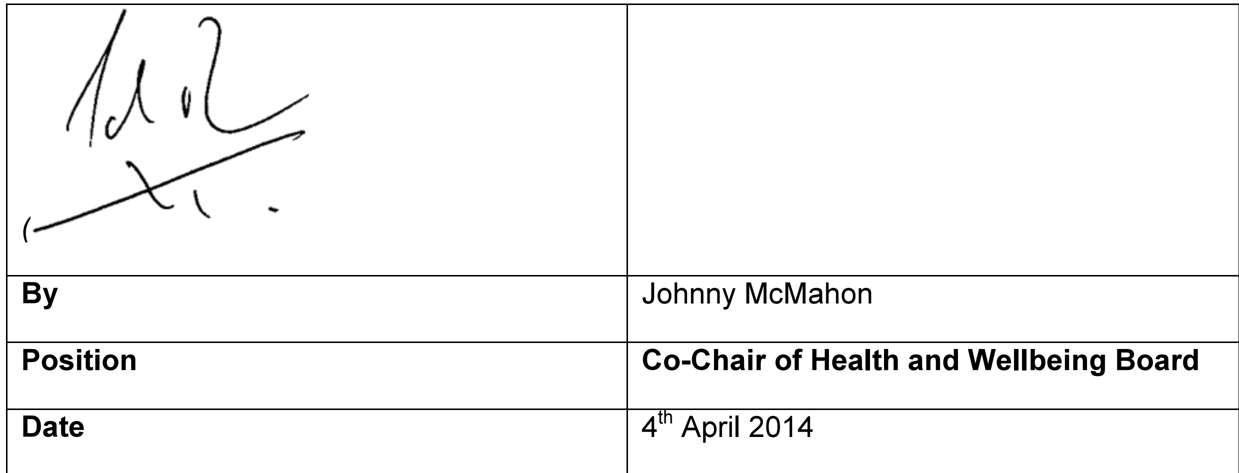
Signed on behalf of the Council	Stafford Borough Council
By	Councillor Finlay
Position	Cabinet Member for Environment and Health
Date	4th April 2014

Signed on behalf of the Council	Staffordshire Moorlands District Council
By	Councillor Gillian Burton
Position	Cabinet Member for Communities
Date	4th April 2014

Signed on behalf of the Council	Tamworth Borough Council
By	Councillor Daniel Cook
Position	Leader
Date	4th April 2014

Signed on behalf of the Health and Wellbeing Board 	Staffordshire Health and Wellbeing Board
By	Robbie Marshall
Position	**Co-Chair of Health and Wellbeing Board**
Date	4th April 2014

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	4th April 2014

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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.

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

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.

Related Documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref.	Document	Synopsis & links
Doc1	"Living Well in Staffordshire" Health and Wellbeing Strategy 2013-2018	The Joint Health and Wellbeing Strategy sets out the priorities and activities which the Health and Wellbeing Board will be pursuing between 2013-2018 across Staffordshire County Council and 5 CCGs.
Doc2	"Seven day services	Detailed planning document covering Northern Staffordshire with regard to implementation of 7-day services in the area. A

	Transformational Improvement Programme”	similar plan is being developed for Southern Staffordshire.
Doc3	“Transforming cancer and end of life care”, Pioneer Application, June 2013	Successful joint application between Macmillan, Staffordshire CCGs and the County Council, in partnership with patients and carers to develop a Principal Provider model for end of life care across Staffordshire, to help people achieve their desired place of care and type of support when faced with cancer, or at the end of their lives. Including innovative approach to integration through use of Principal Provider who has responsibility for patient and carer experience throughout the care pathway, requiring collaboration with Public Health, NHS, CCGs and LA; working with patients to co-design outcomes; using outcomes-based specifications.
Doc4	Stoke Health and Wellbeing Strategy	Stoke on Trent Health and Wellbeing Strategy http://www.moderngov.stoke.gov.uk/mgConvert2PDF.aspx?ID=52269
Doc5	Living My Life My Way	Strategy for Disabled People in Staffordshire 2013-2018
Doc6	Service Development Plan for Learning Disabilities	Service Plan for Specialist Health Adult Learning Disability Services, 2013 2016
Doc7	Metrics	Document setting out in more detail metrics and targets set
Doc8	Schemes	Spreadsheet showing schemes planned, current activity falling into each scheme, and Finance and Commissioning lead for each scheme

2. Vision and Schemes

a) Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19. - What changes will have been delivered in the pattern and configuration of services over the next five years? - What difference will this make to patient and service user outcomes?

Introduction

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

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.

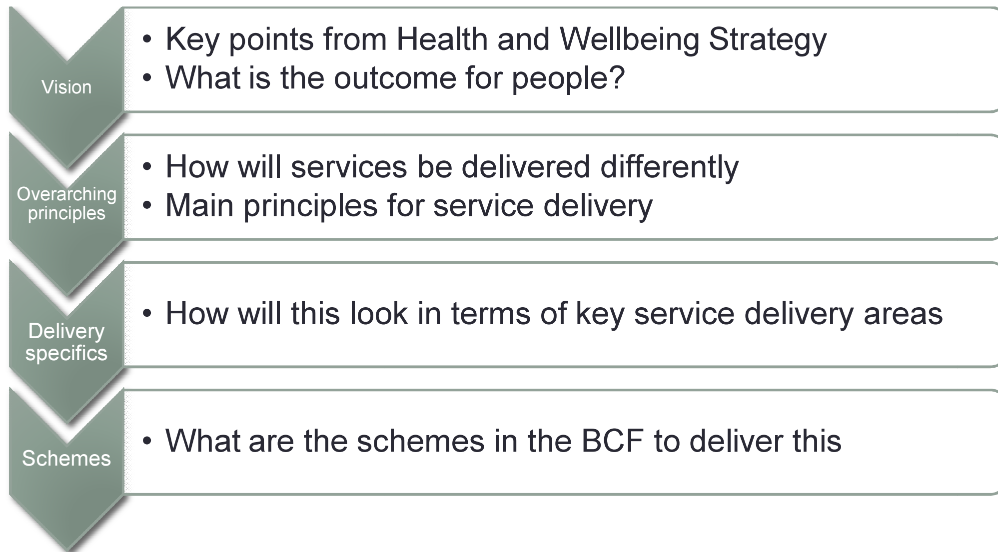
Our aim is to address the following priority areas:

- **Increase life expectancy** for all, and bring it in line with the rest of the country.
- **Reduce health inequalities**, and close the gap between those most and least advantaged.
- Properly **support people with long-term conditions** and/or complex needs to live independently.
- Ensure that **people experiencing mental ill-health get equal access** to physical health and social care services.
- **Improve mortality/survival rates for people with long-term conditions and cancer**.
- 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:

- 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.
- Empowers people to make their ***own choices*** and have ***control over their own lives***
- Ensures that individuals are treated with ***dignity, fairness and respect***
- Supports people to receive the ***right care at the right time***
- ***Promotes self-care*** where safe and practical

This submission addresses the following points:-



Vision

The vision for people in Staffordshire is set out in the Joint Health and Wellbeing Strategy:

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:

- *The people of Staffordshire will:*
    - *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*

Overarching principles

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

- People will be supported at their lowest point of dependency
- 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.
- 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.
- 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.
- People will be supported to take control of their health and wellbeing, and of the services that support them.
- Services will be commissioned smartly and where possible for outcomes rather than activity-based targets

Over the next five years we expect to see significant progress on this vision, with some schemes being implemented at present, and more to be developed over the coming period.

Underpinning all of the principles is the concept of ‘parity of esteem’. Parity of esteem relates to all services, but there is a particular issue around inequalities for people with mental health problems. Much of the investment of the southern CCGs for mental health is in the BCF, and this will be expanded as they move to implement a joint strategy to transform mental health services. North Staffordshire CCG will be working with Stoke-on-Trent CCG to jointly commission mental health services, aligned to but not currently included in the BCF process. These arrangements recognise the different delivery models in the north and south of the County. Not only does the investment through BCF not constitute a risk to mental health services, it offers a positive opportunity to incorporate the implementation of a recovery based model, and deliver a shift in investment from specialist to community based services..

a.1 Better Care Fund Schemes

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

1. Frailty/complex needs, long term physical and organic Mental Health
2. Support to live at home
3. Carers
4. Mental Health (not incl. dementia)
5. Learning Disabilities
6. End of Life Care/Cancer

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, as there is more work to do in some areas, in particular around services for older people and people with long term conditions.

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.

a.1.1 Frailty/complex needs/long term physical and organic mental health conditions

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. If people of this cohort are to be properly supported in the community, the same level of support needs to be available there

There are a number of elements which make up our response to ensure we improve the support available in the community. These include the following:

A revised approach to **intermediate care / re-ablement / rehabilitation**. Whilst there are common principles and outcomes which apply across geographical Staffordshire, the Health and Social Care economy is committed to ensuring that solutions are created with people and communities in mind. As such there will be locally developed delivery models which reflect, and are responsive to, the needs of local communities and are designed to alleviate the pressures within the local health and social care economies.

In the south of the county, the CCGs and the County Council are co-designing and developing Intermediate Care provision at local CCG level which acts to support patients in times of exacerbation and/or crisis. (For some CCGs, this is not at present part of the identified BCF funding stream.) A newly commissioned service will be in place by April 2015.

In the north, intermediate care forms part of the larger three-year Cross Economy Transformation Programme, which has been underway for a year, In both instances support will be delivered either in the patient's own home or in a suitable bed based unit for a short period of reablement.

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.

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.

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.

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.

What will this mean for individuals receiving care?
Individuals will :-

- Have care providers who talk to each other so they only need to tell their story once
- Receive timely health and social care focussed on their needs and preferences
- Feel confident managing their own lives and maintaining personal responsibility as much as possible
- Be linked in to their community and feel safe
- Have support for their carers

The exact service make-up differs from area to area, depending on the key needs of the local populations, but broadly speaking will incorporate a range of services including, medical, nursing support, practice pharmacy, social care, end of life specialists, Allied Health Professionals and voluntary sector providers. This will be a system wide and complex programme of change which will take a number of months to define, commission and deliver.

Domiciliary care
Provision currently does not always adequately meet local needs. Provision is fragmented and does not always support easy and quick hospital discharge processes, creating system blockages. A radical overhaul of domiciliary care provision will take place under the Better Care Fund to deliver home and community support which is more closely integrated with health, and more flexible and responsive.

Informing this work is the model used in Wiltshire and the Royal Borough of Windsor and Maidenhead, which is focussed on commissioning for individual outcomes, rather than using a time- and task-based model;

The design of provision harnesses the use of community assets and social capital to deliver improved outcomes for individuals through encouraging self-reliance and improvement, working in partnership with health.

Improving medication management will be explored as a part of this redesigned service, linking with GP multi-disciplinary teams and the Digital Technology programme.

Personal Health Budgets (PHBs)

These have been piloted nationally, with Staffordshire as one of the leaders in innovation in this area. Evidence shows that PHBs deliver better experience for the user and cost savings. Focusing on Continuing Healthcare patients (approx. 2,000 in Staffordshire), the existing local pilot is aiming to become mainstreamed in 2014/15, with a staged implementation of up to 50 cases transferring, increasing to still larger numbers in 2015/16. Year one will also focus on capturing other savings benefits, such as a reduced number of admissions to hospital, and of GP visits. The potential savings for Staffordshire are significant, estimated as being c.£17m if all CHC patients were to transfer to PHBs.

The right for people eligible for Continuing Healthcare and with Long Term Conditions to ask for and receive Personal Health Budgets is being strengthened by the Department of Health over the coming year.

Staffordshire's work on Personal Health Budgets reflects the importance already attached to delivering personalised services throughout all service delivery; most significantly in social care services.

a.1.2 Support to live at home

The Support to live at home scheme will include integrated prevention work (including falls prevention), digital technology (including medication management), housing, adaptations and community equipment.

Integrated Prevention

Staffordshire County Council, CCGs and District/Borough councils all provide different forms of grants to local organisations. It is anticipated that there is in excess of £2 million currently available.

The desired outcomes for these grants include: reduction in health inequalities, healthier lifestyles (physical activity, nutrition, alcohol, and sexual health), improved mental wellbeing, increase in self-care, supporting carers, getting people back into work and money management. These outcomes are important across the life course.

Work is underway to review how funding streams received by local organisations are processed and allocated and what outcomes they achieve. The aspiration would be to better integrate these funding streams into a single locality commissioning approach adopted. Key principles behind locality commissioning are:

- Decision making shall be delegated to the district Local Strategic Partnerships (LSPs) which will include representation from Staffordshire County Council, the

relevant CCG, the district/borough council and other relevant partners. The LSPs will be accountable to the Staffordshire Health and Wellbeing Board for the investments made and outcomes achieved.
- Funding should be distributed between the districts/localities based on need. The formula for this distribution will depend on the specific outcomes that the funding is intended for.
- Funding decisions should be based on addressing local need as set out in the eJSNA, utilising local assets and contributing towards the Joint Health and Wellbeing Strategy.

The projects funded by the integrated prevention fund will contribute to preventing demand for the other priority areas identified through this Better Care Fund process. For example:

- Physical activity for older adults (particularly activity that promotes lower limb strength and balance) contributes to preventing falls.
- Interventions to support mental wellbeing in older adults (particularly those that promote opportunities to connect) will reduce social isolation and develop a wider community support network. This is important both for frail elderly and for carers.
- Interventions to support mental wellbeing can support recovery and independent living in people with mental health problems and learning disabilities.

We acknowledge that the value of the integrated prevention fund at present is not sufficient to deliver prevention interventions on the scale that is necessary to have the desired impact. However, one of the principles behind the implementation of the Better Care Fund in Staffordshire is that the success of integrated commissioning targeting high need members of the population will release resources to increase the value of the integrated prevention fund over time.

Major housing adaptations (Disability Facilities Grant)

The Disabled Facilities Grant (DFG) is a mandatory means tested grant funded by the 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.

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

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 and delivering improved outcomes for customers. Similarly to integrated equipment services, the speed and efficiency of adaptation through DFGs is crucial.

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 contract will commence in July 2014 to deliver a more efficient and consistent service, focussed on delivering outcomes for each service user.

Further joint working is planned for 2014/15 to adopt a county-wide adaptations policy, improve joint working, develop protocols with housing providers and make better use of properties that have already been adapted. The outcomes will be:

- Appropriate adaptations delivered in a timely manner
- Demand for adaptations moderated by better use of existing housing stock
- More people able to live independently in their own home leading to reductions in domiciliary care and care-home admissions.

For 2015/16 the DFG allocation will be cascaded to district councils in a timely manner such that it can be spent within a year to ensure consistency of service and delivery across Staffordshire.

FlexiCare Housing

The model and philosophy of FlexiCare Housing is of an environment where residents own or rent their properties, and are able to access on-site care and support over a 24 hour period as they require it. FlexiCare Housing is not residential or nursing care, but it does allow a person with high-level care needs to maintain their living situation in the community. The philosophy supports a model of increasing independence and choice and by creating a mixed demographic of care (that is, a range of dependency levels), attempts to nurture an inclusive, supportive community amongst the people who live there.

Staffordshire currently has fourteen schemes which are labelled as FlexiCare Housing with six more currently in development, which in will in total give 1,325 units housing around 2,000 older people.

Ten further localities have been identified for future developments over the period 2015-2018 based on mapping of care needs. A tender for a framework of providers will be completed by April 2014 with, with new schemes set to start on site from April 2015. Consultants have been engaged to identify further sites outside the ownership of the County Council. The intention is to commission a minimum of ten new schemes, with the potential to accelerate delivery if further sites become available.

Plans are in place and being implemented to deliver a consistent vision and model of care across all FlexiCare schemes – based on an integrated service developed in consultation with residents, where people with care-needs have choice and control over how their needs are met. The housing provider will be responsible for providing/facilitating all services on site as part of a turn-key solution, replacing the current artificial split between care, support and housing.

Along with other forms of specialist housing for older people, FlexiCare housing is generally seen to deliver a number of beneficial outcomes. There is emerging evidence to suggest that it can make a considerable improvements in the health and wellbeing of residents, as well as achieving care efficiencies, pre-empting and preventing hospitalisation and where admission is unavoidable reducing the duration of an individual's stay in hospital.

The provision of new FlexiCare and the remodelling and re-provision of existing schemes will deliver benefits to customers and to health and social care partners achieved through a reduction in demand on acute and long term residential and nursing care.

Community equipment

Staffordshire and Stoke-on-Trent have set up a joint commissioning partnership for the delivery of an integrated community equipment service (ICES). An effective community equipment service is an essential element of any system of care and support, and through the consolidation of commissioning power the intention is that this arrangement will deliver both cost benefits through economies of scale, and also improve the speed and efficiency of the service. This will have positive benefits for those that use the service.

From 2015/16, the ICES will be funded through the Better Care Fund.

Delivering Digital Technology at Scale

Staffordshire has a proven track record in developing ground-breaking technological innovations and complementary service approaches to make the most of the support and stability that can be gained from astute use of assistive technology solutions. This will continue to be prioritised, and embedded in the strategic thinking that underpins the work of the Better Care Fund. Staffordshire has recently formed the Staffordshire Digital Programme Board to support implementation of Technology Enabled Care Services (TECS) (previously known as 3MillionLives).

