Appendix 1: Draft BCF plan submission template

Staffordshire County submission

Draft 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 13th February 2014

Date submitted:

14th February 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 *(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>
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>

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>
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
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

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, building on the existing contractual arrangements, while ensuring these discussions are fully informed regarding, and guided by, the broader strategic context. 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.

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.

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.

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	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

	Wellbeing Strategy 2013-2018	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

2. Vision and Schemes

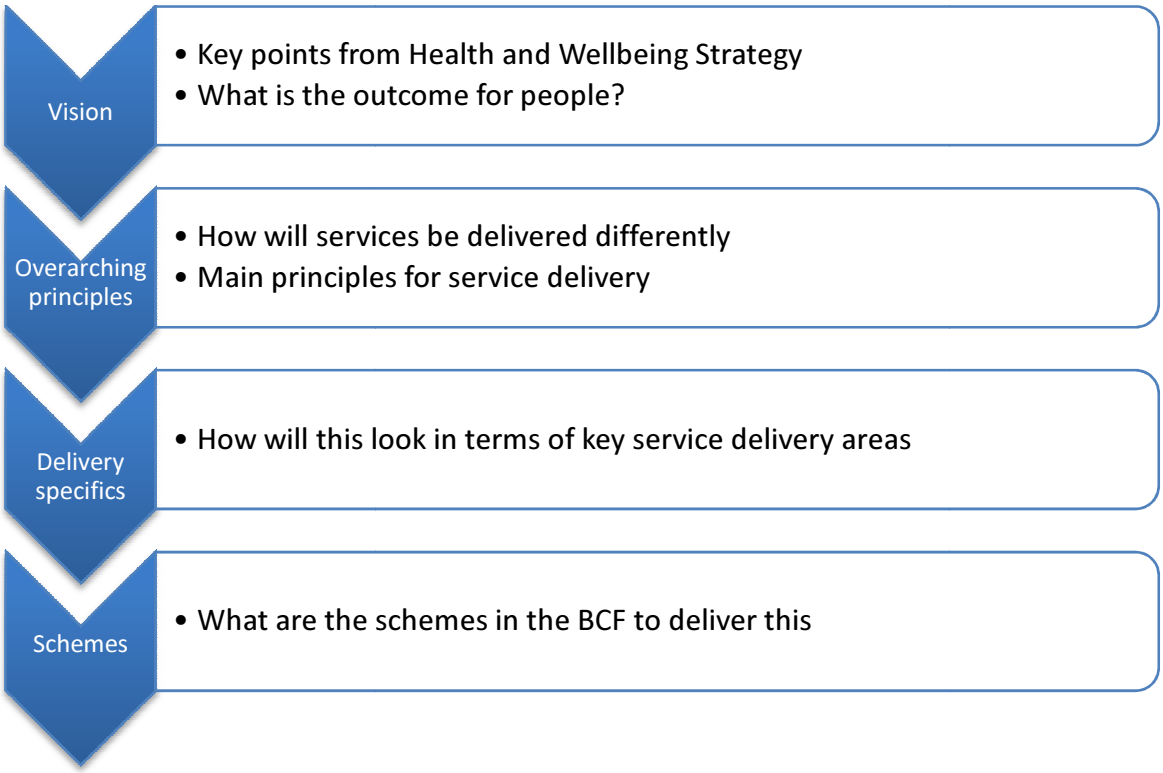
a) Vision for Health and Care Services

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:



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 through overarching principles including:

- 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.

