Staffordshire Better Care Fund

Staffordshire County Council

Cannock Chase Council

East Staffordshire Borough Council

Lichfield district council www.lichfielddc.gov.uk

Newcastle Under Lyme Borough Council

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 xxxxx, work has progressed and this will be evident in this revised version.

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 11th September 2014

Date submitted:

19th September 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

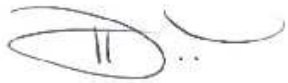
b) Authorisation and signoff

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	xxxxx

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

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

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

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

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

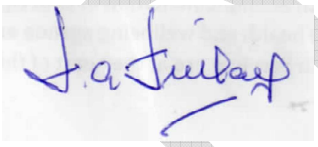
Signed on behalf of the Council Muriel A Davis.	Cannock Chase District Council
By	Councillor Muriel Davis
Position	Health and Wellbeing Portfolio Holder
Date	xxxxxx

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

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

Signed on behalf of the Council 	Newcastle-under-Lyme Borough Council
By	Councillor Gareth Snell
Position	Leader
Date	xxxxx

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

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

Signed on behalf of the Council	Staffordshire Moorlands District Council

	
By	Councillor Gillian Burton
Position	Cabinet Member for Communities
Date	xxxxxx

Signed on behalf of the Council 	Tamworth Borough Council
By	Councillor Daniel Cook
Position	Leader
Date	xxxxxx

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

Signed on behalf of the Health and Wellbeing Board 	Staffordshire Health and Wellbeing Board
By	Johnny McMahon

Position	**Co-Chair of Health and Wellbeing Board**
Date	xxxxxx

Section 2: Vision for health and social care services

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

The vision for the health, social care and associated services of the future for Staffordshire are set out in the Joint Health and Wellbeing Strategy (Doc2) "Living Well in Staffordshire" 2013-18. At the basis of 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:

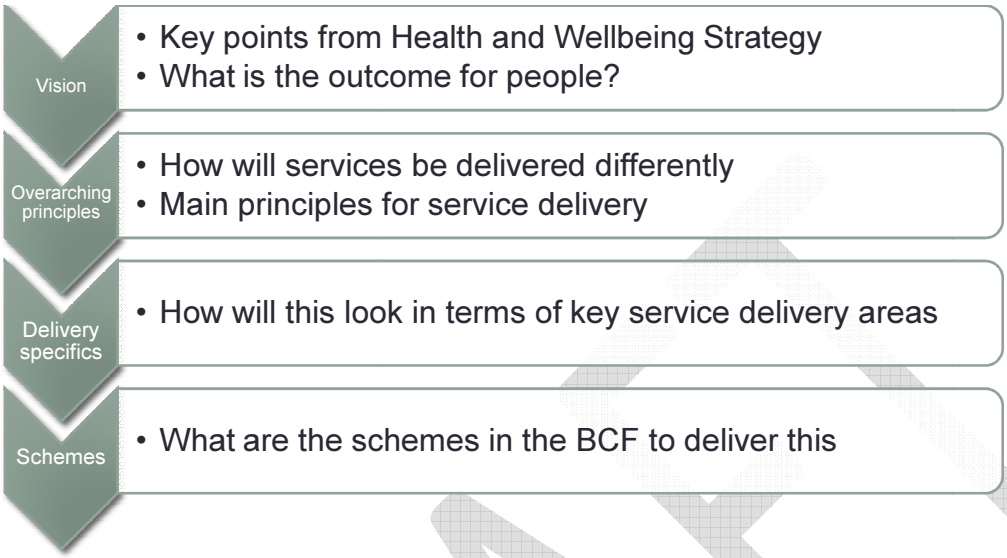
- **Increase life expectancy** for all, and bring it in line with the rest of the country.
- **Reduce health inequalities**, and close the gap between those most and least advantaged.
- Properly **support people with long-term conditions** and/or complex needs to live independently.
- Ensure that **people 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:-



b) What difference will this make to patient and service user outcomes?

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

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*

c) *What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?*

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

- 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
- Should we include some text regarding the KPMG report?

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.

Section 3: Case for Change

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

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

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

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

The result is an increased demand for elective NHS, non-elective NHS and social care services. A 'do nothing' option would result in a massive increase in the need for services, be unaffordable (an estimated deficit in excess of £400m by 2018/19) and lead to system collapse. The scale of change required is dramatic. It has been estimated that this will involve a shift of £200m currently spent in acute hospitals and residential social care (equivalent to 400 beds) to be used to support more effective preventative services in the community. This cannot simply involve a shift in the geographical location of services, doing in the community what used to be done in hospitals. Instead, what is required is a major redesign of the very nature of the care system, doing different things in the community so that needs are met effectively which in turn means there is less demand for bed based acute hospital and residential social care services.