Each stakeholder cannot plan or deliver TECS without considering the implications upon others, in terms of what is possible and what staff and service users want and need.

Partners are committed to working together to deliver technology based solutions at scale through the joint infrastructure.

a.1.3 Carers

Carers are the largest providers of care and support in the UK, providing £119bn of care per year. There is strong evidence to suggest that effective integrated commissioning delivering improved outcomes for carers can have significant impacts on health and social care services. Staffordshire aims to improve outcomes for carers through the development of a co-produced service re-design for delivery from April 2015. Our aspiration to improve

support for carers in Staffordshire will be driven through the ‘Staffordshire Carers Partnership’ which aims to provide governance, strategic direction, meaningful engagement and co-production with stakeholders including carers, providers, social care and health.

Staffordshire will shape a future where the contributions carers make is recognised and supported, a place where carers will be treated as ‘Expert Care Partners’.

By April 2015 we will be working towards increased early identification of carers across the county, we will be providing a range of information, advice and guidance for carers, and we shall be supporting carers to take a break and receive support to access emotional support.

Working with practices we shall be identifying and supporting carers to recognise the importance of their own health, which is often forgotten when caring for another, and Carers will be supported with return to work pathways and will have equal access to services.

We recognise that early identification, provision of information advice and guidance and support for carers is key in terms of the prevention agenda for the health and wellbeing of both carers and the person they care for. There is evidence to suggest that the commissioning of information and advice services, breaks and emotional support for carers can reduce overall spending on care and their need to access mental health services. Effective integrated commissioning for carers can therefore have a significant impact on financial savings for health and social care and will: reduce admissions to hospital and residential care; reduce the costs of delays in transfers of care; reduce carers’ need to access primary care as a result of their caring role and reduce overall spending on care.

Key outcomes identified for carers in Staffordshire include improved health and wellbeing through increased access to information and support and opportunities to have a break from the caring role, these services will be provided through the re-design of services which is currently taking place.

a.1.4 Mental Health (excluding dementia)

As noted above, the concept of ‘parity of esteem’, especially for those with issues of mental ill-health, underpins all of the work towards this Better Care Fund submission for Staffordshire. The partners in Staffordshire recognise that the disjoint between ‘mainstream’ health and social care services and ‘specialist’ services that support people with mental health needs is a major and increasing problem, especially when considering the growing cohort of people with multiple long term conditions requiring coordinated and coherent community-based support. The inclusion of specialist mental health activity and the development of generic mental health capability in all services will be a key priority of this developing agenda for integration.

There has been a gradual shift over time in clinical delivery of mental health care, in that there has been a move from delivering mental health care in acute care settings to delivering care in the community.

As commissioners, we are committed to leading the health and social care agenda to ensure that local people with mental health problems have the opportunity to prosper, be healthy and happy. The overarching ambitions around mental health are common. The commissioning budget for the mental health trust in the South of the County has been placed in the BCF. Due to potential organisational changes in the North, the budget has not explicitly been placed in the BCF for North Staffordshire CCG.

We will be building on the benefits of integrating care not only across the boundaries of health and social care but taking into account the growing support for better integrated healthcare. Achieving parity between mental health, physical health and social care is an essential feature of our intentions going forward as part of a system that expects to reduce inequality and provide the best possible support to individuals.

We are fully engaged with local providers in the discussion around services taking a problem solving, rather than a criteria led approach.

We are now setting out our agenda with other public services including those within the wider areas of the Local Authority, as well as with the Police and other public services, to ensure that mental health is embedded in everyone's agenda. We will have a specific goal around eliminating the detention of people subject to a section 136 being detained in police custody.

a.1.5 Learning Disabilities

The commissioning of learning disability services has been reappraised in consideration of the findings of the National Development Team for inclusion (NDTi), commissioned in 2011 by NHS and local government commissioners for Stoke-on-Trent and Staffordshire to review specialist Adult Learning Disability health services across the two areas, and the DH review of the Winterbourne View Hospital in December 2012. The intention is that, as a product of these reviews, learning disabilities services will be commissioned in partnership on a Staffordshire and Stoke on Trent basis.

The main priorities of this joint commissioning approach adhere to the strategic principles outlined above, but in addition by 2015/16, the approach to both specialised and generalist support for people with learning disabilities and complex needs will privilege inclusion, the enabling of the full rights of citizenship, and parity of treatment of people with learning disabilities in mainstream NHS, social care and associated services.

Through this integrated commissioning approach and the use of the Better Care Fund mechanism, the increasingly integrated delivery of learning disabilities services will benefit from more sophisticated and outcome based specifications, more rigorous monitoring of delivery, and vastly improved outcomes for people with learning disabilities. Working in a collaborative and integrated manner allows us to provide a whole system approach and the most effective pathways to support people by offering a seamless service to the individual making the best use of resources in the system.

The strengthening of social services and the increased focus upon personalisation is being further improved by the development of a new 'all ages' assessment and person centred planning service: 'Independent Futures'. The next stages in this programme of work will be closer integration across health and social care.

Based on the aims and objectives of the BCF, Learning Disabilities should be included as a priority for Phase 2 . Work will be required to fully resolve delegation and issues such as charging, however, SCC and CCGs have made a clear decision to move to an integrated budget by April 2015.

a.1.6 End of Life Care/Cancer

The Staffordshire Transforming Cancer and End of Life Care Programme is one of fourteen national Integration Pioneers. The aim of the Transforming Cancer and End of Life Care Programme is to support NHS and social care commissioners to shift the focus of practice from providers and individual interventions to one that encompasses the whole patient journey, both for cancer care (prevention through to survivorship) and for end of life care (for advanced progressive incurable illness). To achieve this, the CCGs will tender for a prime provider for each pathway (relating to cancer services for four tumour sites initially – lung, breast, bladder and prostate), and one for end of life care who will be held accountable for the whole patient journey and will have all the individual contracts for that journey assigned to it.

There are three core components to the programme.

- Co-designing the best outcome-based integrated health and social care pathways, based on patient/carer need, for end of life care for all long term conditions.
- Changing the way both cancer and end of life care services are commissioned with the move, by April 2015, to prime provider models. It will be up to each prime provider to determine the best pathway, based on outcomes, and appoint thereafter subcontractors to deliver the pathway.
- Supporting the prime provider from 2015-2025 to manage change within the contracts to ensure that outcomes are achieved and that the project becomes self-funding within the first two years, and innovation and system change are achieved for whole scale integrated working.

This integrated approach will enable the development of care and support that is more qualitative, and that is tailored to the needs and preferences of the people receiving the services. The individual outcomes that people experience will be significantly improved.

a.2 How will we deliver this?

a.2.1 Programme Management

The delivery of whole-system transformational change will only be achieved if a range of coordinated developmental programmes is 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.

The Better Care Fund for Staffordshire is an integral part of the developing CCG-led two-year operational and five-year strategic plans for the county, all of which have their strategic basis in the Joint Health and Wellbeing Strategy. As noted above, the BCF embraces and works to coordinate a range of theme-specific areas of strategic development. A simple and coherent set of plans will be delivered through this coordination, and help to render the complex strategic agendas of the NHS, local authority and key partners more understandable.

Risks on a per scheme basis will be developed during 14/15 as part of the development of individual projects which will sit within each scheme. 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.

2.2 Improved strategic commissioning

Central to this transformational vision is the imperative of joined up and coordinated strategic commissioning. If the NHS, local authorities and other contributors are to continue to provide high quality, safe and effective services to those that need them in the face of the financial and demographic challenges of the future, there will need to be diligent attention paid to the use of resources, the avoidance of duplication, and ensuring that activity properly addresses defined need.

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.

a.2.3 Organisational development and the workforce of the future

Pan-Staffordshire cross-economy consideration is required to address the questions of workforce that these challenging new agendas raise. If a significant amount of higher-level planned and non-elective activity is to take place within communities, focussed upon GP practices, then consideration of the competencies required is essential, and reconsideration and redesign of the community workforce is inevitable.

Amongst the existing areas of community activity, General Practice and domiciliary care present some of the starkest workforce challenges. For example, for very different reasons, both areas present major recruitment challenges in some areas of Staffordshire. Any conceivable reimagining of community approaches to care and support will entail reconsideration of the roles and activities of GPs and other health disciplines, domiciliary care and other areas of delivery. This reconsideration must be done ‘whole-system’, as no single organisation will be able to address the global nature of the challenges.

Partners working on the Staffordshire BCF, in the context of broader system-wide strategic work, will engage the support of the HEWM, the LETB, LETC and Area Team to further this element of the enabling programme.

Whilst consideration of the existing workforce, roles and competencies is essential, it is also necessary to pursue alternative and innovative ways of working in communities in order to fully address the spectrum of individual needs that vulnerable people may present. As service approaches become increasingly preventative, lower-level issues that prevent the exacerbation of situations and recourse to high-level non-elective solutions to need will be routinely addressed as part of joined-up and person-centred case management. This will inevitably entail consideration of work delivered outside standard NHS and social care disciplines, and will require new roles which arebest placed to support people to confidently self-care and retain their independence for longer.

a.2.4 Modelling

Initial work on modelling potential areas for further exploration has taken place, using the Anytown and LGA Value Case examples. These indicate that significant benefits could be achieved, however, they need to be treated with a high degree of caution as the detail of the value cases against which they are based in a number of cases reflect existing structures and services locally which are already in place.

Specifications have been agreed for future modelling tools to be developed during 14/15 which will enable regular checks against progress and analysis of future service development.

a.2.5 Integrated Care Records

An integrated care records system is under development, which will cover Staffordshire (including Stoke-on-Trent) and Shropshire. All NHS and social care organisations will

participate in this, as well as a small number of third sector organisations dealing with end of life and/or dementia. The initial implementation will cover end of life and dementia, but this will extend to cover all services within five years. The procurement of a ‘patient portal’ system is being pursued, which will enable patients to see their own records, book appointments, repeat meds, provide agreement to share information and to see who has accessed their records. It will also enable them to enter some of their own information, such as BMI, weight, family history etc.

The system will drive improvements in patient care, particularly where the care is being delivered from multiple organisations. It will improve the quality of care for patients as well as improve the efficiency of clinicians in dealing with patients.

It is anticipated that the project will take five years in total to roll out to a full ICR, with current projected costs of £6M.

a.3 Case studies

In practice the vision can be shown through individual stories that reflect some of the people in Staffordshire and their needs (the stories profiled are not real people):

Dorothy's story – now

(Frail Elderly)

Dorothy is 70 years old and lives at home with her husband David for whom she has been his main carer for over 15 years, following a stroke, which left him paralysed down one side.

Dorothy isn't known to her GP as a Carer, but she often visits her practice, to bring her husband in for regular check- ups and blood tests for his warfarin.

Dorothy struggles to have the time to think about her own health, as she is always busy looking after her husband's care needs, and she rarely gets the chance to have time to herself and do the things she enjoys.

Dorothy is worried about the future and what will happen if she gets ill and is no longer able to care for her husband. Dorothy is diabetic and has to attend regular check-ups at the practice.

There is no plan in place to prepare in case of an emergency and when professionals do visit the house, they can often be brief visits.

Dorothy's story – our vision

Dorothy has been supported throughout her life to make healthy decisions and access services to support those decisions should she need them.

Dorothy is known to her GP as a Carer and is supported in her caring role. She has had a full assessment by her local social worker who has developed a plan to support her continue in her caring role, including ensuring that she has a break every 6-8 weeks when a professional carer comes into the home, and sits with her husband ensuring that he is safe and supported whilst she is able to access her community. Dorothy is a very active member of her local Church and this respite often gives her the time for herself to meet with her friends.

Dorothy is able to monitor her blood pressure at home through a machine and send the results through to her practice for checking. If Dorothy's blood pressure is a concern, her GP is able to make arrangements for her to visit the practice and review her medication.

If Dorothy's health deteriorates she is fully supported by her Integrated Local Care Team based at her practice who are able to put in place the necessary actions to delay or prevent an exacerbation of a condition.

If Dorothy develops another long term condition, she will already be known by her local integrated team who will assess and support her to remain well for as long as possible. She's part of shared decision making, understands the risks and is supported with decisions. Dorothy feels like she has choices and is in control. Should her condition deteriorate she has access to specialist care.

If Dorothy becomes acutely unwell she is supported to stay at home, and her care is co-ordinated by relevant professionals (ie, Nurses, therapists, social workers). Information about Dorothy is held as one central record which can be accessed by a range of professionals including ambulance crews. This will includes an Emergency Plan around her husband should Dorothy be admitted into a hospital.

If Dorothy has to be admitted into a hospital she will only need to stay for a short length of time and she is supported to come home as soon as she is medically stable. She is treated with dignity and respect by the staff who care for her and she receives short term intensive support to regain her independence as soon as possible.

Whilst Dorothy is regaining her independence, her husband is assessed by the Integrated Local Care Team who will ensure that both his physical and emotional needs are met.

As Dorothy approaches the end of life she has the time and opportunity to discuss how she feels about this and her wishes. She is supported to die with dignity in a place of her choosing and with the knowledge that husband will be supported after her death.

Dorothy is empowered to manage the development of any long term condition, she is treated as a 'person' with individual needs and wishes and she is given the confidence that the staff who look after her, care about her.

Sarah's story

(learning disabilities)

Sarah has learning disabilities and is in her mid 40's with a long history of self-injurious behaviour which has led to increasing physical health needs. She originally had a placement in a long stay hospital and then left to move to a private care provider. This was not a good experience and in the late 1980's moved into the NHS 'campus' type accommodation.

Under our new vision, Sarah has moved into a new care provider. She now lives in her own flat with an individual care package for 1:1 support and assistive technology provided. The carers have helped Sarah to learn to cook so she can manage her own meals, and have trained her in using public transport so she can get around by herself. The technology allows her to feel safe cooking for herself (fire & smoke alarms) and accessing public transport (GPS solution), in the knowledge that she can call her carer should she get lost. Sarah is much happier in her own flat, and can choose what she does when, her social network is expanding. Her family are delighted at the change in her independence levels.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

The Joint Staffordshire Health and Wellbeing (JHWS) strategy sets out the following five priority areas, three of which are directly relevant to the issues of challenge at the heart of the Better Care Fund.

- **Starting Well**: Giving children the best start. The highest priority in the Marmot Review was the aim to give every child the best start possible as this is crucial to reducing health inequalities across the course of someone's life. Key areas for action are (1) parenting, (2) school readiness;
- **Growing Well**: Maximising potential and ability. Children, young people and adults who are supported to reach their potential can have greater control over their lives and their health and wellbeing. Key areas for action are (3) Improving educational attainment; (4) Reducing NEETs (5) Children in care;
- **Living Well**: Enabling good lifestyle choices means that people in Staffordshire can lead long and healthy lives. Key areas for action are (6) & (7) reducing harm from alcohol and drugs (8) Promoting healthy lifestyles and mental wellbeing;
- **Ageing Well**: By helping people to live independently and be in control of their lives, we can support older people to be health and well. Key areas for action are (9) Dementia (10) Falls prevention; (11) Frail Elderly with Long Term Conditions – providing good quality personalised care;
- **Ending Well**: Ensuring good quality care and support at the end of someone's life. Key areas for action are (12) ensuring someone is well cared for and where possible in a place of their own choice at the end of their life.

The aim of our integrated system is to to promote a culture of personal and community responsibility on the part of our local population, supported where necessary through joined up care that is focussed on individuals and delivered by providers who work together and recognise that people are not just a clinical diagnosis but an individual and member of our communities.

Key success factors for the delivery of all activity which forms part of the BCF plan will be that the outcomes reflect positively against those set out in the JHWS, thereby delivering the outcomes and priorities stated above.

b.1 Frailty/complex needs/long term physical and organic mental health conditions

Targeted prevention and early help – Staffordshire already focuses on boosting people's independing, supporting them in their own homes where necessary, and thereby avoiding higher levels of intervention. The further development of step up (reducing the likelihood of needs escalating) and step down (enabling people to regain a maximum level of

independence and ensuring interventions are time limited and the likelihood of future crisis reduced) services are key to expanding this ambition and will form part of the BCF linking with Integrated Care Teams and as part of the Intermediate Care service delivery set out below.