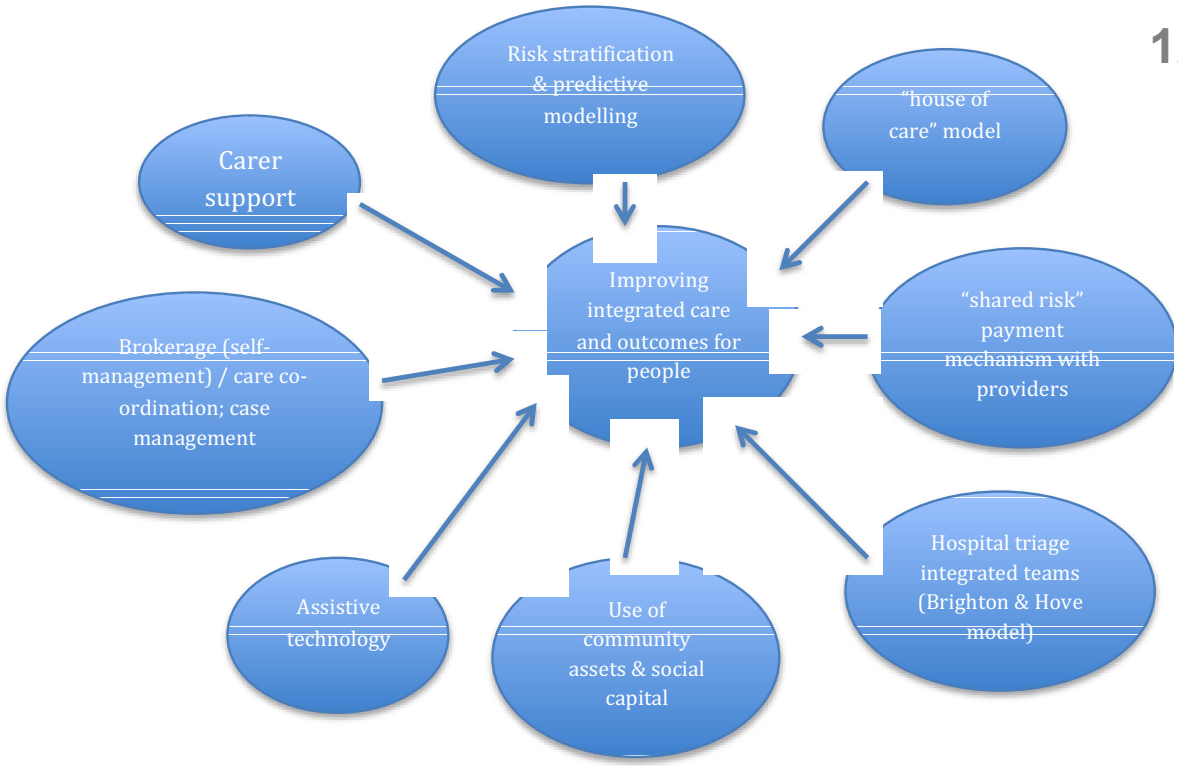
Work is already well underway in Staffordshire (aligned with strategic partners in Stoke-on-Trent) to address the above-noted issues in the context of the following areas of activity. These will be the basis of this Better Care Fund submission.

- **Frailty/complex needs/long term physical and organic mental health conditions**
- **Learning disability**
- **Mental health**
- **Carers**
- **End of life care/Cancer**
- **Community equipment**
- **Major housing adaptations (Disabled Facilities Grant)**

Service delivery

In practice this is likely to translate into different approaches for different service delivery areas. As an overarching approach, a number of areas are being developed and/or expanded as set out below. 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.



What follows is the planned approach for different service areas:

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 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.

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.

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.

Falls Prevention is a major plank of the Frail Elderly programme, with plans taking shape for increased involvement of Districts to work with Public Health partners in delivery of improved Falls Prevention programmes linked with Equipment and DFG delivery.

Re-organising **domiciliary care** provision to deliver home and community support which is more integrated with health, is in early discussion. The model being considered is based on the work of Wiltshire, Royal Borough of Windsor and Maidenhead, and Oxfordshire, and looks at commissioning for individual outcomes, rather than a time and task-based model, and linking with health. Improving **medication management** may be a part of this redesigned service, although equally may sit separately as part of the GP multi-disciplinary teams.

Personal Health Budgets 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.

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 Stoke-on-Trent and Staffordshire 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 specification, 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.

Mental Health

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.

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.

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.

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.

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 all long term conditions). To achieve this, the CCGs will tender for a prime provider for each pathway (relating to cancer services for three tumour sites initially – lung, breast and bladder/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.

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.