- *Include risk stratification of entire population and segmentation of opportunity to improve quality and reduce costs*
- *Be bespoke to your area, i.e. not a generic narrative about the need for integration that could be relevant to any local area*

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

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

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

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

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

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

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

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

- *Be supported by data – e.g. data that quantifies levels of unmet need, issues of service quality, or inefficiencies in service delivery*

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

- *Provide visualisations of data if appropriate – do you have any graphs or diagrams that illustrate these issues?*

Figure 1 : Non Elective trajectory (is this all age?)

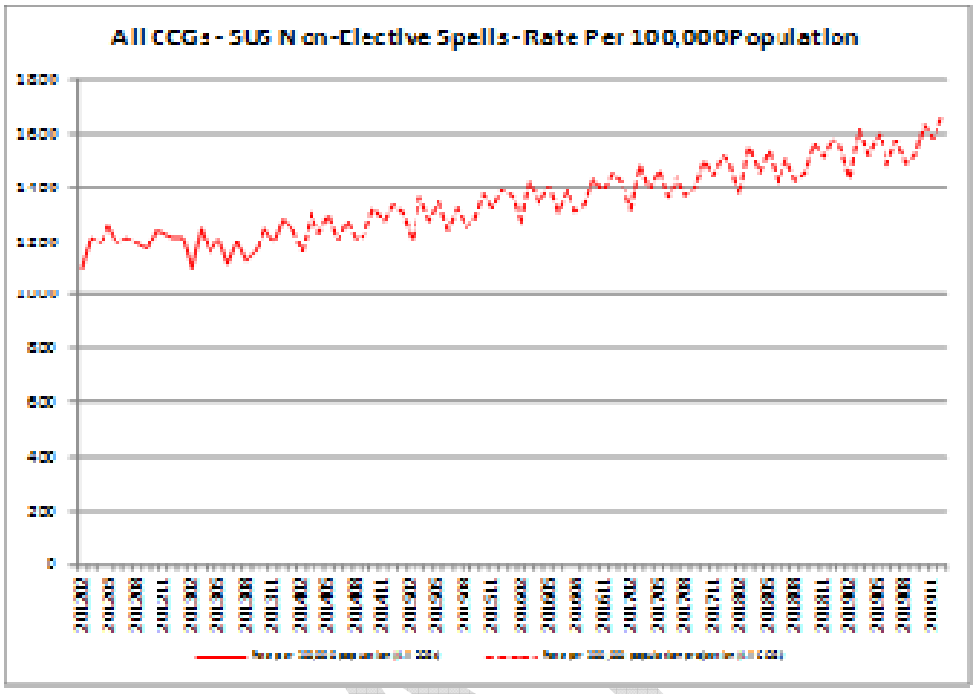
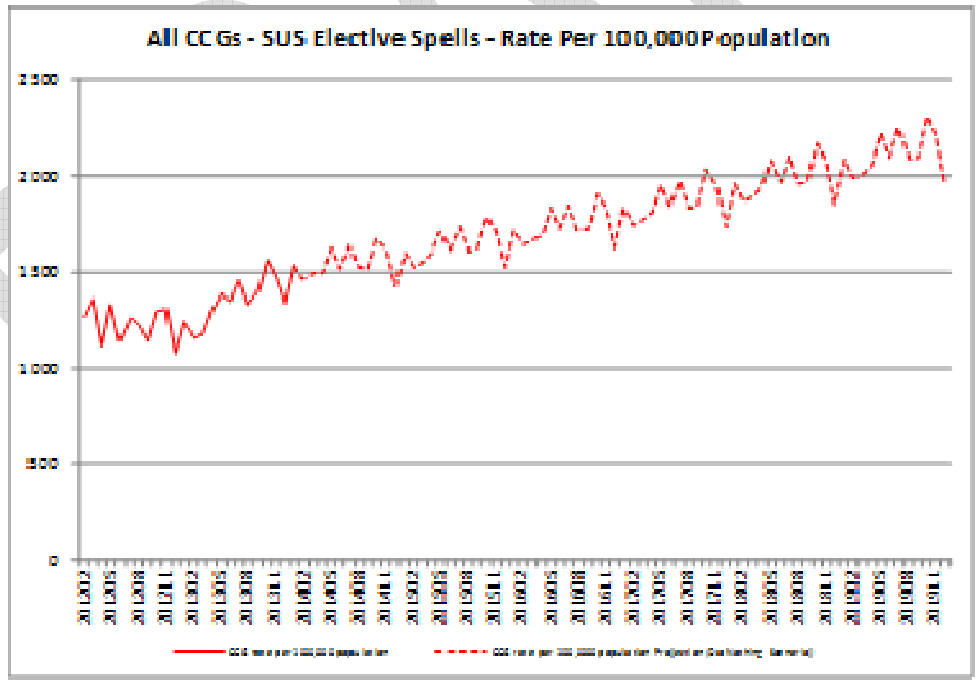