Linked outcome measures	*Permanent admissions to residential and nursing care:* By March 2015, there will be 1% fewer admissions to residential and nursing care per 100,000 of the over—65 population. Given the demographic changes this will mean a small increase in absolute numbers entering care homes.
	Proportion of older people who were still at home 91 days after discharge: By March 2015, this rate will have remained static at 85.9%, despite an sharp increase in the proportion of the over 85 population
	Delayed transfers of care: By March 2015, there will be 24 fewer delayed transfers of care per 100,000 of the over 18's population in Staffordshire, despite an increase in the absolute number of over 18s' by almost 9,000.
	Avoidable Emergency admissions: By 2015, we will see a reduction of 130 avoidable admissions, despite a growth in the total population numbers in Staffordshire of ca. 15,000. If the population remained static, this would equate to a reduction of approximately 4,700 fewer non-elective admissions to UHNS from North Staffordshire population, and a reduction from Southern Staffordshire CCGs and to their key acute sector providers of approximately 2,000.
	Patient/service user experience: TBC
	Injuries due to falls: numbers are increasing currently by 5% p.a. as the ageing population grows. This rate of growth will be brought down to 2.5% by targeted interventions. The Integrated Prevention programme will contribute considerably to this target
	Proportion of adult social care users who have as much social contact as they would like: This metric is based on the annual service user survey which asks people to state if they have as much contact with people they like. The Integrated Prevention programme will contribute considerably to this target.
Other measures of success	By 2015/16, number of people (to be defined) using Integrated Care Teams will report that their wellbeing and experience of care has improved since they were using the service.
	By 2015/16, an estimated 24,000 people across Staffordshire and Stoke on Trent will have an active care plan supported by Integrated Care Teams.
	A significant amount of resource presently committed to non-elective urgent care services in the acute sector will shift to fund this community-based activity
	As set out in the JHWS, a range of other measures will be developed to track improvements, including: • Increased healthy life expectancy • Reduced gap in life expectancy between defined areas reflecting health inequalities • Reduced premature deaths from respiratory conditions, CVD, and other defined LTCs • Reduced inappropriate admissions for defined cohorts of people with LTCs, frailty and complex conditions • Improved health related quality of life for people with LTC's • Reduced inappropriate admissions for people with dementia • Reduced inappropriate length of stay for people with dementia • Improved patient experience • Demonstrable transition from 'reactive' to 'proactive' care approach • Enhanced quality of life for carers •

	• People have better control over symptoms • Reduced days off work

Integrated Care Teams (ICTs) – providing joint case management, a single focal point for the person using the service, and supporting people with complex needs and circumstances to make sense of their situation and regularise their lives. Diverse multi-agency teams (featuring NHS, social care, housing, community and voluntary sector contributors) will be based at locality levels covering populations of between 25-30,000 people.

Intermediate care - In South Staffordshire, an innovative approach around Experience Led Commissioning has resulted in a new model of intermediate care, which is more focussed on supporting people back into their communities. During 2013/14, Stoke-on-Trent and North Staffordshire CCGs have invested in the consolidation of, and staffing of Intermediate Care services. With the first phase of this activity complete, the improved capacity is making a positive difference to the overall effectiveness and efficiency of the urgent care system. Phase two (2014/15+) will see the alignment of social care Intermediate Care/reablement services with the NHS activity, and the consequent development of a single admission avoidance/discharge hastening pathway which will continue to shift the community service emphasis from being on discharge to being on admission avoidance.

Impact on the acute sector:

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.

b.2 Support to live at home

Integrated Prevention – this approach, working through Local Strategic Partnerships will focus on local needs, and is anticipated to help older people remain active and mentally well, maximising their personal independence and control, in order to reduce falls and increase their ongoing wellbeing.

The development of more appropriate housing solutions, coupled with improved access to equipment, a coordinated approach to DFGs, and a focus on developing improved technology solutions, will support people to live well at home for longer.

Linked outcome measures	*Permanent admissions to residential and nursing care:*
	Proportion of older people who were still at home 91 days after discharge:
	Delayed transfers of care:
	Avoidable Emergency admissions:
	Patient/service user experience: TBC
	Injuries due to falls:
	Proportion of adult social care users who have as much social contact as they would like.
Other measures of success	A range of other measures will be developed to track improvements, see above.

b.3 Carers

Carers provide a significant role in community, and the draft Care Bill places a duty of Local Authorities to assess Carers' needs regardless of the level of care that they provide. While responsibility for assessment rests with the County Council, districts play an important role in supporting and signposting Carers.

By re-tendering all of our Carers services across Staffordshire, we will deliver more integrated services, which are aligned more appropriately with population needs, supporting them in remaining independent and in control of their own lives, despite the burden of their caring responsibilities.

Providing improved support to Carers will support the measures in place for all schemes within the BCF.

Linked outcome measures	*Permanent admissions to residential and nursing care:*
	Proportion of older people who were still at home 91 days after discharge:
	Delayed transfers of care:
	Avoidable Emergency admissions:
	Patient/service user experience:
	Injuries due to falls:
	Proportion of adult social care users who have as much social contact as they would like:
Other measures of success	A range of other measures will be developed to track improvements, as for section b.1

b.4 Mental Health (excluding dementia)

By June 2014, we will have a clearly articulated strategy, co-produced with providers and service users, to describe how services should to respond more effectively to support those suffering mental distress. As with other client groups, the aim is to shift care to prevention and maximising personal independence and control, in order to reduce the need for more specialist services. We will significantly increase the range of psychological therapies citizens can access and improve access to community mental health services, thereby freeing up resources from the intensive services..

Linked outcome measures	
	Patient/service user experience:
	Proportion of adult social care users who have as much social contact as they would like:
Other measures of success	A range of other measures will be developed to track improvements, as for section b.1

b.5 Learning Disabilities

- The Learning Difficulties programme will expand the use of community-based services, reducing impact on acute care through a specialist team offering intensive support services. This will be driven by our common strategy, which is based on the principle of people with a learning disability being able to 'live their lives their way', maximising personal independence, control and choice. By March 2015, an integrated approach will be in place, reducing dependency on high cost out of area placements and independent hospitals; reducing demand on specialist and acute services; developing local solutions for local people; and developing an integrated intensive community-based support service for people with complex needs and challenging behaviour.

Linked outcome measures	*Permanent admissions to residential and nursing care:*
	Avoidable Emergency admissions:
	Patient/service user experience:
	Proportion of adult social care users who have as much social contact as they would like:
Other measures of success	A range of other measures will be developed to track improvements, as for section b.1

b.6 End of Life Care / Cancer

The Pioneer project covering the majority of the County will deliver significant benefits in terms of care coordination for people at the end of life. Clearly this will need to link closely to the core ILTs.

Linked outcome measures	*Permanent admissions to residential and nursing care:*
	Proportion of older people who were still at home 91 days after discharge:
	Delayed transfers of care:
	Avoidable Emergency admissions:
	Patient/service user experience:
	Injuries due to falls:
	Proportion of adult social care users who have as much social contact as they would like:
Other measures of success	A range of other measures will be developed to track improvements, as for section b.1

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

We recognise that achieving our vision will mean delivering a radical shift in how our resources are spent. We intend to focus on early help and prevention rather than reaction at a point of crisis. But reducing demand on the acute hospital system, so that expenditure can be reduced, while maintaining the quality of care, will require a significant reshaping of that system. We recognise the challenges involved in this. The CCGs and local authority commissioners who make up Staffordshire County are committed to working together to create a marketplace, and effect the required behavioural and attitudinal change in the acute

sector to ensure that this happens. There must be a balanced mix of investments to protect current services, identify those at most risk and target services appropriately, while redirecting resources longer term to preventative and early intervention activity.

Using the growing wealth of information available in the Joint Strategic Needs Assessment for the area, locality mapping has taken place in North Staffordshire as part of the strategy to create a locality-based and focussed approach to community service delivery. Each locality has benefited from a detailed breakdown of its presenting health needs, demographic characteristics, level of deprivation and related information. Through these, future commissioning activity at the locality level will be locality-specific, in order to ensure the style and scope of community services meet the presenting needs of the population.

A similar approach is taking place in southern Staffordshire, using the HWB to strengthen learning and shared action across the whole system, taking into account the work in Stoke-on-Trent and North Staffordshire.

There has been much recent work to engage both the people in receipt of, and those delivering, the services of the local health economy in Staffordshire. The aim has been to discuss with people what they think about local health, social care and associated services. Some of the key summary outcome themes coming from these engagement processes are listed below.

- More avoidance of crisis/improved planning ahead – proactive/preventive
- Better focus on all of the individuals' needs
- Services should value and support Carers
- Single coordinator of care/case management
- More support for those to give people the tools and skills to self manage
- Improved quality of domiciliary care provision (care, timing and reliability)
- Improved timeliness of and access to services – improved accessibility of community services
- Better access to GPs
- Improved working between all agencies
- Better continuity of care
- Improved hospital discharge process
- Improve the sharing of patient data to support the patients/Carers

These outcome themes have been incorporated into the overarching principles for the future vision for health, social care and associated services in Staffordshire as set out in section 2 a) above.

Across Staffordshire, the vision set out for the BCF plan will be delivered against the following timeframes:

Scheme	14/15 activity	15/16 activity	Benefits
Frailty/complex needs/long term physical and organic MH	• Continuing co-design with providers to deliver our vision of integrated services, focusing on Long Term Conditions, Frail Elderly and Intermediate	• Locality teams in place in all areas • Long Term Conditions Year of Care pilot started across Northern Staffordshire • Consolidated NHS intermediate care and social care reablement	£12-20m North Staffordshire programme (£15m for South Staffordshire in

	care and Rehabilitation, Dementia and Telecare / Telehealth • Dementia care, reviewing current service delivery to assess where more integrated services could be implemented working with 3rd sector and NHS providers to co-design delivery models. • Phase 2 of the Stoke on Trent and North Staffordshire Intermediate Care pilot programme will see the alignment of social care Intermediate Care/reablement services with the NHS activity, and the consequent development of a single admission avoidance/discharge hastening pathway which will continue to shift the community service emphasis from being on discharge to being on admission avoidance. •	services covering Staffordshire using locally determined commissioning specifications • Long Term Conditions primarily managed in communities by GPs and Integrated Locality Teams with specialist input from acute sector consultants • Domiciliary Care full Staffordshire & Stoke review taken place • Appraisal of workforce and workforce map showing competencies required to deliver vision of community-based services • Support for people with dementia embedded in community service offer – development of lifetime pathway	16/17 onwards) Patients feel more empowered, in control, more knowledgeable about the nature of their condition
Support to live at home	• Falls prevention programme developed and agreed with Districts • Staffordshire Digital programme board established to drive the adoption of technology to improve outcomes, transform services and create efficiencies at "scale and pace", it will encompass all modalities of digital health, this includes:- ○ Tele-care (reminders and devices to support independence) ○ Tele-health (remote monitoring of health parameters) ○ Mobile Apps and online self management support (patient facing support for tele-care & tele-health) ○ Clinical video conferencing & Tele-diagnostics (near patient	• All District Council areas have a consolidated local plan for supporting frail elderly people to stay safely and well supported at home including housing solutions, DFGs, equipment etc.	More frail elderly people supported to live safely and well at home More generalist support for people with long term conditions Improve health and wellbeing for local populations. People supported to feel safe and secure in their own homes, actively participating in their local communities

	testing, remote diagnostics and video conferencing) • Expansion of Flexi-care homes, offering better choice of appropriate accommodation for people. • Integration at County level of housing adaptations, leading to more consistent approaches, improved service delivery and reduced delays.		
Carers	• Carers support programme in place across Staffordshire, providing respite breaks, and leisure and learning activities to support carers to achieve and maintain good health and wellbeing	• Integrated locality teams support identification of and support delivered to Carers	Carers better supported to continue in their caring role
Mental Health	• Rehabilitation and recovery services for people with complex mental health needs mapped and reviewed, for gap analysis. These services are aimed at reducing the time people need to spend in ward-based services, and improving the support within the community. • Map and review services responding to people in crisis to ensure that early and rapid intervention is in place reducing the need for more costly specialist services – including those people who are identified through other public services, specifically the police. • Scope capacity to Integrate mental / emotional wellbeing into clinical pathways for people with LTC and chronic disease and people in acute care.	• Rehabilitation and recovery services for people with complex mental health needs – pathway and services in place. • Work underway to put in place recovery focused services • 24 hour mental health crisis response • Effective psychiatric liaison in place across acute and community services	
Learning Disabilities	• Learning Difficulties programme to expand the use of community-based services, reducing impact on acute care through a specialist team offering	• Specialist and generalist support will privilege inclusion, enabling full rights of citizenship, and parity of treatment. • By end March 2015, an integrated approach in place to deliver the	All service users have personalised care plans

	intensive support services.	following outcomes: ○ reduce dependency on high cost out of area placements and independent hospitals ○ reduced demand on specialist and acute services, including hospital admissions and re-admissions, residential and nursing care ○ enable a more flexible use of resources and whole system approach to deliver the right solutions locally ○ enable the joint commissioning of an appropriate range of services including the development of an integrated Intensive Support service in the community to support people with complex needs and challenging behaviour avoiding unnecessary admissions to hospitals ○ Support the continued development of the market to offer more personalised services ○ Enable the commissioning of integrated community learning disability teams with health and social care ○ Ensure the continued inclusion of people within their local communities •	
End of Life/Cancer	• End of Life Care Integration Pioneer programme working with Macmillan in Staffordshire is established and developing a range of innovative approaches to provide Principal Provider approach working with patients, carers, providers & commissioners to co-design outcomes-based services for the next 10 years.	• Prime provider in place, outcomes for local people starting to be delivered, with whole patient journey for cancer care and end of life care in place. • Clear strategy for areas not covered by Pioneer Programme	
Programme Management	• Manage the implementation and benefits tracking for live integrated services and developing the next stage of joint commissioning plans in line with local	• Further development and implementation of the next wave of pilots and programmes to deliver our vision for integrated care, taking heed of pilot and programme outcomes from 2014/15 and prior.	

	needs, JSNA and the HWS. • Modelling tool developed • Agreement on programmes of work to deliver outcomes between finance, commissioners • Programme management structure and governance in place and reporting monthly on progress		

County Council Strategy – work is being undertaken to identify priority outcomes and a plan to deliver a fundamental shift in public expectations over a generation. This will frame the delivery plan in terms of our ambition to support people to take more control of their lives.

CCG Five Year strategies – the CCGs collectively are in the process of articulating their five year vision and delivery strategy. The work to support this will include detailed modelling of the impact of changes which will underpin more detailed plans for the BCF.

Strategic Service Review – We recognise there is a disconnect between commissioner plans and provider plans in term of sustainability. A strategic review has just begun to clearly identify and address inconsistency in commissioner and provider assumptions.

Through current governance and programme management mechanisms now being put in place, activity in the County will be carefully managed to ensure alignment between the JHWS, JSNA and CCG and Local Authority commissioning plans. There is a long history of joint commissioning, through a previously established Joint Commissioning Unit. This arrangement has been replaced recently with a clear governance structure around integrated commissioning, linking directly to the Health and Wellbeing Board.

The JSNA informs the JHWS, and supports the identification of priority areas for action. The JHWS is a five year strategy but is reviewed on an annual basis in the light of new data to check the priorities remain appropriate.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes.

Current arrangements are that the HWB has overarching responsibility for the achievement of the BCF plan, with executive responsibility delegated to the Staffordshire Senior Officers 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, governance may be reviewed with some changes to the existing structure as set out below:

The Integrated Commissioning Executive (ICE) will act as the collaborative management committee with executive responsibility for the Better Care Fund, making recommendations to the Health and Wellbeing Board and local commissioning and finance committees/board where appropriate for agreement.

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.

The ICE (or separate partnership board if required) will: -

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

3. NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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 services and increasing budgetary pressures on councils. We will maintain current 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 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.

.

Please explain how local social care services will be protected within your plans

Funding currently allocated under the s256 transfers from NHS England to 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.

There are huge pressures on Adult Social Care budgets across the country and the county council has made significant savings in recent years to enable social care outcomes to be achieved. One of the six national conditions for access to the Better Care Fund is that it is used to protect social care outcomes. This is in recognition of the severe funding reductions local authorities face following the 2013 Spending Review. In Staffordshire, the existing £16m of transfers from the NHS to social care through s256 arrangements will be continued under the BCF. In addition, we have estimated the cost of protecting social care services for future years, and calculate a minimum of £15m will be required in 2015/16. This requirement for a further £15m already takes account of other cost saving actions being taken by the Council, which will deliver a £6m reduction in preventative former 'Supporting People' funding, an additional £5m saving from core social services and an estimated £4m of extra Care Bill implementation costs. Given uncertainties over the deliverability of some of these savings and the potential for further costs around the Care Bill to emerge, it would be prudent for the BCF to allow for a transfer of an additional £25m to social care in 2015/16, on top of the £16m already set aside for 2014/15. Without this additional funding from the BCF in 2015/16, the Council would be forced to reduce services for older people by more than 10%, with significant consequential impact on smooth functioning of the health system, or make dramatic cuts in its other non-care services, which would lead to reduced health across the county as a whole.

We recognise the £15m-£25m gap and CCGs and the County Council will work together to enhance the transformation programme required to meet this significant challenge.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and 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 confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

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.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

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.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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.

4. RISKS

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

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.