Major housing adaptations (Disability Facilities Grant)

Currently held and delivered separately by District authorities, 2014/15 will see a major shift in activity towards the development of a pan-Staffordshire approach to commissioning and delivery of DFG's. The outcomes for people will be a better aligned and more cost-effective

delivery with improved outcomes for people at local levels. The new shape of delivery of DFG's will deliver better outcome in the following areas:

- Enable people to remain living safely and independently in their own homes
- Promote resilience and sustainability so less likely to need care and health support
- Ensure consistency of service delivery and quality across Staffordshire

Improved strategic commissioning

Central to this 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 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.

Case studies

In practice the vision can be shown through individual stories that reflect some of the people in Staffordshire and their needs:

I have learning difficulties. I live at home with my mum who is called Rose. I am 50 and my mum is 76. I went to the local school and I have had different kinds of jobs, sometimes I haven't worked. My mum and I have always looked out for each other. I recently had a cervical smear test. I have noticed that mum is not remembering to do the things she used to do and we have started shouting at each other. She sometimes has problems getting to the toilet and I am not sleeping well. We had a big fight and mum fell over and hit her head. I called an ambulance. When we got to hospital they arranged for some people to come to the house for a few days to check mum was ok. Mum now gets someone who comes in everyday and I know who I can ring if I need help. We are thinking about what might happen in the future and I had some extra help for a short time to help me learn some of the jobs mum has always done.

Jenna is helped to plan for her future and to increase her independence skills, thus potentially offsetting the costs of future high-cost residential care for her when her mum is no longer able to care for her. Mum is checked regularly and provided with respite care so that she can continue to act as carer to her daughter as long as she wants to and is able to. Both Jenna and her mum have a named care coordinator and a single patient and care record so they only tell their story once when needing care.

I am 86. I have type 2 diabetes, arthritis and need regular sight tests. I live in my own home, where I have lived for 30 years. My wife died 3 months ago. I get advice from my GP practice about my diabetes. In the last 6 weeks I called an ambulance twice because I had fallen at home, ending up at accident and emergency the second time. The intermediate care team visited me at home after discharge from A and E. They said they thought I might benefit from some extra support at home for a few weeks as I explained I had stopped doing most things as my wife was the organiser. I said I didn't want lots of strangers coming into the house.

They had a chat with the 'floating support' service who sent Alan and Mary to come and see me the next day. They sat down and we talked about the things I was finding hard to do and the fact that I was lonely. They organised for me to buy a personal alarm system and found out what happened at the community centre. I wanted to go back to church. Alan helped with both. I have some meals brought to the house now. I have had new glasses and I get a lift to the centre from a neighbour I had lost contact with, I go to church very week. Alan and Mary stopped coming after a few weeks.

John is able to increase his ability to care for himself, and his GP is going to provide him with telehealth services, which monitor John's diabetes and send the details straight to his GP. This reduces the need for John to travel to visit his GP and increases his sense of being in control of his disease. John's GP surgery coordinates all his care needs and he has a single care record using his NHS number to make sure he only has to tell his story once. John knows that if he needs to go into hospital there will be support 7 days a week so he doesn't have to worry about becoming ill at the weekend. The local community now provide support so John doesn't need paid carers any more, but he feels confident about who to talk to if he should need more support in the future.

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 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 be 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 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

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.

- 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 through the following mechanisms:

Targeted prevention and early help – Staffordshire already focuses on supporting people in their own homes, boosting their independence and preventing them from requiring higher levels of intervention. The further development of step up (reducing the likelihood of needs escalating) and step down (enabling people to achieve a maximum independence and ensuring interventions are time limited and the likelihood of 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.

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 comprising populations of between 25-30,000 people.

Stoke-on-Trent and North Staffordshire CCGs Long Term Conditions Year of Care pilot programme will, by 2015/16 fully underpin the activity of the ICTs, first by supporting the early identification of people who would most benefit from such coordinated community support, and second with the implementation of 'capitated' community budgets, incentivising prime providers to take responsibility for individual peoples' 'year of care', and encouraging the development of person-centred, community-based and cost-effective responses to peoples' needs. This knowledge will be complemented by experience in the South around Personal Health Budgets.