Figure 2 : Elective trajectory



Need to redo for just Staffordshire and add a trajectory about residential care.

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

In Staffordshire we will use integration of systems, process teams and budget to:

- **Simplify care services** by breaking down organisational and administrative barriers, so that people can access the right care at the right time (our approach to integrated commissioning is the means to deliver this)
- **Coordinate service delivery** enabling earlier and faster delivery of more effective care in cooperation with GP practices, community health, mental health, acute providers and the 3rd sector
- **Align our approach to prevention , self-care and support** for people, their families and carers to increase the individuals and family/carers' capability to manage care needs
- **Commission responsive and intensive community based services** supporting people and their families /carers to manage their needs at the least invasive level as possible (our approach to managing risk is key to delivering this)
- **Understand individual needs** by personalised care planning and effective case management in primary /community care, linked to effective proactive case finding and early intervention

Section 4: Plan for Action

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

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.

b) Please articulate the overarching governance arrangements for integrated care locally

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.

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

Current arrangements are that the HWB has overarching responsibility for the achievement of the BCF plan, with executive responsibility delegated to the 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.

d.) List of planned Better Care Fund Schemes

In terms of our strategic intent, these are the schemes which form the basis of this Better Care Fund submission (so far….15.8.2014).

Scheme	Projects	Scheme Ref:
(1) Frail Elderly	Social Care Transfers – Recurrent Funding (S256)	1.1
	Frail Elderly - Admission avoidance and delayed discharges (Stafford & Cannock CCG)	1.2
	Frail Complex – Intermediate Care (South East & Seisdon CCG)	1.3
	Frail Complex – End of Life care (South East & Seisdon CCG)	1.4
	Dementia Care Services	1.5
	Frail Elderly – Reablement & Intermediate Care (North Staffs CCG)	1.6 (Annex 1 missing)
(2) Support to live at home	Disabled Facilities Grant	2.1
	Adult Social Care Capital Grant	2.2 (Annex 1 missing)
	SSoTP Community Frail Elderly (Stafford and Cannock)	2.3 (Annex 1 missing)
	Integrated Locality Teams – (North & Stoke)	2.4 (Annex 1 missing)
	JCU contribution – (North Staffs CCG)	2.5 (Annex 1 missing)
	Children's Equipment - (North Staffs CCG)	2.6 (Annex 1 missing)
	Prevention and Treatment of Acute Illness in Children and Young People	2.7
	Primary Care Contracts & Alcohol (South East & Seisdon CCG)	2.8 (Annex 1 missing)
(3) Carers	Carers Breaks	3
	Mental Health Carers Support	
	Moorlands Older People's Homelink (north)	
	Carers Information	
(4) Mental Health	Psychiatric Liaison	4.1
	RAID	
	IAPT/ Primary Care MH	4.2
	Emotional Wellbeing and Mental Health (CAMHS)	4.3
(5) Care Act Implementation	Care Act Implementation (Revenue Funding)	5
(6) Learning Disabilities	(Funding included from SES CCG)	6 (Annex 1 missing)

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

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.

Section 5 Risks and contingency

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

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

a) Risk Log

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

Risk	Owner	Timeline	Risk rating/ Likelihood	Mitigating Actions
High level of savings required across the health and social care economy (c.£45m) in 2015/16 are unachievable			High	Further discussions with NHS England, Monitor, TDA and DCLG as part of the 'Intensive Support for Planning' work to take place between April and June. Develop a whole system service and financial transformation programme, which addresses the challenges facing each of the partners. Some elements of this plan may be focused on specific parts of the system, building on existing change initiatives. Review good practice from elsewhere, including LGA value

