Staffordshire Better Care Fund

Staffordshire County Council

Cannock Chase Council

East Staffordshire Borough Council

Lichfield district council www.lichfielddc.gov.uk

Newcastle Under Lyme

South Staffordshire Council

Stafford Borough Council

Staffordshire Moorlands District Council

Tamworth Borough Council

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.

Contents

Appendix 1: BCF plan submission template

Staffordshire County submission

1. Plan Details

a) Summary of plan

Local Authority

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

Clinical Commissioning Groups

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

Boundary Differences

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

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

Final sign-off 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

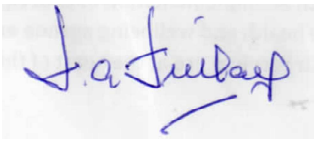
Signed on behalf of the Council 	East Staffordshire Borough Council
By	Councillor Dennis Fletcher
Position	Deputy Leader (Built Environment)
Date	4th April 2014

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

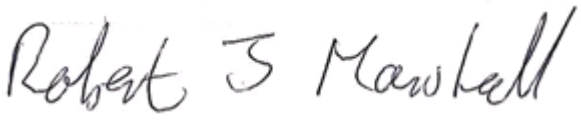
Position	Leader
Date	4th April 2014

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

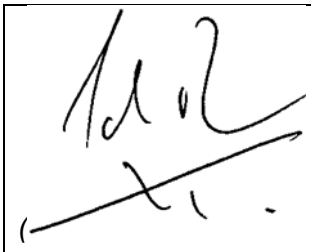
Signed on behalf of the Council 	Stafford Borough Council
By	Councillor Finlay
Position	Cabinet Member for Environment and Health
Date	4th April 2014

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.

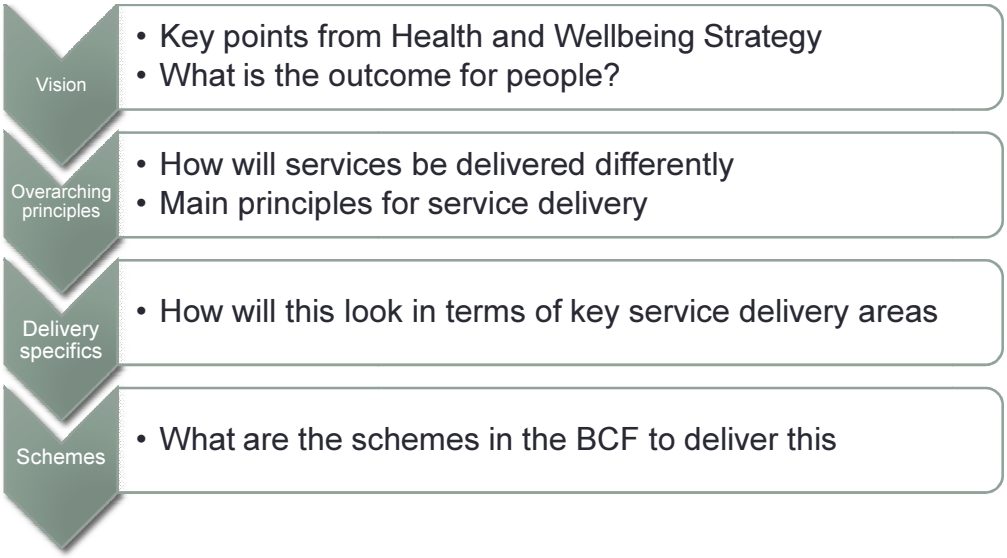
Our aim is to address the following priority areas:

- **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:- o Tele-care (reminders and devices to support independence) o Tele-health (remote monitoring of health parameters) o Mobile Apps and online self management support (patient facing support for tele-care & tele-health) o 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.

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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.