Risk	Risk rating	Mitigating Actions
CCGs are unable to release 3% of their budgets to fund BCF plans	High	Focus activity planned on approaches which are most likely to deliver immediate financial benefits to CCGs as well as population outcomes. Review good practice from elsewhere, including LGA value cases and outcomes of Anytown modelling to identify opportunities for greater impact.
High level of savings required from current CCG budgets (c.£15m-£25m) in 2015/16, on top of the existing £16m s256 payments, to be re-focused to protect social care services are unachievable within the total funding available in the BCF	High	Further discussions with NHS England, Monitor, TDA and DCLG as part of the 'financially distressed' economy to take place
CCGs are unable to reduce hospital intake leading to inability of partners to make savings intended through the plan	High	Gradual transformation with staged approach to investing in preventative options. Negotiation on new contracts with Hospitals agreeing caps on intake numbers and shared risk with Hospitals on overspends
Money going into BCF already tied up in mainstream services, therefore cannot fund additional activity	Low	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 Hospital rather than supporting changes set out in BCF	Medium	Gradual transformation with staged approach to investing in preventative options. 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 may prevent signatory partners gaining sufficient assurance to develop s75 agreement(s). • **Arrangements for (S75) budget pooling.**	High	LAT to accept 'work in progress' commitments within Feb 14th submission, to lobby nationally for answers to key questions, and to support the development of locally relevant trajectories/targets where applicable. Further discussions with LAT following submission

• **Establishment of reasonable local improvement trajectories and targets.** • **Mechanism for determining 'failure', apportioning responsibility, and withholding resource.**		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)	High	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.	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.

Government Association

England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

please see attached BCF doc7 for details of measures, what they are based on and how they have been chosen

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National Metric to be adopted

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The metrics have been supplied by Staffordshire County Council Performance unit. All measures and targets will be monitored by HWB or under delegated authority to the Programme managers. Targets set must be agreed jointly with delivery partners and therefore must be treated as draft targets until agreement is reached with providers.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

n/a

Metrics		Current Baseline as at September 2013	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	661.1	N/A	654.5
	Numerator	1,094		1,155
	Denominator	165,475		176,477
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	85.90%	N/A	85.90%
	Numerator	455		>=455
	Denominator	530		>=530
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	256.1	241.3	231.9
	Numerator	15,845	15,023	9,689
	Denominator	687,473	691,771	696,351
		(April to December 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure) - Average per month	*Metric Value*	197.9	174.0	212.6
	Numerator	20,232	9,018	11,084
	Denominator	852,123	863,907	868,757
		(April 2012 to March 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
Injuries due to falls in people aged 65 and over (age standardised rate per 100,000 population)	*Metric Value*	1,760	1,834	1,858
	Numerator	3,443	3,653	3,717
	Denominator	160,620	168,000	170,000
		January 2013 - December 2013	January 2014-December 2014	July 2014-June 2015
Proportion of adult social care users who have as much social contact as	*Metric Value*	35.3%		39.2%

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My Ref: GS/SH

Councillor Stephen Sweeney
Leader of the Opposition
Newcastle-under-Lyme Borough Council
Civic Offices
Merrial Street
Newcastle-under-Lyme
ST5 2AG

25th February 2014

Dear Councillor Sweeney

Re: Asset Management Strategy

It has been clear from the comments that you and your group have made regarding the Asset Management Strategy that your group is not opposed, in principle, to the idea of selling council owned assets to generate capital receipts for future investment.

My administration has been clear in our political decisions that, even in the face of severe Government cuts, we wish to invest in the Borough and ensure that our community assets, our council buildings, our fleet and vehicles and our investment in affordable and social housing is all sustainable.

When the Asset Management Strategy was discussed at the call-in held on the 6th February 2014, your group proposed that a cross-party group consider preparing a new list of potential disposal sites, including those originally considered under the former 'Newcastle Development Programme'.

Your group has argued that the decision by my cabinet to remove the Newcastle Development Programme sites from consideration, as promised in our manifesto, has put unfair pressure on remaining council assets and therefore a fresh start was required.

While this aim is understandable, it appears to be at odds with the public campaigns being led by your party and supported by members of your group who are seeking exemption for sites that are currently under consideration.

Given this confusion and your group's clear objection to the sites currently listed for consideration, I have made arrangements for you and your group to meet with Neale Clifton in order for you to draw up your own proposals on which sites should be considered for disposal in order to meet our capital future requirements.

I will also be placing an item of the April Cabinet agenda to allow you or your nominated representative to present your proposals of which sites which you would consider to be more appropriate for disposal.

Alternatively, I have also made arrangements for you to meet with Kelvin Turner to propose alternative ways of financing the future capital demands, including determining which services you would cut in order to facilitate the immense costs associated with borrowing sufficient capital to meet need.

/Continued….

I make this offer in good faith and look forward to seeing your alternative proposals on the 2nd April 2014.

Regards

Councillor Gareth Snell
Leader, Newcastle under Lyme Borough Council

cc: Mr John Sellgren, Chief Executive
Mr Neale Clifton
Mr Kelvin Turner

MEETING BEING SUBMITTED TO: CABINET 020414

1.	**HEADING**	**Applications for Discretionary Rate Relief**
	Submitted by:	**Head of Revenues & Benefits**
	Portfolio:	**Finance and Resources**
	Ward(s) affected:	**All**

Purpose of the Report

To consider the granting of Discretionary Rate Relief in accordance with powers under Section 47 of the Local Government Finance Act 1988.

Recommendations

That, in accordance with Section 47 of The Local Government Finance Act 1988, Discretionary Rate Relief is either granted or refused in respect of the organisations and premises detailed in Appendix A of this report.

Reasons

To enable the Borough Council to provide financial assistance to charitable and not for profit organisations occupying business premises within the council area where it is deemed appropriate in accordance with regulations detailed in The Local Government Finance Act 1988.

1. **Background**

Section 47 of The Local Government Finance Act 1988 gives Councils the discretion to grant relief from the payment of business rates for charitable or not for profit organisations or in the case of charities already receiving mandatory charity relief, to grant additional discretion relief.

2. **Issues**

Section 47 of The Local Government Finance Act 1988 enables charitable or not for profit organisations to make application to the Council for consideration of assistance or additional assistance, with the statutory rates liability in respect of the premises they occupy for the furtherance of their activities. The cost of granting the relief is shared in accordance with the Business Rates Retention Scheme local and central share arrangements, which are currently 50% by central government, 40% by the billing authority (Newcastle-under-Lyme Borough Council), 9% by the County Council and 1% by the Fire and Rescue Authority.

The Borough Council grants relief in accordance with the type and nature of an organisation's activity.

3. **Options Considered**

Not applicable

4. **Proposal**

That the discretionary relief set out in the attached appendix A be granted or refused as indicated.

5. **Reasons for Preferred Solution**

Legislation enables the Council to provide financial assistance towards the payment of business rates in respect of charitable and not for profit organisations. The roles these organisations carry out contribute to the health, wellbeing and activity of the area, often helping with the creation of opportunities for individuals and groups who would otherwise be unable to access such services. However, there is a cost to granting such relief and the Council needs to be mindful of this when deciding to grant any relief and assess the overall benefit provide in doing so.

6. **Outcomes Linked to Corporate Priorities**

Granting discretionary relief where appropriate fits well with the Council's corporate priorities of Creating a cleaner, safer and sustainable Borough, Creating a Borough of Opportunity and Creating a Healthy and Active Community.

7. **Legal and Statutory Implications**

Section 47 of The Local Government Finance Act 1988 enables the Council to grant discretionary relief for the payment of rates in respect of business premises where it see fit.

8. **Equality Impact Assessment**

Not applicable

9. **Financial and Resource Implications**

The cost of any discretionary relief is split between the national and local rating pools 50% each. The 50% cost to the local pool is then split 40%, 9% and 1% between Newcastle-under-Lyme Borough Council, Staffordshire County Council and the Fire and Rescue Authority respectively. Although the costs of any discretionary relief are shared, the decision to grant the relief or not lies solely with the billing authority.

10. **Major Risks**

Failure to provide assistance to these charitable or not for profit organisations may lead to undue financial pressures being placed upon them, risking their ability to continue with their activities. This could lead to the loss of important work being carried out on behalf of the wider community.

11. **Key Decision Information**

Not applicable

12. **Earlier Cabinet/Committee Resolutions**

Not applicable

13. **Recommendations**

That, in accordance with Section 47 of The Local Government Finance Act 1988, Discretionary Rate Relief is either granted or refused in respect of the organisations and premises detailed in Appendix A of this report.

14. **List of Appendices**

Local Government Finance Act 1988 – Applications for Discretionary Rate Relief

15. **Background Papers**

Not applicable

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Appendix A

Local Government Finance Act 1988 –
Applications for Discretionary Rate Relief

1. **Rotary Club of Wolstanton Charitable Trust Fund, 1-3 High Street, Newcastle, Staffordshire, ST5 1RB**

   The Rotary Club of Wolstanton Charitable Trust Fund is part of the Rotary Club movement and is a registered charity. As such, it already receives 80% mandatory charity relief. It occupied 1-3 High Street as a charity shop to raise funds to support its charitable works with the young, the elderly and disabled.

   It is your usual practice to grant such an organisation 5% additional discretionary rate relief, to the mandatory charity relief it already receives

   The Rotary Club of Wolstanton Charitable Trust Fund were only in occupation of 1-3 High Street for the period from 5 November 2013 until 4 February 2014, during which period they incurred a gross rates liability of £842.90, reduced to £168.58 by mandatory charity relief. Granting 5% discretionary rate relief would further reduce this amount by £42.15 to £126.43 at a cost to the Borough Council of £16.86.

   Recommendation: That additional discretionary rate relief at 5% is granted.

2. **Trustees of The Salvation Army, 102a High Street, Talke, Stoke-On-Trent, ST7 1PY**

   Trustees of The Salvation Army are a registered charity and as such already receive 80% mandatory charity relief. It occupied 102a High Street on a temporary basis for the purposes of storage and distribution of toys to needy families at Christmas.

   It is your usual practice to grant such an organisation 5% additional discretionary rate relief, to the mandatory charity relief it already receives.

   The gross rates payable for the temporary occupation will be £334.22, reduced to £66.84 by mandatory charity relief. Granting 5% discretionary rate relief would further reduce this amount by £16.71 to £50.13 at a cost to the Borough Council of £6.68.

   Recommendation: That additional discretionary rate relief at 5% is granted.

3. **ADSIS, Unit 2, Fellgate Court, Froghall, Newcastle, Staffs, ST5 2UA**

   ADSIS (formerly Alcohol and Drug Service in Staffordshire) is a registered charity and as such already receives 80% mandatory charity relief. It occupies Unit 2, Fellgate Court as offices to help facilitate its work with the prevention of alcohol and drug misuse and the treatment of individuals with alcohol and drug related problems.

It is your usual practice to grant such an organisation 5% additional discretionary rate relief, to the mandatory charity relief it already receives.

ADSIS have been in occupation of Unit 2, Fellgate Court since 11 February 2013. The gross rates payable for the current financial year will be £4,771.80, reduced to £954.36 by mandatory charity relief. Granting 5% discretionary rate relief would further reduce this amount by £238.59 to £715.77 at a cost to the Borough Council of £95.44 in 2014/15, with a further cost of £105.43 to back date the relief to the date of occupation of the premises.

Recommendation: That additional discretionary rate relief at 5% is granted.

4. **Evolve YP Ltd, 90 King Street, Newcastle, Staffs, ST5**

Evolve YP Ltd are a not for profit organisation. They occupy 90 King Street to provide offices, IT facilities, meeting rooms and den facilities to help in their work with looked after children and care leavers in the age group 13 to 21 or over 21 year olds if still in full time education. Although Evolve YP Ltd have been in occupation of 90 King Street since November 2009, they only applied for discretionary relief in October 2013, so it will only be possible to consider relief from 1 April 2013 onwards.

It is your usual practice to grant such an organisation 85% discretionary relief

The gross rates payable for the current financial year will be £15,183.00. Granting 85% discretionary rate relief would reduce this amount by £12,905.55 to £2,277.45 at a cost to the Borough Council of £5,162.22 in 2014/15, with a further cost of £5,044.41 to back date the relief to the 1 April 2013.

Recommendation: That discretionary rate relief at 85% is granted.

5. **Midlands Air Ambulance Charity, 88 High Street, Newcastle, Staffs, ST5 1QQ**

Midlands Air Ambulance Charity is a registered charity and as such already receives 80% mandatory charity relief. It occupies 88 High Street as a charity shop to raise funds to support its work in providing rapid response emergency services for events of medical trauma.

It is your usual practice to grant such an organisation 5% additional discretionary rate relief, to the mandatory charity relief it already receives.

Midlands Air Ambulance Charity has been in occupation of 88 High Street since 19 December 2013. The gross rates payable for the current financial year will be £19,882.50 reduced to £3,976.50 by mandatory charity relief. Granting 5% discretionary rate relief would further reduce this amount by £994.13 to £2,982.37 at a cost to the Borough Council of £397.65 in 2014/15, with a further cost of £109.65 to back date the relief to the date of occupation of the premises.

Recommendation: That additional discretionary rate relief at 5% is granted.

6. **VAST, 12 Merrial Street, Newcastle, Staffs, ST5 2AD**

VAST (Voluntary Action in Stoke-on-Trent) is a registered charity and as such already receives 80% mandatory charity relief. It occupies 12 Merrial Street as offices to help facilitate its aims of promoting any charitable purpose for the benefit of the local community, particularly with regard to the advancement of education, the furtherance of health and relief of poverty, distress and sickness.

It is your usual practice to grant such an organisation 5% additional discretionary rate relief, to the mandatory charity relief it already receives.

VAST has been in occupation of 12 Merrial Street since 8 January 2014. The gross rates payable for the current financial year will be £5,061.00 reduced to £1,012.20 by mandatory charity relief. Granting 5% discretionary rate relief would further reduce this amount by £253.05 to £759.15 at a cost to the Borough Council of £101.22 in 2014/15, with a further cost of £22.49 to back date the relief to the date of occupation of the premises.

Recommendation: That additional discretionary rate relief at 5% is granted.

7. **University Academy Kidsgrove, Gloucester Road, Kidsgrove, Stoke-on-Trent, ST7 4DJ and -**

8. **University Academy Kidsgrove, Playing Fields Gloucester Road, Kidsgrove, Stoke-on-Trent, ST7 4DJ**

University Academy Kidsgrove is the former Maryhill Comprehensive School and its rating liability is split over two hereditaments. As part of a registered Academic Trust it already receives 80% mandatory relief.

The majority of educational establishments are unable to claim any rate relief but for various reasons, a number are able to register as charities or academies and receive 80% mandatory relief. It is your usual practice to grant no further discretionary relief in these cases.

The gross rates payable for the current financial year will be £49,164.00 reduced to £9,832.80 by academy status for the main assessment and £1,711.10 reduced to £ 342.22 for the playing fields.

Recommendation: That no additional discretionary rate relief be granted in respect of either of the hereditaments.

9. **The Newcastle Co-operative Learning Trust, Seabridge Primary School, Roe Lane, Newcastle, Staffs, ST5 2HY**

The Newcastle Co-operative Learning Trust is the former Seabridge Primary School and as part of a registered Academic Trust it already receives 80% mandatory relief.

The majority of educational establishments are unable to claim any rate relief but for various reasons, a number are able to register as charities or academies and receive 80% mandatory relief. It is your usual practice to grant no further discretionary relief in these cases.

The gross rates payable for the current financial year will be £27,474.00 reduced to £5,494.80 by academy.

Recommendation: That no additional discretionary rate relief be granted.

10. **S.V.R Leisure LLP, Warehouse @, Knowle End Farm, Barthomley Road, Audley, Stoke-On-Trent-Staffs, ST7 8HT**

S.V.R Leisure LLP (Storm Valley Raceway) are a not for profit organisation. They have occupied the Warehouse @, Knowle End Farm since 30 May 2013 to provide a race track and associated facilities for the racing of remote control cars. They are a club affiliated to the British Radio Car Association and provide facilities for all age groups and ability levels in the North Staffordshire and South Cheshire area.

It is your usual practice to grant such an organisation 80% discretionary relief

The gross rates payable for the current financial year will be £7,832.50. Granting 80% discretionary rate relief would reduce this amount by £6,266.00 to £1,566.50 at a cost to the Borough Council of £2,506.40 in 2014/15, with a further cost of £2,014.07 to back date the relief to the 30 May 2013.

Recommendation: That discretionary rate relief at 80% is granted.

Classification: NULBC **PROTECT** Management

NEWCASTLE-UNDER-LYME SPORTS COUNCIL – GRANT AID 2014/15

Submitted by: **Executive Director - Resources & Support Services and Executive Director - Operational Services**

Portfolio: **Finance and Resources/Leisure, Culture and Localism**

Wards Affected: **All**

Purpose of the Report

To consider awarding a grant to the Newcastle-under-Lyme Sports Council and to inform members of the grants awarded by the Sports Council to individuals and sports clubs in the borough in 2013.

Recommendation

That the Cabinet award a grant of £19,000 to the Newcastle-under-Lyme Sports Council to support the contribution it makes to sport in the borough.

Reasons

The Council recognises the importance of sport, not only as an activity in its own right but also for its benefits in relation to health and positive activities.