With the development of joined-up approaches to commissioning in upcoming years, all of the learning gained in parts of the county from localised and smaller-scale initiatives will be shared with partner CCGs.

Intermediate Care - Whilst it is desirable to support people and meet their needs with services at the lowest level of acuity as near to their homes as possible, it is inevitable that people will on occasion need acute hospital care. However, people can stay for too long in acute sector services for want of the specific support that they need to regain their strengths and skills and return home.

Intermediate Care responds to the needs of people requiring rehabilitation, reablement and recovery in the least dependent settings appropriate to their needs, resulting in improved outcomes for patients, reduction in unplanned attendances and admissions, and with a greater emphasis on community rather than bed based services. Joined-up Intermediate Care services are a key service component to ensure people stay healthy and independent for longer.

In South Staffordshire, an innovative approach around Experience Led Commissioning has resulted in a new model of intermediate care; more focussed on supporting people back into communities.

In 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.

Frail and complex approach – 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. In North Staffordshire, the community model of care specifies a specialist frail and complex MDT and ‘directorate’ that works across acute, community and primary care. This is based on integrated and co-ordinated provision that recognises the value of combining expertise from multiple organisations and crosses traditional boundaries to deliver continuity of care throughout the patient journey.

Approach in North Staffordshire

This Frail Complex capacity will work in conjunction with the Intermediate Care service and will provide access for GPs to consultant geriatricians. A ‘Star Chamber’ of senior clinicians in North Staffordshire has been established to further this work, some elements of which have commenced. The fully-fledged Frail Complex capacity will be mobilised in 2014/15. The support will

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

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

Approach in South Staffordshire

In South Staffordshire there is a slightly different approach. Whilst recognising the need to ensure appropriate medical support to frail older people, there is an enhanced focus on building an asset based community development approach.

The key elements in South Staffordshire are as follows.

- Support to nursing homes
- Community geriatrician support
- Wellbeing hubs where older people can enjoy activities such as singing groups.
- Scaling up programmes such as ' Lets Work Together' which is a programme across agencies e.g. voluntary sector, police, fire and rescue and health which identifies individuals at risk and co-refers for relevant support

Locality Based Capacity Building

As a two tier authority Staffordshire recognises the unique role of districts and boroughs in delivering the HWS and the ambitions of BCF. The specific element in the BCF around Disabled Facilities Grants (DFGs) is a small part of their contribution. District Councils are vital in the process of bringing in wider local partnerships, co-ordinating and facilitating local delivery to maximise opportunities and to ensure connectivity. Districts have that local intelligence and can co-ordinate to ensure county/health commissioning intentions are translated effectively on the ground to reflect local need. For example, councils will use levers around planning, leisure etc. to link into initiatives to support delivery e.g. Tai Chi classes for older people to improve balance and reduce falls.

The Health & Wellbeing Strategy has a strong focus on empowering communities to become more cohesive and resilient, exploring opportunities to create connections in communities which help support the preventative agenda. Districts will play a major role in delivering this.

Support to Carers

Carers provide a significant role in community, and the draft Care Bill places a duty of Local Authorities to assess Carers 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.

Primary Care Led Services

Primary Care Led Services are currently being explored by South East Staffordshire & Seisdon Peninsula CCG, and offer a similar approach to the Integrated Local Care Teams in North Staffordshire. These Primary Care Led Services based around GPs will not only offer 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.

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 the 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.

Mental Health Services Transformation

In April 2014, we will have a clearly articulated strategy, co-produced with providers to describe how we want services to respond differently to those suffering mental distress. As with other client groups, the aim is to shift care to prevention 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.

Transforming Cancer and End of Life Care Programme

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.

Delivering Digital Technology at Scale

Partners will take a coordinated approach to digital health and social care to ensure we maximise benefit and pool expertise. **Linked Programmes of Work**

The Staffordshire Health and Social Care economy has a solid foundation based upon joint working, a clear strategic direction and priority initiatives to deliver. We recognise, however, we are on a journey and need further pieces of the jigsaw before we can have full assurance about our delivery. Further work is required to model the impact of these changes and create a joint plan which creates a sustainable system going forward.