				cases and outcomes of Anytown modelling to identify opportunities for greater impact.
CCGs are unable to deliver plans to reduce hospital emergency admissions leading to inability of the system to make savings intended through the plan			High	Gradual transformation with staged approach to investing in preventative options. Good programme management 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			High	Plans already in place for re-commissioning of services at lower cost which will fund expansion of preventative / community investment
Potential impact of Mid-Staffordshire NHS Foundation Trust changes where redesign is focused on maintaining financial viability of the Hospital rather than supporting changes set out in BCF			Medium	Gradual transformation with staged approach to investing in preventative options. 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.** • **Establishment of reasonable local improvement trajectories and targets.** • **Mechanism for determining 'failure', apportioning responsibility, and withholding**			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 of 4/4 BCF

resource.				
National benchmarks/baselines upon which performance is to be premised may present unrealisable trajectories/targets for local health economy/CCG areas. (See appended metrics document)			Medium	LAT to support the development of locally relevant trajectories/targets where applicable.
Lack of progress against BCF plans leading to not meeting targets and achieving benefits across the system as a whole			Medium	Robust approach to Programme Management. Development of principles around 'rules of engagement' between all partners for the BCF. This will include the development of a number of risk sharing agreements which will clearly articulate the impact of not achieving the deliverables in the BCF Plan. Any risk sharing will include clear lines of responsibility and accountability against performance within the Plan.
Challenge of delivering 7-day working			Medium	These issues will be central to the work on Intensive Support for Planning, addressing the health system aspects of 7-day working. With regard to third party social care provision, steps to expand the ability of the system to extend the times during which assessments can be carried out will be built into wider work to redesign the sector.

b) **Contingency plan and risk sharing**

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

Section 6 Alignment

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

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

c) ***With your plans for primary co-commissioning***

Section 7 National Conditions

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services (not spending)

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

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

By proactively intervening to support people at the earliest appropriate opportunity and ensuring that they remain well, are actively engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services once people have

experienced a crisis. In many cases, this will require a new way of looking at ensuring people's needs are met, with consequent implications for service redesign.

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

Funding currently allocated under the s256 transfers from NHS England to the County Council has been used to enable the local authority to sustain the current level of eligibility criteria and hence to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs. In addition, funding has been employed to ensure effective information and signposting is available to those who are not FACS eligible. In Staffordshire, these existing £16m of transfers from the NHS to social care will be continued under the BCF.

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

This level of financial challenge in the system as a whole demands that we identify new solutions that deliver sustainability across all partners. The County Council and the CCGs are therefore actively seeking to draw together their respective financial and transformational planning. The CCGs and the County Council will work together during the next phase of the BCF process to enhance the transformation programme required to meet this significant challenge.

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

In Staffordshire, the following arrangements apply.

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

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

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

b) Data sharing

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

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

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

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

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

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

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

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

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

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

d) Joint assessment and accountable lead professional

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

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

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

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

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

- Coordination of resources around individuals with multiple chronic disease from one single health or social care professional. Thus recognising the growth in numbers of these individuals and the limitations of traditional 'single disease specific' strategies.

- Reducing the impact of these individuals on acute care resource through prevention (admission avoidance) and slowing of disease progression.

- Potential efficiencies in the delivery of care, particularly against a back drop of rising demand from an ageing population and increase in multiple chronic disease prevalence.

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

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

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

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

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

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

Alongside a range of performance measures

- Percentage of care plans in place
- Percentage of individuals seeing a reduction in risk score
- Percentage of individuals/carers reporting they are confident in managing their own health

- Percentage of individuals reporting an improvement in quality of life
- Percentage of individuals achieving goals set
- Admission avoidance

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

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

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

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

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

professionals who will case manage and use them as a tool for personal and professional development.

- Use the case management competencies to support integrated service redesign and performance management

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

Section 8 Engagement

a). Patient, service user and public engagement

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

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.

b.) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

ii) primary care providers

iii) social care and providers from the voluntary and community sector

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

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

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

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

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

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

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

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

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

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

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

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

c). Implications for Acute Providers

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

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

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

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

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

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

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

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

UHNS is the main acute provider in North Staffordshire and Stoke-on-Trent. There is direct consistency between the Stoke-on-Trent BCF and the North Staffordshire element of the Staffordshire equivalent. As patients from Stafford and surrounds recourse to UHNS, strategic planning between that CCG and those in the north will become increasingly integrated.

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

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

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

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

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

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

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

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

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

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

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

Part 1 – Annex 1: Detailed Scheme Description

See Appendix 1

Part 1 – Annex 2: Provider Commentary

See Appendix 2