1. **Background**

1.1 The Newcastle-under-Lyme Sports Council is a body that is concerned with the promotion of sport in the borough. Affiliation to the Sports Council is open to any club in the borough. The activities of the Sports Council are directed by an Executive Committee which includes five borough councillors and one county councillor. The rest of the committee is made up of the representatives of sports clubs, parish councils, the Staffordshire Playing Fields Association and the Partnership Director of Sports Across Staffordshire and Stoke-on-Trent.

1.2 The Sports Council's main activity is to award grants to promising sportsmen and sportswomen to help them meet the costs of their chosen activities. Individuals who receive funding must live in the borough. The Sports Council also supports clubs and organisations located in the borough. Grants are given to clubs and organisations to help them improve their equipment and facilities. As at the end of the financial year 2013/14, the Sports Council has awarded grants to 56 individuals and 10 clubs/organisations.

1.3 This report provides an overview of how the Sports Council has used the grant it received from the Borough Council in 2013/14 (£22,550), and the Sports Councils accumulated funds brought forward (£11,326 as at 1st April 2013) to encourage participation and performance in sport by both individuals and clubs. A total of £30,572 has been given to support 22 different sporting activities, leaving a balance of £3,665.79 as at 31st March 2014.

1.4 The following table illustrates the number of awards made by sport and the amount that was awarded to each sport:

Sport	Number of Awards	Amount (£)
Angling	1	700
Archery	1	300
Athletics	9	4,500
Badminton	3	1,500
Biathlon	1	200
Canoeing	1	700
Cricket	16	7,333
Cycling	2	1,200
Dancing	1	1,000
Football	6	3,750
Youth Drop In	1	400
Golf	1	400
Gymnastics	2	1,000
Karting	1	400
Netball	2	680
Rowing	3	1,350
Skiing	1	500
Swimming	1	750
Table Tennis	2	300
Tennis	1	300
Triathlon	1	500
Volleyball	9	2,809
Total	**66**	**30,572**

2. **Issues**

2.1 Every application for grant aid was considered by the Sports Council on its merit and was supported by references from a coach/club official and evidence of expenditure.

2.2 Individual grants ranged from £100 to £1,000. While relatively small in value, they have been a great encouragement to all successful applicants, contributing to improved standards of sport in the borough.

3. **Proposal**

3.1 It is proposed that the Borough Council consider awarding a grant of £19,000 to the Newcastle-under-Lyme Sports Council to support the contribution it makes to sport in the borough.

4. **Reasons for Preferred Solution**

4.1 The work of the Sports Council supports the sports voluntary sector in the borough and promotes the value of sport, recognising the need to support individuals in their personal quest for achievement and the wider community benefits this brings.

5. **Outcomes Linked to Sustainable Community Strategy and Corporate Priorities**

5.1 Sport has a positive effect on all four of the Council's corporate priorities:

- A Clean, Safe and Sustainable Borough – sport deters anti social behaviour by providing positive activities.
- A Borough of Opportunity – the grant awards offer encouragement and opportunities for individuals and teams to overcome some of the financial barriers to participation.
- A Healthy and Active Community – sport contributes to a healthy lifestyle.
- A Co-operative council delivering high quality, community-driven services - by working in partnership with the Sports Council, we target our investment to maximise impact on community outcomes.

6. **Legal and Statutory Implications**

6.1 There are no legal or statutory implications. The Council has the power to make the grant under its general duties.

7. **Equality Impact Assessment**

7.1 The grants are allocated with full regard to equal opportunities as illustrated by the broad range of activity covered.

8. **Financial and Resource Implications**

8.1 A grant of £22,550 was awarded to the Sports Council in 2013/14. There is sufficient provision to award a grant of £19,000 to the Sports Council in 2014/15 if this is desired.

8.2 The amount available for 2014/15 has reduced following a funding review and assessment of the levels of Council grants and contributions available. The review was undertaken in consultation with relevant stakeholders with regard to the levels of funding available to the Council.

8.3 In addition to the grant, the Borough Council also provides administration for meetings of the Sports Council together with free room hire. This is estimated to be approximately £2,500 of "in-kind" contribution.

9. **Major Risks**

There are no major risks associated with this funding.

10. **Background Papers**

None

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NEWCASTLE-UNDER-LYME BOROUGH COUNCIL

REPORT TO CABINET

Date: April 2014

Title: **Short Term Hire of Vehicles**

Submitted by: **T Nicoll**

Portfolio: **Environment and Recycling**

Ward(s) affected: **All**

Purpose of the Report

- **To highlight the need for short term hire of vehicles across the Council Fleet.**
- **To agree an approval process for tendering and award.**

Recommendations

- **That the Cabinet agrees that officers proceed with the tendering process.**
- **That subject to the above, Cabinet delegates the authority to award the contract to the Executive Director (Operational Service) after consultation with the Cabinet Portfolio Holder - Environment and Recycling.**

Reasons

- **To provide the Council with a short term supplier for the supply of vehicles.**
- **To enable the Council to undertake operational services for the benefit of residents and local businesses.**

1. Background

The Council has followed a process of capital purchasing the majority of its specialist fleet vehicles over the last 5 years, however there are still a small number of vehicles operated by the Council that are obtained via short term hire agreements with specialist hire providers. There are a number of reasons why we currently do this including pressures on capital budgets, increased flexibility for operational services, and options for longer term service provision and development.

2 Issues

The two most expensive vehicles that we have on the fleet via a short term contract arrangement are the two 26 tonnes refuse collection vehicles that are use on the trade waste collection services. The cost of short term hiring these two vehicles is in the region of £80,000 per year. As the value of the providing these vehicles is likely to exceed the threshold for supplies as set out in the Public Contracts Regulations 2006 and the Councils

Standing Orders, the Council either needs to undertake a full procurement exercise or utilise a compliant call-off framework provided by one of the purchasing organisations.

We have undertaken a short option appraisal exercise regarding these two vehicles, which has led to the following findings:-

- **Failure to have these vehicles on fleets –** this would lead to the Council not being able to provide a Trade Waste Service leading to a loss to income per year in the region £400,000 to the Council.
- **Outright Purchase of Vehicles –** Currently the replacement of vehicles are not identified with 2014/15 Capital Budget and short term hire provide the Council greater flexibility during times of change, in providing this service, budget is in place within the service revenue budget.

3 Proposal

The Cabinet providers Officers of the Council the authority to tender and award for the provision of these two refuse collection vehicles for a maximum period of three years.

Officers will first review various framework provisions to see if this method provides best value through a Most Economically Advantageous Tender (MEAT) process and the flexibility required for the provision of the items. If a suitable framework can not be determined Officers would them tender via open procurement method.

It is requested the Cabinet delegates the authority to enter into the contract with the preferred supplier after tendering to the Executive Director (Operational Service) after consultation with Cabinet Portfolio Holder - Environment and Recycling.

4 Outcomes Linked to Corporate Priorities

The proposals relate to the effective delivery of high quality operational services, which would contribute to the following:

A clean, safe and sustainable borough

- The negative impacts that the Council, residents and local businesses have on the environment will have reduced
- Our streets and open spaces will be clean, clear and tidy

A co-operative Council delivering high quality, community driven, services.

- High performing services will be delivered for all residents and customers.

5 Legal and Statutory Implications

The procurement process is being conducted to meet the requirements of the Public Contracts Regulations 2006 and the Councils Standing Orders.

The contract document pertaining to this service has been prepared by legal/framework provider and agreed by Procurement Officer.

6 Equality Impact Assessment

An equality impact assessment is not required in respect of this procurement process.

7 **Financial and Resource Implications**

During the tendering process officers from the Recycling and Fleet Service with the support of officers within the Finance Department will develop a costing model to ensure that the Council is not exposed to a financial risk. Revenue budgets are already in place in various cost centres to cover the cost of scheduled short term hired vehicles.

To mitigate and minimise risk to the authority third party credit checks would also be undertaken on the preferred tenderer prior to the award of contract.

8.0. **Major Risks**

The major risks are considered to be:

- Failure to undertake and award tender would leave the Council open to challenge under the Public Contracts Regulations 2006.
- Without tendering or utilisation of a framework the Council would find it difficult to demonstrate that best value has been achieved.

9.0 **Recommendations**

The recommendations include the following:

- **That the Cabinet agrees that officers can proceed with the tendering process.**
- **That subject to the above, Cabinet delegates the authority to award contract, to the Executive Director (Operational Service) after consultation with the Cabinet Portfolio Holder - Environment and Recycling.**

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DRAFT VERSION 3 – 13th March 2014

NEWCASTLE – UNDER-LYME BOROUGH COUNCIL

Report To: CABINET – 2nd April 2014

TITLE: Review of Allotment Service

Submitted by: Head of Operations – Roger Tait

Portfolio: Environment and Recycling

Wards Affected: All

Purpose of the Report

To report the outcome of the work of the Active and Cohesive Communities Overview and Scrutiny Committee to the Cabinet.

To present the draft Allotments Policy to the Cabinet.

Recommendations

That the report is received.

That the Cabinet endorses the findings of the Active and Cohesive Communities Overview and Scrutiny Committee and that the draft Allotments Policy is approved for consultation.

That a report is brought to a future meeting of the Cabinet, detailing the outcome of the consultation on the draft Allotments Strategy and recommending that the strategy is formally adopted, subject to any changes arising from the consultation responses.

Reasons

To update the Allotments Policy and improve the management of the Allotment Service provided by the council.

1. Background

1.1 The Borough Council's Allotment Policy was last reviewed in 1989/90. There have been significant changes in a number of factors affecting the demand for allotments and the way allotments are provided and managed since this time, meaning that the policy is now no longer fit for purpose.

1.2 A report regarding a proposed review of the allotments service was considered by Cabinet at the meeting on 14th November 2012. It was resolved :

a) That the Active and Cohesive Communities Overview and Scrutiny Committee undertake a review of the issues identified with particular reference to local management, meeting future demand and reducing the current cost.

b) That a report on the outcome of the scrutiny and consultation process be brought to a future meeting of the cabinet, in conjunction with a draft reviewed Allotments Policy.

At the meeting of 25th February 2014, the Active and Cohesive Communities Overview and Scrutiny Committee considered a report on the work of the Task and Finish Group and resolved to recommend to Cabinet that it's findings be endorsed and that the draft Allotments Strategy be approved for consultation. The Task and Finish Group will prepare a consultation plan for implementation by officers. The report is attached to this report at Appendix 1.

2. Issues

2.1 A summary of the main recommendations for consultation are as follows:

Number	Recommendation
1	That an annual review and rationalisation of the waiting list is carried out
2	That applicants from outside the borough can be considered for plots but priority is to be given to borough residents
3	That a basic needs assessment be carried out and local standards for allotment provision be set for Newcastle based on current provision and demand levels
4	That engagement with other providers is carried out to explore shared service potential and to consider additional provision if demand arises and external funding is available
5	That a register of land that is Council owned and would be suitable for future allotment sites should be prepared
6	That varying plot sizes and tenancies be offered
7	That allotment plots be measured and charged per m2 according to the size of the plot
8	That systems are improved to make them more efficient
9	That the proposed Tenancy Agreement and Operating Procedure attached to the draft Allotments Policy as Appendix A and B respectively are approved
10	That differing community management models are to be considered and progressed where appropriate
11	That plotholders are encouraged to set up "Allotment Tenants Association Committees" on each of the larger sites and a combined committee for the 3 smaller sites
12	That the overall annual cost of £57,860 for the service balanced against £10,500 income is reviewed
13	That recharges are to be reviewed and reduced if possible following the proposed changes to management systems and the transfer of two of the allotment sites to Silverdale Parish Council
14	That a rise of £11.80 for a full plot (23p per week) commencing April 2015 (allowing 12 months notice) and thereafter annual incremental rises to move towards a reduction in subsidy and higher proportion of cost recovery is approved
15	That the level of concessionary rate offered to tenants over 60 years of age and unemployed is to be reduced from 50% to 20% with effect from April 2015
16	That the system for sending out the annual rent invoices and monitoring payments is improved. The billing period should change from January to April each year with one annual non-refundable bill
17	That the development of any further allotment sites should be explored if demand arises and if external funding is available
18	That enquires from residents living within parished wards are directed to the respective Parish Councils
19	That it is included within the tenancy agreement the requirement for tenants to dispose of their own waste and to return a plot in clean order, or the cost will be recharged to the ex-tenant to clear the rubbish left behind
20	That all allotment sites have re-cycling bins located if possible to assist with the

	removal of surplus green waste

Number	Recommendation
21	That all skips for general waste are to be removed from sites as general waste should be disposed of responsibly by the tenant
22	That water costs are charged directly to the plot holder as a proportion of the overall site usage. The use of water butts is to be encouraged for plot holders
23	That allotment associations are to manage and pay for the provision and cleaning of their toilets if required
24	That if individual sites wished to actively encourage biodiversity (such as allotments at Lyme Valley) then this would be supported with the individual allotment association committees
25	That there is not a need to either market the sites or develop additional plans with partners such as the NHS at this moment, although the NHS was considered to be a potential source of future funding if a project was to be developed
26	That the benefits of allotment gardening should be recognised and included in the Health and Well-being Strategy
27	That while it is considered that there was limited potential at present, the option of developing partnerships in the future is incorporated into the policy and opportunities will be explored if and when they arise

2.2 The above issues have been incorporated into the draft Allotments Policy which is attached to this report at Appendix 2. The policy sets out how allotments will be managed over the next 5 years in line with the findings and recommendations of the Active and Cohesive Communities Overview and Scrutiny Committee. It includes an action plan setting out specific tasks and timescales to assist in delivering the aims of the policy. The policy will be reviewed annually and a progress report will be brought to appropriate meetings of the cabinet.

2.3 It is proposed that the draft policy be approved for consultation and that a consultation plan be prepared by the Active and Cohesive Communities Overview and Scrutiny Committee.

3. Proposal

3.1 That the Active and Cohesive Communities Overview and Scrutiny Committee endorse the findings of the Allotments Review Task and Finish Group and approve the draft Allotments Policy for consultation.

3.2 That a report is brought to a future meeting of the Cabinet, detailing the outcome of the consultation on the draft Allotments Strategy and recommending that strategy is formally adopted subject to any changes arising from the consultation process.

4. Reasons for proposed solutions

4.1 To update the Allotments Policy and improve the Allotment Service provided by the council.

5. Outcomes linked to Council Plan and Corporate Priorities

5.1 Creating a cleaner, safer and sustainable Borough**.**

5.2 Creating a healthy and active community

5.3 Becoming a co-operative council

6. Legal and Statutory Implications

6.1 There are a number of legal and statutory implications relating to the provision, maintenance and charging of allotments which were considered during the scrutiny process and policy review.

7. Equality Impact Assessment

7.1 An assessment has been undertaken as part of the review process and this is included at Appendix 3.

8. Financial and resource implications

8.1 The current net annual cost of the allotment services provided by the council is £47,360. Financial implications have been considered as part of the review process and the Active and Cohesive Communities Overview and Scrutiny Committee have made the following recommendations to seek to reduce costs and increase income with a view to closing the gap between service cost and income incrementally each year over the life of the policy:

1. Review support service recharges and request that recharges are reduced/minimised wherever possible
2. Reduce annual spend on repairs, waste removal and phase out subsidised provision of mains water to sites (tenants to pay for mains water as a surcharge on rent)
3. Rationalise and improve systems for administration work, billing etc for allotments.
4. Reduce concession rates from 50% to 20%
5. Increase rents by £11.80 for a full plot (23p per week) initially in 2015 and by an agreed percentage each year thereafter for an initial 5 year period.
6. Transfer the two allotment sites in Silverdale to Silverdale Parish Council

8.2 If the above recommendations are approved and adopted as part of the proposed Allotments Policy, it is estimated that the net annual cost of the Allotments Service will reduce to approximately £34,000 in 2015/16, subject to current occupancy levels being maintained when the higher rents/reduced concessions are implemented. Any subsequent reductions in cost would be subject to further rent increases and minimising internal recharges.

9. Major Risk

9.1 The risk associated with each option has been considered as part of the review process. A full risk assessment has been prepared and is attached at Appendix 3.

10. Key Decision Information

10.1 This initiative impacts on more than 2 wards and has been included in the forward plan.

11. Earlier Cabinet Reports

11.1 Cabinet 30th November 2011
Cabinet 14th November 2012
Active and Cohesive Communities Overview and Scrutiny Committee 25.02.14

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NEWCASTLE – UNDER-LYME BOROUGH COUNCIL

Report To: Active and Cohesive Communities Overview and Scrutiny Committee

TITLE: Review of Allotment Service

Submitted by: Head of Operations – Roger Tait

Portfolio: Environment and Recycling

Wards Affected: All

Purpose of the Report

To report the outcome of the work of the Allotments Review Task and Finish Group to the Active and Cohesive Communities Overview and Scrutiny Committee.
To present the draft Allotments Policy to the Active and Cohesive Communities Overview and Scrutiny Committee.

Recommendations

That the report is received.

That the Active and Cohesive Communities Overview and Scrutiny Committee endorse the findings of the Allotments Review Task and Finish Group and officer recommendations. and that the draft Allotments Policy is approved for consultation.

That a report is brought to a future meeting of Cabinet, recommending that the findings of the Active and Cohesive Communities Overview and Scrutiny Committee are accepted and that the draft Allotments Policy is approved for consultation.