There are a number of pieces of work going on which will move us to a position by the summer of 2014 where further clarity is achieved.

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.

An overview of the timeline of the anticipated implementation of aspects of the programme is set out below:

Timeline for BCF plan implementation

	Scheme	sub-element of scheme	narrative	2014/15
1	**Existing NHS Transfers**			
2	**Care Bill / transformation / care expansion**		assessment of financial impact and re-evaluation of funding sources	
3	**CCG reablement**			
4	**Carers**	Carers support programme	develop co-produced service re-design impement redesigned service	
5	**DFGs**		integration at County level of housing adaptations, leading to more consistent approaches, improved service delivery and reduced delays	
6	**ASC Capital Grant**			
7	**Community Equipment**		programme continues	
8	**Learning Disabilties**		Programme expanded to increase the use of community-based services, reducing the impact on acute care through a specialist team offering **intensive support services.** work with market and independent sector to co-design supported living options for the future. Work with housing and district/borough councils to increase opportunities and reduce the need for intensive residential care packages	
9	**End of Life Care**		Integration Pioneer programme working with Macmillan across Staffordshire 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 model in place delivery of services to achieve outcomes set	
10	**Flexicare Homes**		expansion of flexi-care homes, offering better choice of approapriate accommodation for people	
11	**Frailty / Complex Needs / LTC / OP**	Intermediate Care, reablement, rehabilitation	Service specification developed, Tender planning new service in place	
		Long Term Conditions	Service specification developed, Tender planning new service in place	
		Stoke on Trent and North Staffs Intermediate Care pilot	programme will see the alignment of social care Intemediate 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.	
		North Staffs & Stoke on Trent Intermediate Locality Care Teams Long Term Conditions	integrated locality teams in place and operational	
		Year of Care staffordshire hospital avoidance scheme	pilot started exploration of schemes, focusing initially on the Brighton & Hove approach to hospital triage teams to steer people away from A&E and reduce non-elective admissions. implement pilot	
		GP-based Integrated Care Teams in place		
		Falls Prevention programme	work continues with Districts, Public Health and CCGs to coordinate and expand offer	
		Domiciliary Care programme	evaluation of existing good practice, develoment of pilot programme	
		Personal Health Budgets	expansion of PHB programme	
12	**Mental Health incl. Dementia**	Rehab and recovery	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. pathway and services in place	
		Dementia care	Review of current service delivery to assess where more integrated services could be implemented working with the 3rd sector and NHS providers to co-design delivery models.	
14	**Assistive Technology / Telehealth**	Telecare/health	Digital Programme Board driving the adoption of technology to improve outcomes, transform services and create efficiencies at scale and pace. Will include: Telecare; telehealth; mobile apps and online self-management support; clinical video conferencing and tele-diagnostics manage implementation and benefits tracking for live integrated services and developing next stage of joint commissioning plans in line with local needs, JSNA and HWS	
15	**overarching**		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 2015/15 and prior.	

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 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 steps are working this plan through in more detail with NHS partners.

Some early signs of potential for savings are set out below, these are indications from individual schemes which form part of the BCF plan.

In North Staffordshire, 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.

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.

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 telecare has just been launched as part of the BCF plan and 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 and 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
- 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. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is 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 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.

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.

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.

Staffordshire County Council has a contract option to work with their IT supplier (CareWorks) to aim for PDS (Personal Demographics Service) integration in the coming year to enable us to search live and retrieve NHS numbers and related demographic data directly from the NHS. CareWorks are currently working with Coventry City Council and Connecting for Health on a first of type integration. SCC already has an N3 connection in place and is close to achieving the prerequisite 95% of clients already having a valid NHS number through our DBS work.

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

34

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 not the case, 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 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

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

Risk	Risk rating	Mitigating Actions
CCGs are unable to make the 3% savings required	Medium	
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 recommissioning 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	Medium	As above

to protect existing services		
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	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
Different local population needs may prevent development of Staffordshire-wide solutions	High	Local solutions will be appropriate in many areas, and options for geographical approaches will be part of the service delivery planning
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.