Reasons

To update the Allotments Policy and improve the management of the Allotment Service provided by the council.

1. Background

1.1 The Borough Council's Allotment Policy was last reviewed in 1989/90. There have been significant changes in a number of factors affecting the demand for allotments and the way allotments are provided and managed since this time, meaning that the policy is now no longer fit for purpose.

1.2 A report regarding a proposed review of the allotments service was considered by Cabinet at the meeting on 14th November 2012. It was resolved :

a) That the Active and Cohesive Communities Overview and Scrutiny Committee undertake a review of the issues identified with particular reference to local management, meeting future demand and reducing the current cost.

b) That a report on the outcome of the scrutiny and consultation process be brought to a future meeting of the cabinet, in conjunction with a draft reviewed Allotments Policy.

1.3 The Active and Cohesive Communities Overview and Scrutiny Committee subsequently set up the Allotments Review Task and Finish Group, comprising 6 members, chaired by the Chair of the Active and Cohesive Communities Overview and Scrutiny Committee and supported by officers. Five key issues from the cabinet report were highlighted which were to be investigated by the Task and Finish Group. These were broken down into the following issue and sub headings :

a) Provision:
- Needs assessment
- Local standards
- Current provision and providers
- Demand / waiting lists
- Future provision and providers

b) Management:
- Administration
- Waiting Lists
- Plot sizes
- Tenancy agreements
- Enforcement
- Community Management
- Stewardship

c) Resources:
- Cost to the Council
- Charging policy (subsidy v cost recovery)
- Collection of rent
- Capacity
- Funding

d) Sustainability
- Waste management
- Water
- Toilets
- Biodiversity

e) Marketing
- Benefits
- Health and Well –being
- Barriers
- Consultation
- Partnership

2. Issues

2.1 A work programme and timetable was prepared for the Task and Finish Group covering a list of topics for the group to discuss and a series of presentations by officers. These covered the following dates and subjects :

- January 2013 - Planning meetings (agree work plan and time scale)
- February 2013 - Legal framework and Implications (presentation from legal officer)
- March 2013 - Current cost and charging options (presentation by Community Manager).
- April 2013 - Demands and provision options (presentation by Community manager)
- May 2013 - Consultation (Representatives from other allotment groups and societies)

- June 2013 - Site visits (visit cross section of allotment sites and plots)
- July 2013 - Local Management (Discussions on Options)
- September 2013 - Meeting future demand (discussions on options)
- October 2013 - Reducing current costs (Discussions on options)
- November 2013 - Review and analysis (agree direction of policy)
- December 2013 - Draft report (presentation of draft policy)

The work was completed in December 2013 and officers drafted the proposed policy which is attached to this report at Appendix 1. The following sections provide a summary of the debate and conclusions on each topic.

2.2 Provision:

Needs assessment/local standards/current provision and providers/demand and waiting list/ future provision and providers.

- The waiting list was thoroughly reviewed and those on the waiting list were contacted in writing and asked if they wished to remain on the list and to name the site that they wanted to be placed upon. The waiting list had 420 multiple entries and after the review it reduced from 283 to 133 people. The task and finish group recommended that the waiting list should be reviewed every year. This will speed up the process of letting plots and give a realistic waiting list figure. Applicants from outside the borough can be considered for plots but priority is to be given to borough residents.

- Geographical maps were prepared to show the task and finish group the position of the allotment sites, the location of the tenants in relationship to the position of the allotment sites and the position of the residents on the waiting list for that particular site. This exercise showed that there is good local take up from residents who live close to the allotment sites, along with a waiting list of local residents. There were few examples of residents living a great distance from the allotment sites.

- It was recommended by the task and finish group that a basic needs assessment be carried out and local standards for allotment provision be set for Newcastle based on current provision and demand levels shown on the waiting list. The national standard was not considered to be appropriate for Newcastle. Measures are to be put in place to speed up the process of letting and eviction. It was also recommended to engage with other providers to explore shared service potential and to consider additional provision if demand arises and external funding is available. A register of land that is council owned and would be suitable for future allotment sites should be prepared.

2.3 Management:

Administration/waiting list/plot sizes/tenancy agreements/enforcement/community management/stewardship.

- The task and finish group recommended that varying plot sizes and tenancies be offered.
  It was recommended that all allotment plots be measured and charged per m2 according to the size of the plot, to ensure fairness and consistency.

- The current methods of administering allotment services were examined by the task and finish group. Officers highlighted areas where delays occur with the current process of administration and enforcement and the present tenancy agreements. Changes were proposed in the method of administration by improving systems to make them more efficient. The new proposed tenancy agreement was designed to streamline processes and more robustly manage tenants who do not pay, which

should ultimately reduce overhead costs. Eviction powers could be delegated to allotment associations where they exist and where they are able to manage this process. Assistance from the council can be made available if necessary.

The proposed Tenancy Agreement and Operating Procedure are attached to the draft Allotments Policy as Appendix A and B respectively.

- The task and finish group also recommended that as part of the management of sites, differing community management models are to be considered and progressed where appropriate. Efforts should be made to set up "Allotment Tenants Association Committees" on each of the larger sites and a combined committee for the 3 smaller sites. These committees would be encouraged to affiliate to the National Allotment Society, and to become self sufficient. They would also be encouraged to nominate stewards for each site. This would also allow the allotment site committees to access and apply for local and national funding streams.

2.4 Resources:

Cost to the council/charging policy (subsidy v cost recovery)/collection of rents/capacity/funding

- The task and finish group looked at the cost of the service in detail.I It was clear that the overall annual cost of £57,860 for the service balanced against £10,500 income was an area which needed addressing. The cost was broken down into the following areas of expenditure:

  - **Premises charges = £31,270**
    These cover building repairs, water charges and grounds maintenance works carried out by Streetscene. The group proposed that water charges of £4,500 are to be charged to the allotment tenants as a proportion of the individual allotment site bill. Building repairs charges are reduced from £6,500 - £4,000
    Streetscene charges of £18,870 to be reduced by approximately £6000 when two sites are transferred to Silverdale Parish Council. This sum will be reapportioned to another area of work where the capacity is redeployed, so there will be no net saving to the council.
  - **Supplies and services charges = £1,550**
    These charges cover removal of waste, print room charges, material general, and contribution to unrecovered debts
    Within this section of cost, the recommendation from the task and finish group was to cease providing skips for allotment sites ensuring that rubbish was either composted or taken home for disposal by tenants.

  - **Support service / capital financing = £25,044**

    These charges cover £204 of capital financing, and the remainder of recharges are made by the following teams for officer time spent on allotment related work:

A101	Accountancy	1,000.00
A107	Sundry Debtors	2,540.00
A112	Creditors Section	330.00
A141	Agresso Financial Information System	270.00
A302	Legal Services	1,540.00
A401	Operational Services Admin	910.00
A402	Engineers	1,940.00
A404	Public Buildings	7,080.00
A406	Community Team	9,230.00

	TOTAL	24,840.00

The group expressed concern that the support charges were close to 50% of the total allotment service cost. Officers were asked to contact the respective Heads of Service to ask for recharges to be reviewed and to see if these charges could be reduced in the light of the proposed changes to the management of the allotment sites and the transfer of two of the allotment sites to Silverdale Parish Council. However, for the purpose of estimating future costs, these charges have been retained at current levels for the time being.

- **Rents - general rents income = £10,500.**

There were two elements to this area which needed to be reviewed, the first being the cost of an allotment plot (current rent for a plot after April 2014 will be £59.00) The group proposed a rise of 20% commencing April 2015 (allowing 12 months notice). This will bring the cost of a full plot to £70.80 and thereafter annual incremental rises are to be implemented to move towards a reduction in subsidy and higher proportion of cost recovery. The second issue related to the income is the level of concessionary rate offered to tenants over 60 years of age and unemployed. The group proposed that the concessionary rate be reduced from 50% to 20% with effect from April 2015.

At current levels of occupation, and taking out the income from the two Silverdale sites which will transfer to the parish council, the increase in rent and reduction in concessions would mean that estimated income for 2015 would increase to approximately £7,300 from £4,900.

- **Collection of rent**

The group considered that it would be operationally effective to improve the system forsending out the annual rent invoices and monitoring payments. The billing period should change from January to April each year with a view that those who have not paid their rent within 28 days will be sent eviction notices in accordance with the revised tenancy agreement. This will streamline the administration process and assist in managing vacant and non-cultivated plots more effectively.

- **Capacity**

The task and finish group decided to recommend that the development of any further allotment sites should be explored if demand arises and if external funding is available. It was suggested that enquires from residents living within parished wards are directed to the respective Parish Councils and that a list of potential future sites within council ownership is prepared so that future demand could be serviced dependent on funding being secured from appropriate sources. It was proposed to monitor the waiting list by reviewing it annually and seeking to relet any plots vacated as quickly as possible.

- **Funding**

The task and finish group proposed the setting up of allotment associations groups for each of the large sites and a combined group for the small sites. The groups will be encouraged to apply for funding for local and national funding sources. Officers will continue to seek to identify potential sources of funding to improve allotment sites or create new sites if demand arises. Engagement with

other potential providers will also take place to explore the possibility of shared services.

2.5 Sustainability:

Waste management/water/toilets/biodiversity

- **Waste management**

  To ensure all tenants are held responsible for the amount of rubbish left on the allotment plot when vacating the site, the group decided to include within the tenancy agreement the requirement for tenants to dispose of their own waste and to return a plot in clean order, or the cost will be recharged to the ex-tenant to clear the rubbish left behind. It was also agreed to recommend that all allotment sites had re-cycling bins located if possible to assist with the removal of surplus green waste. All skips for general waste are to be removed from sites as general waste should be disposed of responsibly by the tenant.

- **Water**

  The task and finish group looked at the cost of mains water for allotment sites, and decided to follow the route which many other authorities have adopted in that water costs are charged directly to the plot holder as a proportion of the overall site usage. The longer term view of the group is to reduce the provision of water, allowing the respective allotment association committee to determine whether or not their site wants a mains water supply or not, and if so, to be paid for by the tenants. The use of water butts is to be encouraged for plot holders.

- **Toilets**

  The task and finish group looked at the cost of the provision of toilets on allotment sites (only two sites have a toilet), and decided that allotment associations should either manage and pay for the cleaning of their toilets if the site has one, or if the allotment association decide that they need to develop a toilet on their site that the allotment association committee fund this and maintain it from their own funds.

- **Biodiversity**

  The task and finish group looked at this issue and decided that if individual sites wished to actively encourage biodiversity (such as allotments at Lyme Valley) then this would be supported with the individual allotment association committees.

2.6 Marketing:

Benefits/health and well – being/barriers/consultation/partnership.

- **Benefits / Health and Well-Being**

  The task and finish group felt that as there were a number of people on the waiting list, there was not a need to either market the sites or develop additional plans with partners such as the NHS at this moment, although the NHS was considered to be a potential source of future funding if a project was to be developed similar to the Lyme Valley Allotment project. The benefits of allotment gardening should be recognised and included in the Health and Well-being Strategy.

- **Consultation**

  The task and finish group met representatives from:
  - Parish Council sites at Audley
  - National Allotment Association
  - The Acre allotment site
  - Lyme Valley allotment site
  - Dimsdale allotment site

  Discussions with the representatives explored areas such as forming allotment associations, issues with the current system of management, rent payment and how this is managed (by Parish tenants), what the tenants hopes for the future are. Many of the areas discussed have been addressed with the new draft policy, tenancy agreement and method of operation.

- **Barriers/ Partnership**

  The task and finish group discussed the potential involvement of partners in providing allotment services. While the group considered that there was limited potential at present, the option of developing partnerships in the future should be incorporated into the policy and that opportunities should be explored if and when they arise.

2.7 The above issues have been incorporated into the draft Allotments Policy which is attached to this report at Appendix 1. The policy sets out how allotments will be managed over the next 5 years in line with the findings and recommendations of the Task and Finish Group, including additional officer recommendations relating to technical or operational issues. It includes an action plan setting out specific tasks and timescales to assist in delivering the aims of the policy. The policy will be reviewed annually and a progress report will be brought to appropriate meetings of the cabinet.

2.8 It is proposed that the draft policy be approved for consultation and that a consultation plan be prepared by the Task and Finish Group for recommendation to Cabinet.

3. Proposal

3.1 That the Active and Cohesive Communities Overview and Scrutiny Committee endorse the findings of the Allotments Review Task and Finish Group and approve the draft Allotments Policy for consultation.

3.2 That a report is brought to a future meeting of the Cabinet, recommending that the findings of the Active and Cohesive Communities Overview and Scrutiny Committee are accepted and that the draft Allotments Policy is approved for consultation.

4. Reasons for proposed solutions

4.1 To update the Allotments Policy and improve the Allotment Service provided by the council.

5. Outcomes linked to Council Plan and Corporate Priorities

5.1 Creating a cleaner, safer and sustainable Borough**.**

5.2 Creating a healthy and active community

6. Legal and Statutory Implications

6.1 There are a number of legal and statutory implications relating to the provision, maintenance and charging of allotments which were considered during the scrutiny process and policy review.

7. Equality Impact Assessment

7.1 An assessment has been undertaken as part of the review process and this is included at Appendix C

8. Financial and resource implications

8.1 The current net annual cost of the allotment services provided by the council is £47,360. Financial implications have been considered as part of the review process and the Task and Finish Group have made the following recommendations to seek to reduce costs and increase income with a view to closing the gap between service cost and income incrementally each year over the life of the policy:

1. Review support service recharges and request that recharges are reduced/minimised wherever possible
2. Reduce annual spend on repairs, waste removal and phase out subsidised provision of mains water to sites (tenants to pay for mains water as a surcharge on rent)
3. Rationalise and improve systems for administration work, billing etc for allotments.
4. Reduce concession rates from 50% to 20%
5. Increase rents by 20% initially in 2015 and by an agreed percentage each year thereafter for an initial 5 year period.
6. Transfer the two allotment sites in Silverdale to Silverdale Parish Council

8.2 If the above recommendations are approved and adopted as part of the proposed Allotments Policy, it is estimated that the net annual cost of the Allotments Service will reduce to approximately £34,000 in 2015, subject to current occupancy levels being maintained when the higher rents/reduced concessions are implemented. Any subsequent reductions in cost would be subject to further rent increases and minimising internal recharges.

9. Major Risk

9.1 The risk associated with each option has been considered as part of the review process. A full risk assessment has been prepared and is attached at Appendix 2.

10. Key Decision Information

10.1 This initiative impacts on more than 2 wards and has been included in the forward plan.

11. Earlier Cabinet Reports

11.1 Cabinet 30th November 2011
Cabinet 14th November 2012

Newcastle under Lyme Borough Council

Allotment Strategy 2014 - 2020

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1. Introduction

The Borough Council's Allotment Strategy was last reviewed in 1989/90. There have been significant changes in a number of factors affecting the demand for allotments and the way allotments are provided and managed since this time, meaning that there is now a need for a modern, fit for purpose strategy.

Since early 2000 there has been a significant improvement in the quality of Council allotments as a result of better management and administration, through the provision of more support to voluntary associations, targeted investment, better publicity and information, the closure of unusable plots and the introduction of minor improvements and changes over this period. These changes have been mirrored by an increase in occupancy reflecting a growing interest both locally and nationally in allotments. As a result occupancy rates on the Council's sites have remained at the 80 – 89% occupancy rate over the last 3 years, with the waiting list sitting at 133 residents spread over the Council's 6 sites.

To help maintain this momentum of improvement it is proposed to adopt an Allotment Strategy with the aim of creating an efficient, flexible and effective service that reflects best practice. The adoption of the proposed Strategy action plan will then guide the work of the allotment team over the coming 5 years.

The Allotment Strategy is a response to these demands. It has been prepared in conjunction with the Council's Allotment Review Task and Finish Group, and in consultation with plotholders and voluntary site association members, Parish Councils, residents who are on the waiting list and other stakeholders. Advice has also been provided by the Allotment management team and the National Society of Allotment and Leisure Gardeners.

The Allotment Review Task and Finish Group set out to capture the future aspirations and needs of the tenants, whilst looking into detailed areas were improvements could and should be made, such as current expenditure, rules and regulations, working methods, rents and concessions. These areas of improvements along with many other ideas have all been woven into the strategy and action plan to create a working document that will take the allotment service through to 2020 and beyond. The Strategy laid out below will be used by staff and partners of Newcastle-under-Lyme Borough Council as a working document to ensure that the allotments are being managed efficiently and effectively and meet our customers' needs and aspirations.

2. Background

Newcastle-under-Lyme Borough Council allotment sites are managed by the Operations Service, including all grounds maintenance, construction works and administration.

The Borough Council currently manages 6 allotment sites offering 188 allotment plots. The demand for allotments is significant, with a current waiting list of 133 people. The size of allotment sites vary considerably with the smallest site having only seven plots and the largest having 70 plots. The sizes of the plots also vary ranging from 150 m2 – 350 m2 with each tenant paying a standard rate.

Concessionary rates apply to tenants who are over 60 years of age and those who are unemployed. This concession has been set at a 50% reduction for many years.

The service is currently managed by the Councilwhich in the main is an administration role in managing the allotment waiting list , dealing with complaints and enquiries and the letting and eviction process.

The Council also carries out regular site inspections and identifies and manages any work required for regular maintenance, repairs or construction,subject to the limited budgets available.

There are also a number of other allotment sites within the Borough which are managed by Audley and Madeley Parish Councils and Kidgrove Town Counci, as well as other charitable and voluntary organisationsl. These allotment plots number approximately 174 in total across 8 sites. With allotments becoming more and more publicised on TV programmes such as Gardeners World and through organisations such as the Royal Horticultural Society and the National Trust, the demand for allotments nationally is rising.

3. Legislation

Allotments are governed by a number of pieces of legislation.

- The Small Holdings and Allotments Act of 1908
- The Land Settlement Facilities Act 1919
- The Allotments Act 1922
- The Allotment Act 1925
- The Town and Country Planning Act 1947
- The Allotments Act 1950

The Small Holdings and Allotments Act of 1908 consolidated previous allotment legislation and established the modern day allotment system that is seen today. This Act placed a responsibility on the local authority to provide allotments so to meet the demand of the general public.

The Land Settlement Facilities Act 1919 provided some assistance to servicemen and opened allotments up to the whole population rather than the ‘laboring population’. The popularity of allotments increased to a peak of 1,400,000 plots nationally at the height of ‘Dig for Victory’. Following this high demand for allotments there has been a slow decline since, with 265,000 plots nationally in 1997.

The Allotments Act 1922 and the Allotment Act 1925 both provided the allotment holder with more security over their tenure, and greater compensation at the termination of a tenancy. The Allotments Act 1925 also intended to initiate the further acquisition of allotments. This was later removed under the Town and Country Planning Act 1947.

The Allotments Act 1950 made better provision for compensation following the termination of a tenancy. It also clarified the system for collecting rent, and included some further allotment management issues. Other further acts have influenced allotment legislation; however the Allotments Act 1950 is still the dominant legislation.

4. Benefits of Allotments

Allotments have been an important and valuable part of the urban community for over 150 years. They were created to empower those on low incomes to improve their quality of life, health and diet, by growing their own food. The common land these people worked was the remains of land that had once been communal agricultural land. Post war Britain saw a fall in allotment use due to changes in society with 'cheap' food and the negative stereotyping of allotment gardening as the leisure pursuit of those on low incomes, or the white, retired male.

Allotment law was last updated under The Allotments Act 1950. There remains the need for alteration in the law to reflect changes in allotment gardening. In modern allotment gardening people of all ages and backgrounds are creating vibrant communities that produce fresh, healthy food and offer a healthy lifestyle too. In 1998 the Department of Environment Transport and the Regions published a White Paper on the Future of Allotments. 'A Good Practice Guide' from the Local Government Association has followed this. Both documents highlight the contribution that allotments make to an improved quality of life.

During the past ten years gardening has become a very popular leisure activity in the UK because it offers a relaxing alternative to the stressful pace of modern day life. Increasingly allotments are being valued for their therapeutic benefits in providing a quiet refuge, where people can have the sense of gardening in the country, within an urban environment.

There has been a recent surge in demand for allotments, with an estimated 13,000 people on waiting lists in the UK. Another reason for this demand for allotments is increasing concerns over the safety and quality of our food. Food scares and the poor vitamin and mineral quality of food grown in depleted, intensively farmed soils have led to an increasing awareness of the value of home grown produce, free of chemicals. This desire for 'home grown food' and concern over environmental damage from 'air miles', is leading many people to turn to allotment gardening as a means of producing healthy, fresh, locally produced food that is often organically grown. This concern over our diet is acknowledged at government level with increasing concern over obesity in the population. Public health campaigns are consistently highlighting the necessity of a diet high in fruit and vegetables, along with adequate exercise.

The benefits of open spaces and in turn allotments are increasingly being recognised and documented in the public domain. This is through such schemes as Green Flag, BTCV's Green Gym's and various bodies such as Natural England.
Over the last few years there is an increasing amount of research being undertaken regarding the benefits of allotment gardening. These benefits assist local authorities in meeting government objectives in areas such as health, education, environment, social inclusion and crime reduction.

5. Purpose of the Strategy

As there are no nationally agreed standards for the provision of allotments either in terms of quality or quantity it is difficult to judge how well the Borough compares nationally. The National Society of Allotment and Leisure Gardeners suggest that there should be a minimum of 15 plots per thousand households (or 1 plot for every 65 households). For Newcastle-under-Lyme Borough Council and other providers (Parish and Town Councils/voluntary and charitable organisations) there are 8.6 plots per thousand households. Other authorities compare the number of plots per thousand populations; this would give the Borough a figure of 3.9 plots per thousand population.

Many developments have taken place during 2000 -2014, which have led to an increase in demand for allotments in Newcastle Borough. The purpose of this Strategy is to build on these improvements in order to create an efficient, flexible, effective Allotments Service that reflects best practice in allotment management and provision. This will enable the Borough's allotment sites to be used to their full potential, whilst improving the service offered to allotment tenants.

In order to achieve this vision, the Allotment Strategy provides recommendations to allotment gardeners and council officers on the policies, procedures and guidelines for allotment management.

The Allotment Strategy will:

- Support the uptake of allotments and the development of associations
- Improve and speed up the administration processes relating to allotments
- Decrease the over-all cost of allotments to the public
- Increase the sustainability of allotments
- Reflect recognised good practice in allotment management

The Allotment Strategy reflects wider corporate objectives such as "A Healthy and Active Community", "A Clean, Safe and Sustainable Borough" and "Becoming a Co-operative Council".

In summary Newcastle Borough Council's allotments will offer:

- The opportunity to grow fresh food and flowers
- The opportunity to grow organic produce
- The opportunity for fresh air and exercise
- The chance to be part of a community
- The ability to take part in an enjoyable leisure activity
- Valuable areas for people without a garden
- Places for children to experience the outdoors and to learn
- The opportunity for adults to develop new skills and participate in lifelong learning
- The opportunity to develop skills that could assist with employment
- Places to grow food locally so reducing an area's environmental footprint
- Support for biodiversity and conservation
- Contribution to sustainability
- Green corridors in urban and suburban settings

6. Next Steps for the Allotment Service

Aims and Objectives

To deliver the Strategy five aims have been identified. The aims and objectives have been drawn up in accordance with the outcomes agreed by the Allotment Review Task and Finish Group/

The intention is to use the Strategy document to manage the Borough Council's allotment sites, through an improved method of operation. This is detailed in appendix B and through a new set of rules and regulations (tenancy agreement) which are detailed in appendix A.

The new working methods combined with the improved rules and regulations will bring in efficiencies which will reduce revenue expenditure, speed up the re-allocation of plots and increase income.

These objectives along with the new rules and regulations and improved methods of working will be delivered by the Community Management Section over the next 5 years, and reviewed thereafter.

Aim 1: To ensure appropriate provision of allotments in the Borough

To regularly review and rationalize the waiting list to improve the lettings and eviction process

To carry out a basic needs assessment and set a local standard for allotment provision based on current demand and provision levels

To engage with other providers to explore shared service potential

To consider the potential for additional provision should demand arise

To explore opportunities for funding for additional provision and/or improvements to existing provision

To identify potential sites for future provision should demand arise

Aim 2: To manage allotments co-operatively

To offer varying plot sizes and tenancies to meet differing needsTo set rents based on varying plot sizes (charged per m2 rather than standard rate) to ensure fairness and consistency

To improve administrative and billing procedures to achieve efficiencies

To improve enforcement procedures to tackle non-payment, non-cultivation and speed up eviction/re-letting

To review tenancy agreements and operating procedures to achieve efficiencies and devolve responsibilities to tenants

To develop community management models for all allotment sites

To assist community management groups to identify funding sources to manage and improve sites

To encourage site membership of the National Allotment Organisation

To encourage volunteering, education and learning opportunities on allotment sites

Aim 3: To make best use of resources

To review support service recharges to manage down costs

To reduce maintenance and repair costs and devolve responsibilities to tenants and community management groups (water charges, waste removal, toilets)

To increase rents incrementally over the life of the strategy to reduce the gap between cost and incomeTo reduce the concession offered from 50% to 20% to reduce the gap between cost and income

To review the billing procedure to issue one annual bill, payable in advance and non-refundable

Aim 4: To improve sustainability

To devolve responsibility for waste management and removal on allotment plots/sites to tenants/community management groups and to encourage recycling/re-use wherever possible to improve the efficiency of site management

To devolve responsibility for mains water supply and costs on allotment plots/sites to tenants/community management groups and to encourage sustainable water supplies such as water butts increase tenant involvement with the management of allotment sites

To devolve responsibility for toilet provision, maintenance and cleansing on allotment sites to community management groups and to encourage sustainable toilet provision if it is required to provide efficient allotment administration

To encourage bio-diversity on allotment sites and assist community management groups to develop habitats where appropriate

To encourage sustainable practices including reduced use of chemicals, reduced pollution and organic gardening

Aim 5: To promote allotment gardening and it's benefits

To promote the benefits of allotment gardening through a variety of media and events

To promote links with the Council's Health and Wellbeing Strategy

To develop partnerships to improve allotment provision, management and improvement where opportunities arise

To consult stakeholders on the Strategy and action plan, and on other issues affecting allotment provision, management and improvement

To review the Council's webpages and provide good quality information to service users and non-users

Outcomes of an Allotment Strategy

The delivery of this Allotment Strategy will ensure:

- Good access and security, well-maintained pathways, adequate water provision and a system for dealing with neglected plots
- Promotion and encouragement to individuals and communities interested in becoming involved in the cultivation of allotment gardens
- Sustainable allotments
- Efficient, effective and accessible allotment administration
- Active involvement of gardeners in allotment management through tenants meetings, allotment associations and site secretaries/stewards
- Effective and appropriate allocation of resources
- Equal opportunities
- Educational opportunities
- Improving social inclusion
- Developing partnerships
- Promotion of organic gardening
- Increased opportunities for recycling and composting
- Fully occupied allotment sites
- Development of good environmental practices

Action Plan

The following action plan sets out the specific tasks and timescales which will be undertaken over the 5 year life of the Strategy to deliver the aims:

Year 0 (2014/15)				
ID Number	**Task**	**Timescale**	**Lead Officer**	**Commentary**
A001	Report to Cabinet	April 2014	RT	Approve draft strategy for consultation
A002	Consultation with stakeholders	July 2014	SM	Consider responses and amend draft strategy
A003	Report to Cabinet	September 2014	RT	Approve and adopt strategy
A004	Complete transfer of Park Road Allotments to Silverdale Parish Council	April 2014	SM	Sign transfer agreement

A005	Complete transfer of Acre Allotments to Silverdale Parish Council	September 2014	SM	Rationalise plots and sign transfer agreement
A006	Give notice to plotholders of new tenancy agreements and rents	April 2014	SL	Issue letters and update webpages
A007	Set up new billing arrangements	September 2014	SL	Create database and plot measurements to determine rent
A008	Measure all plots	September 2014	SL	Determine charge based on m2
Year 1 (2015/16)				
ID Number	**Task**	**Timescale**	**Lead Officer**	**Commentary**
A009	Set up Allotment Associations for all sites	April 2015	SL/BS	Complete constitutions
A010	Affiliate Allotment Associations to NAO	September 2015	SL/BS	Complete registration/membership
A011	Issue rent bills and review rent for following year	April 2015	SL/BS	Single annual bill in advance, including supplement for water charges. Determine rent increase for following year
A012	Review waiting list	April 2015	SL/BS	Rationalise list
A013	Set local standard	April 2015	SM	Needs assessment and plans showing demand and provision
A014	Identify sites for future provision	September 2015	SM	Plans showing potential sites and capacity
A015	Promote allotment gardening	April 2015	SL	Organise local competitions, open days, projects

Year 2 (2016/17)				
ID Number	**Task**	**Timescale**	**Lead Officer**	**Commentary**
A016	Issue rent bills and review rent for following year	April 2016	SL/BS	Determine rent increase for following year
A017	Review waiting list	April 2016	SL/BS	Rationalise list
A018	Update webpage	April 2016	SL/BS	Provide up to date information
A019	Hold stakeholder meeting	September 2016	SL/BS	Annual meeting to discuss issues and opportunities
A020	Promote allotment gardening	April 2015	SL	Organise local competitions, open days, projects
Year 3 (2017/18)				
ID Number	**Task**	**Timescale**	**Lead Officer**	**Commentary**
A021	Issue rent bills and review rent for following year	April 2017	SL/BS	Determine rent increase for following year
A022	Review waiting list	April 2017	SL/BS	Rationalise list
A023	Hold stakeholder meeting	September 2017	SL/BS	Annual meeting to discuss issues and opportunities
A024	Promote allotment gardening	April 2015	SL	Organise local competitions, open days, projects
Year 4 (2018/19)				
ID Number	**Task**	**Timescale**	**Lead Officer**	**Commentary**
A025	Issue rent bills and review rent for following year	April 2018	SL/BS	Determine rent increase for following year
A026	Review waiting list	April 2018	SL/BS	Rationalise list
A027	Hold stakeholder meeting	September 2018	SL/BS	Annual meeting to discuss issues and opportunities
A028	Promote allotment gardening	April 2015	SL	Organise local competitions, open days, projects

Year 5 (2019/20)				
ID Number	**Task**	**Timescale**	**Lead Officer**	**Commentary**
A029	Issue rent bills and review rent for following year	April 2019	SL/BS	Determine rent increase for following year
A030	Review waiting list	April 2019	SL/BS	Rationalise list
A031	Hold stakeholder meeting	September 2019	SL/BS	Annual meeting to discuss issues and opportunities
A032	Review Strategy	September 2019	SM	Report to Cabinet
A033	Promote allotment gardening	April 2015	SL	Organise local competitions, open days, projects

7. Monitoring and Review

It is proposed that the aims and objectives will be reviewed and updated every year so that they reflect any changes in government, corporate, site and tenant priorities. Part of this review process will be undertaken through meetings with site representatives and tenants, as well as regular research and feedback. In addition developments with national allotment organisations such as the National Society of Allotment and Leisure Gardeners, will be included within the review processes. The Action Plan will be amended accordingly each year and progress will be reported annually to the Cabinet of the Council.

At the end of the 5 year life of the Strategy, a full review will be undertaken.

8. Conclusion

The history of allotments has always reflected the changing needs of our society. At the beginning of the twenty first century people are increasingly searching for ways of improving the quality of their lives. Concerns over health and diet are encouraging people to garden on an allotment. The intensity of urban living and loss of open spaces strengthens the value of allotment sites as ‘being in the country whilst living in a town.’ The variety of habitats within an allotment site allows them to develop as vital wildlife habitats, enhancing the biodiversity of an area and adding to ‘green corridors’.

Finally the fast pace of twenty first century life leads increasingly to a sense of isolation and loss of community. Allotments allow people to enjoy a sense of being in a strong community, where people get to know each other well, to talk, share ideas and make friends.

In recognition of the vital role allotments have to play within the Borough this Allotment Strategy aims to build on current good practice and from this develop a vibrant, sustainable allotment community.

APPENDIX A

Allotment Tenancy Agreement and Rules

The Allotment site is managed ("the site") on behalf of Newcastle-under-Lyme Borough Council ("the Council")

This agreement explains the rules that you and we must obey when the council let you an allotment. Do not sign this agreement unless you understand and agree to be bound by these rules.

1. Rent

a. The plots are to be let on an annual tenancy, which commences on 1st April each year and ends on the 31st March the following year.
b. All tenants agree to pay a rent payable in advance for the months due up to 31st March that year or following year, this will be apportioned at a rate of 1 / 12th of the annual sum. This payment is due in one annual payment in advance on issue of the agreement, and each subsequent rent demand on April 1st each year, which is non-refundable.
c. Failure to pay the rent by the due date will result in termination of the agreement.
d. The current rent for the year (20---) is £0.----- pence per m2
e. The council will review and fix the rent annually and advise tenants in writing 3 months before the increase is to take effect. The tenant will be deemed to have accepted the rent increase unless they give notice to terminate the tenancy.
f. There will be a surcharge for mains water and the council will review and fix the charge annually and advise tenants accordingly.
g. A concessionary rate of 20% reduction in the annual rent will be available to tenants who are over 60 years of age or who are unemployed. Tenants will be required to provide proof of qualification for the concessionary rate every year prior to tenancy renewal and payment of rent.

2. Conditions of Letting for the Council.
The Council will:

a. Divide the allotment land into plots (allotments) of an approximate size of between 150 - 250 Sq m or other size to be agreed in advance.
b. Provide a key for each allotment holder (there will be a £10.00 deposit paid by the tenant with the initial tenancy rent, with £5 returned at the end of the tenancy)
c. Not agree to succession tenancies. A plot may only be recorded as being a joint tenancy with the prior written agreement of the Council at the outset of the tenancy.
d. Define the proportion split of the allotment between leisure area and vegetable growing, this will be a maximum of 25% leisure area, with the remainder for vegetable, fruit and flower growing.
e. Have a plan of the site, with a register of plot holders, the vacant plots, keep and manage a waiting list of those persons wishing to rent a plot on that site
f. Identify any plot deemed as neglected and will give notice to the plot holder

that the situation will have to be rectified within 30 calendar days otherwise the tenancy will be terminated and the plot allocated to the next person on the waiting list. Mitigation such as illness will be taken into account where this has been advised to the Council Officer managing allotment sites.

g. Allow a person to be on only one allotment waiting list, and have only one plot.
h. Priority in plot lettings will be given to residents of the Borough of Newcastle-under-Lyme.

3. Conditions of Letting for the Tenant

The Tenant will:

a. Use the allotment / leisure garden during daylight hours for growing vegetables, fruit and flowers for their personal use (but not by the way of trade or business)
b. Not cause any nuisance or annoyance to any other person, including other allotment tenants and neighboring residents.
c. Not use glass in constructions of any sort e.g. greenhouses, cold frames etc without the prior agreement of the council, and keep all glass maintained safely, removing broken glass immediately.
d. Not light fires or burn anything on the site.
e. Be restricted to one shed per plot, which will be apex in style, maximum size 2.44 x 1.83 (8 ft x 6 ft) and or a poly-tunnel no longer than 5 meters in length x 1.83 wide by 2.44 meters high.
f. Require written permission from the Council prior to erecting any additional structure on the plot (e.g. poly tunnels, additional sheds) (see note above)
g. Not keep any livestock (e.g. cattle, pigs, horses, rabbits, chickens, pigeons etc)
h. Park within the defined parking bays only (where these are provided) and use the site roadway for unloading purposes only
j. Not use any of the following items on the plot: barbed/razor wire, tyres, carpet underlay (horticultural weed suppressant material is allowed)
k. Remove any harmful material from the allotment plot
i. Be responsible for any guests and their subsequent actions. Any child under the age of 16 must be accompanied by a responsible adult
n. Lock the gates upon entering and leaving the site.
o. Report any damage to the site to the Council or Site Steward as soon as is possible.
p. Not use the allotment for storage of vehicles or goods, or the storage of any crops which have not been grown on site
q. Keep all paths clean and tidy, maintain and trim hedges and not obstruct access for other allotment users.
r. Not fly tip or dump rubbish on any part of the allotment site.
s. Not underlet, share, sign or part with the possession of the allotment or any part of it.
t. Allow access to council staff, at any time to enter and inspect the allotment. This includes access to any building.
u. Keep all dogs on a lead when on allotment land, including when on the paths.
v. Advise the council if changing your address to allow correspondence to be sent to you.
w. Give back the allotment in good condition at the end of the tenancy period. (the Council will pursue recovery of cost to clear a badly littered plot from tenants)
x. Not remove from the plot any identification number affixed to the plot by the

Council.

y. Maintain the plot in a proper state of cultivation; weed free with the soil kept in fertile condition.

4. Termination of the Agreement

If any of the rules are breached termination of this agreement may result.
It is hereby agreed and declared that the tenancy may be terminated:

a. By the Council, by giving twelve months notice to quit, expiring on or before the 6th day of April, or on or after the 29th day of September in any year;or.
b. By the Tenant, by giving three months or longer notice to quit; or
c. By the Council, by re-entry upon the allotment garden after three months previous notice in writing to the Tenant on account of the same being required by the Council for a purpose (not being the use of land for agriculture) for which it was acquired by the Council, or has been appropriated under any statutory provision; or
d. By the Council, by re-entry upon the allotment garden for non-payment of rent or breach of any term or condition of this agreement by the Tenant, or on account of the Tenant becoming bankrupt or compounding with his creditors.
e. In the event of non-cultivation, the Council will give 30 days notice, followed by 7 days Notice to Quit if cultivation is not resumed within the 30 day period.

5. Notice of Termination

Any notice to be served on the Tenant may be served personally, by the Council , or by leaving it at his/her last known address, or by recorded delivery addressed to him/her or by posting a notice on the allotment plot.

6. Agreement

As witness the hands of the parties hereto the day and year first before written.

SCHEDULE

Plot Number: :

Site: :

Signed on behalf of the Council
and in the presence of:-

Head of Operations

Counterpart
Signed by the tenant in the presence of :

Name & Address:
Telephone:

ALLOTMENT OPERATING PROCEDURES

Procedure for Notice of Non-Cultivation: -

1. Any complaints received to be forwarded via service request e-mail to Community Management Section.
2. Community Management Section to follow up complaints and undertake general inspections of sites.
3. Community Management Section to issue a non-cultivation notice (30 days) to plotholder if appropriate.
4. Community Management Section to re-inspect plot 30 days later.

Procedure for Notice to Quit: -

1. Following the above, if non-cultivation still evident, Community Management Section to issue a Notice to Quit (7 days) as follow up to Non-cultivation notices.
2. Community Management Section to re-inspect plots 7 days later.
3. If no improvements have been made Community Management Section to evict tenant and offer allotment plot to next person on the waiting list.

Procedure for new tenants: -

1. Current procedure to be followed when offering vacant plots to potential tenants

2. Community Management Section to ascertain what services the new tenants require from the Council to help them start.

   It should be noted that the service is offered as an aid to the new tenant for an agreed fee and that the tenant is free to undertake the work themselves which may prove more beneficial in the long term [especially cultivation].

   - The four services on offer are;
   - Plot clearance – removal of rubbish, old sheds etc. = £
   - Vegetation removal – Usually strimming but also removal of unwanted fruit trees etc. = £
   - Weed killing – with glyphosate weedkiller = £
   - Cultivation – Usually rotavating = £

   When offering service, tenant to be advised that work will be undertaken upon receipt of payment.

3. Community Management Section to advise Streetscene team by e-mail which if any of the above services are required by new tenant.

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REPORT TITLE **On Street - Civil Parking Enforcement**

Submitted by: **Engineering Manager – Graham Williams**

Portfolio: **Environment and Recycling**

Ward(s) affected: **All**

Purpose of the Report

To seek approval of the proposal for on street Civil Parking Enforcement within the Borough of Newcastle under Lyme to continue to be operated on behalf of Staffordshire County Council using existing staff.

Recommendations (to be in bold)

That members:

1. **receive the report**
2. **approve the proposal to continue to undertake on street Civil Parking Enforcement on behalf of the county council under the terms as contained within this report**

Reasons

The on street Civil Parking Enforcement has been operated by NBC staff since November 2007, the County Council are undertaking county wide of how the service is provided by each of the district councils. The County Council intend to give 12 months termination of the current agreement by the end of March 2014. They have requested that each district produce a proposal how the district council would undertake the enforcement.

1. Background

1.1 The County Council introduced on street Civil Parking Enforcement (CPE) within the Borough in November 2007.

1.2 The Borough Council entered into an agreement to undertake the on street enforcement on behalf of the county Council.

1.3 All the other district councils have also entered into a similar agreement.

1.4 When the scheme was set up there was an expectation that the income from the issuing of the penalty charge notices (PCN) would fund the costs of the enforcement.

1.5 As part of the original scheme on street charging has been introduced, in parts of the Borough. Some of the districts have not introduced on street charging.

1.6 There has been a slight surplus which is currently paying back the set up costs. In future years when the set up costs have been repaid, the surpluses would be used to fund traffic related schemes within the area of the Borough Council. The Borough Councils element of the original setup costs was £22,000.

2. Issues

2.1 Whilst Newcastle BC has been showing a slight annual surplus from operating the on street enforcement, some of the other district councils have been operating at a loss (a contributory factor of this loss is due to the lack of on street charging in some of the districts).

2.2 Overall the County Council is operating at a deficit and under the agreements have to reimburse the district councils their losses.

2.3 The back office processing is undertaken by Stoke City Council for both the on and off street issued penalty charge notices. Separate agreements exist between the district councils and Stoke City Council.

2.4 Last year the County Council commenced a review of how the on street enforcement is undertaken in all of the district councils, with a view of improving the efficiency of the service. There has been engagement throughout the process both at officer and member levels. Back ground papers are available on request.

2.5 The County Council intend to give 12 month notice of the agreement to all of the district councils by the end of March 2014, with a new service commencing April 2015.

3. **Options Considered** (by the County Council)

3.1 The County Council have not ruled out any proposals for the on street parking enforcement. Some of the options are:

3.1.1 District councils continue to operate along similar lines that currently exist, under a new agreement. This would provide an efficient and resilient team covering both the on and off street enforcement using NBC existing staff, whom have good local knowledge of area.

3.1.2 A district led consortia provides the enforcement service both on and off street. This could be:

A single consortium which included all the district councils.

A combination of individual districts and consortia of district councils.

3.1.3 One of the main issues with these alternatives is the distance to our closest neighbours and the travelling time that would be incurred on a daily basis.

3.1.4 A County Council contract which would include all the on street enforcement and options for the district councils to buy into the contract for their own off street car parks. The use of an out sourced contract for the whole of the county, would not have the same degree of flexibility in the use of the enforcement staff for ad-hoc alternative duties.

3.1.5 The provision of all the services using a County Council directly employed enforcement team. There would potentially be an increased level of travelling time which would have a effect on the efficiency of the service.

3.2 The existing management of the parking service is lean and efficient, and it is noted that any outsourced elements would need to be adequately monitored to ensure the desired outcome.

4. Proposal

4.1 In view of the apparent success of the previous arrangements within this Borough the preferred option would be for the Borough Council staff to continue to enforce the parking regulations both on and off street.

4.2 The current method of dividing the costs between on and off street is primarily in proportion to the number of PCN's issued; this is relatively simple to administer and it is proposed to continue to use this method.

4.3 Whilst NBC has always returned a slight surplus and has not had any financial support from the county council, any new agreement should include a clause to indemnify the Borough Council of any losses should the legislation change which would have an adverse financial effect on the service.

4.4 Due to the relatively small size of the parking enforcement team, there would be more resilience if the team continued to enforce both on and off street.

4.5 Enforcement of the Newcastle BC's car parks will still be required and it is proposed that some of the existing staff be retained for this purpose, should the County Council not offer the on street enforcement to NBC.

4.6 Upon receipt of the termination of the agreement from the County Council, NBC will give notice to Stoke City Council to terminate the NBC/Stoke agreement.

4.7 A new agreement with Stoke City Council or other provider would need to be produced, the details of which are dependant on the outcome of the County Council's CPE review.

5. Reasons for Preferred Solution

5.1 By having the same staff operating both on and off street there is greater efficiency.

5.2 A combined enforcement team provides greater resilience compared with a team which only carries out off street (car park) enforcement.

5.3 There is no evidence to suggest that there would be any significant improvement to the service as any alternative would still require adequate management.

5.4 The current arrangement has generated a consistent surplus.

6. Outcomes Linked to Sustainable Community Strategy and Corporate Priorities

The proposal contributes to the following corporate priorities:

- A clean, safe and sustainable borough
  The on street enforcement manages the traffic freeing up spaces closer to businesses and our residents.

7. Legal and Statutory Implications

The County Council, the Highway Authority, have the enforcement powers. The Borough Council acts on their behalf in carrying out the on street parking enforcement.

8. **Equality Impact Assessment**

The proposal to continue using the Borough Council parking team to enforce both on and off street would have no change to the impact assessment

9. **Financial and Resource Implications**

9.1 The on street enforcement element of the service does not require Borough Council funding.

9.2 Whilst the Borough Council will not derive any income from any future surpluses, these would be used to undertake traffic related projects in the area.

10. **Major Risks**

10.1 Should the County Council not approve the Borough Council undertaking enforcement on street any surpluses may not be used within the area of the Borough.

10.2 A county wide model may be less effective to due longer travelling distances and the lack of local knowledge built up over a number of years.

11. **Key Decision Information**

This report is not a key decision as defined in the Council's Constitution.

12. **List of Back Ground Papers**

Copies of:

1. Report presented at the December meeting of the Staffordshire Parking Board 2013.
2. Summary of the individual meetings between the district councils and the county council.

HEADING **Proposal for Selective Licensing**

Submitted by: **Gill Taylor**

Portfolio: **Planning and Assets**

Ward(s) affected: **All but specifically Kidsgrove and Ravenscliffe**

Purpose of the Report
To outline the Council's proposal for Selective Licensing to address areas of low demand and anti-social behaviour in key areas.

Recommendations
That officers are authorised to take the necessary steps to prepare a Business Case for the introduction of a Selective Licensing scheme with a detailed report setting out the scheme proposal to be prepared for a future Cabinet.

Reasons
There are several areas within the Borough which suffer from anti-social behaviour and low demand. It is appropriate that the Council considers the extent of the problems and seeks to work in partnership with agencies such as the Police to tackle issues. This report seeks authority to re-align and dedicate officer resources to commence the Selective Licensing project.

1. **Background**

1.1 Over a significant period of time elected members have been raising issues of concern about anti-social behaviour and instability within a small number of neighbourhoods in the Borough, most notably Galleys Bank at Kidsgrove. The focus of these concerns would appear to arise from the transient nature of households occupying private rented accommodation.

1.2 The Housing Act 2004 provides the Council with a range of tools with a view to encouraging private sector landlords to improve management, amenity and safety standard of their properties, and to tackle antisocial behaviour, which in turn will help to improve living standards and improve areas of low housing demand. Under Section 80 and 81 of the Act the Council can designate areas as subject to selective licensing in respect of privately rented accommodation. Selective licensing can be introduced where:

- The area is experiencing low housing demand and licensing, when combined with other measures, will lead to improved social and economic conditions.
- The area is experiencing "significant and persistent" anti social behavior and that private landlords in the area are not taking appropriate action to tackle this.

1.3 Selective Licensing means that private landlords who own properties in designated areas will have to obtain a licence in order to operate. There are certain mandatory conditions which must be included in a licence. These are for landlords to:
• provide a gas safety certificate annually;
• keep electrical appliances and furniture (supplied under the tenancy) in a safe condition;
• keep smoke alarms in proper working order;
• supply the occupier with a written tenancy agreement; and
• demand references from persons wishing to occupy the house.

Additional conditions can also be included in the licence, these could be:

- to take reasonable and practicable steps to prevent or reduce antisocial behaviour;

- to supply tenants with their contact details; and
- to carry out repairs and other legal obligations within a reasonable time.

2. Issues

2.1 In order to develop the Selective Licensing project a number of work streams will be undertaken and these can be summarised as follows:

- A statistical evidence base to demonstrate that selective licensing is justified,
- The Council must consult with people who are likely to be affected – tenants, landlords, managing agents, local residents and businesses for a minimum period of 10 weeks.
- Selective licensing must be coordinated with wider strategies for dealing with anti social behaviour and regeneration.
- Consider whether there are alternative means of addressing the issues e.g voluntary accreditation.

3. Options Considered and Reasons for Preferred Solution

3.1 Cabinet members wish to explore the scope for introducing selective licensing or identifying other appropriate ways forward and therefore it is recommended that officers commence data collation and the required analysis. The outcome of this exercise would then be assessed against relevant strategies and existing work programmes to establish the most appropriate course of action. It is envisaged that officers would report back to Cabinet before proceeding with any public consultation exercise.

4. Outcomes Linked to Sustainable Community Strategy and Corporate Priorities

4.1 Tackling low demand and antisocial behaviour clearly contributes to the Corporate Priorities of a Clean Safe and Sustainable Borough and a Borough of Opportunity.

5. Legal and Statutory Implications

5.1 Prior to introducing any Selective Licensing scheme the Council will consult all persons likely to be affected and produce a report with robust evidence of the problems and indicate other strategies which have been tried and failed. Failure to meet the requirements could result in local authority facing a threat of judicial review and an award of costs against the Council.

6. Equality Impact Assessment

6.1 An Equality Impact Assessment will need to be completed as part of any consideration of a proposed scheme.

7. Financial and Resource Implications

7.1 At this stage it will be necessary to commit to adequately resourcing the project and to that end the service work plans will be reprioritised to provide the necessary capacity. The setting up of a licensing scheme will be resource intensive and a full business case will be presented alongside the proposals. A multi agency working group will also need to be established. Information on the resource requirements will be presented as part of the Selective Licensing proposal.

7.2 In order to collate information on antisocial behaviour and property ownership officers will work with partner agencies such as the Police. This will be cross referenced with suitable information from Council Tax and Housing Benefit records alongside land registry checks.

The costs of completing the land register checks for a pilot area like Galleys Bank will be in the region of £1,500 and this will be funded from existing budgets.

8. **Major Risks**

8.1 The Council needs to ensure that any scheme is thoroughly researched and supported by a robust evidence base and that proper consideration is given to the appropriate scheme prior to the necessary consultation been undertaken. Any such consultation exercise in its self will need to be undertaken both rigorous and robustly in order that the Council can demonstrate the views of all interested parties have been taken into account in the process. A full risk assessment and legal opinion should accompany the project proposal to minimise the risk of legal challenge to the implementation of any scheme.

9. **Key Decision Information**

9.1 This is not a key decision.

10. **Earlier Cabinet/Committee Resolutions**

10.1 None.

11. **List of Appendices**

11.1 None.

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