DRAFT

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

Scheme ref no. 1.1

Scheme name:

Social Care Transfers – Recurrent Funding

What is the strategic objective of this scheme?

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

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

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

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

Overview of the scheme

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

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

Include narrative from local account about the population supported through Adult Social Care.

The funding is currently allocated under the s256 transfers from NHS England to the County Council and has been used across a wide range of social care interventions, to enable the local authority to sustain the current level of eligibility criteria and to improve outcomes for people who access health and social care systems. The result has been to provide timely assessment, care management and review and high quality commissioned services for people who have assessed substantial or critical needs (as defined within the Fair Access to Care Eligibility Criteria) In addition funding has been employed to ensure effective signposting is available to those who are not FACs eligible.

Specific areas of investment for 2014/15 have been

Service	Planned Investment	Rationale
13/14 Schemes Rolled Forward		
Integrated Community Intervention	£4,226000	Enhancing the core service to offer rapid intermediate care is key to the successful reablement of individuals. Evidence shows that getting clients, particularly those who are frail or

		suffer dementia home after hospitalisation is important in terms of their ability to recovery their independence. Often it is not health related issues which prevent hospital discharge but the fact there is no food in the fridge.
Enablement Teams (LIS)	£4,672,000	This relates to a number of teams, including the Living Independently Staffordshire Teams which provide specialist social work and therapy input to get people home and ensure they recover as much independence as possible
Hospital Discharge Teams	£1,854,000	All areas have hospital discharge teams, but in order to boost capacity and support Urgent Care Plans there is a small investment. In addition, much work has been undertaken to streamline processes, e.g. dispensing with Sections 2s and 5s to support rapid flow and reduce bureaucracy.
Assistive Technology	£508,000	There are approximately 2,000 clients receiving simple telecare in Staffordshire. In addition, about 12,000 have community alarms. The aim of this investment is to continue to improve the offer of simple telehealth and further embed use of telecare by all Living Independently Teams. The funding will also continue to support the 'Live at Home' facilities which allow people to try out assistive technology in mock homes and receive support in a community hub setting. In many cases, these facilities are jointly delivered with partner agencies e.g. Staffordshire Fire and Rescue Service.
Independent Sector Respite/Intermediate Care Beds	£843,000	Although the aim of the services is to shift spend to prevention in some cases we recognise there is a need to commission short term beds to support hospital discharge, carer respite and support winter planning. Work is ongoing to ensure we get best value out of these arrangements
Mental Health: Out of Hours, EMI, CPN	£0	We know a high proportion of people with long term conditions also have related issues around mental health. There is also a known gap in Staffordshire around services for people with dementia.
Improving Domiciliary Care	£1,800,000	Quality of and access to domiciliary care is variable across Staffordshire, with concerns expressed by all partners on the ability of these services to deliver positive outcomes and avoid Delayed Transfers of Care and hospital admissions. Work has begun to review current dom care provision, and a longer-term vision has been agreed by all partners. Investment will ensure ongoing stability of the

		domiciliary care provision by maintaining increased payments to providers in areas where provision was previously failing. The newly established SSOTP/SCC project team is working to transform service delivery to focus on outcomes rather than task and time over the next few years, and short-term solutions to maintain stability of the market. Withdrawal of this funding will have a severely detrimental effect on DTOCs.
14/15 Additional Schemes		
Enablement Flats	£22,000	This is payment towards rental and utility costs of some enablement flats in Newcastle. The enablement flats help people to become more independent thus avoiding longer-term support.
Hospital Discharge Service (Age Concern)	£30,000	This contract purchases additional capacity for domiciliary care, focusing on services for older people. The service ensures that people are well supported in their own homes, thus reducing the need for hospital or residential care.
Community Equipment (SCC ICES)	£1,387,687	The initial budgets allocated to the pooled fund did not reflect spend figures, and discrepancy between the two resulted in a perceived overspend of the fund. Significant SCC resource has been used in 13/14 to untangle the issues and the financial situation is now more stable with greater clarity of spend and activity achieved for 14/15. Reports indicate that the ICES is delivering more equipment more quickly to customers, resulting in greater user satisfaction, helping to reduce hospital & care home admission/readmission, and enabling earlier hospital discharge. A full cost benefit realisation will be completed by the end of September to demonstrate the full impact and this will be shared with all ICES partners. This funding will ensure that equipment delivery continues to be improved as the ICES pooled arrangement beds down and becomes part of 'business as usual' for all partner organisations.
Great Wyrley CSU (Respite beds)	£653,280	Great Wryley CSU is an SCC run registered Care Home located in South Staffordshire currently used for respite only, for older people with a substantial or critical level need. Residential respite provides short-term care for mainly older people (65+) who normally live at home, often with relatives or someone else who cares for them. The main purpose is to provide a break for the carer to enable them to continue to undertake their role as carer and reduce the risk of hospital or care home admission. Between 2013/14 GWCSU was used by 139 people; 3,720 nights capacity used. The usage of the unit is

		split between Cannock CCG residents (70%), South East Staffs and Seisdon CCG residents (15%) and Stafford and Surrounds CCG (15%). SCC are currently completing a review of all in-house and external respite provision across the county and analysis of demand and supply to inform future provision, and are seeking to increase benefits through this review.
Carers – Stroke Rehab/Comm (South)	£87,740	• Assists stroke survivors with Aphasia and their carers to develop new ways of communicating to increase confidence and regain independence. • Life after Stroke group provides a 6 - 8 week programme of group activity to enhance understanding of stroke and provide new opportunities for stroke survivors and their carers to increase their involvement in the local community though social activity and learning. Also provides opportunity for clients to join a user-led stroke forum providing ongoing long term sustainable peer support. • Stroke Rehab/Comm Services is a preventative service which aims to prevent hospital readmissions of stroke survivors and the prevention of poor health and wellbeing for their carers.
Carers – End of Life (pilot)	£59,520	• Provides information, practical and emotional support to enable carers to continue in their caring role when the cared-for person is nearing the end of life. • This pilot is also undertaking a needs analysis of support for end of life Carers which will be used as part of the Carers Whole System Redesign in Staffordshire
Alzheimers Cafes	£90,773	This service was re-tendered recently. The two incumbent providers won the new contracts. The new services commenced on 1st June 2014. The new contract requires providers to utilise the funding more towards direct service provision, care planning and improving outcomes through: • Peer support • Structured carer activities • Cognitive stimulation therapies • Contingency planning for carers (to avoid a crisis and possible admission to acute or long term care) • Information for those either newly diagnosed or new carers • Carer education, information & advice The new services will improve outcomes for carers of people with dementia, and increase the number of carers supported – also making the service appropriate for young and older carers as well as

		those who are unable to attend cafes i.e. those who might benefit from telephone support. The contract value is also being used in order to generate methods of self-sustainability for the future – encouraging people to donate and contribute to the service costs. Carers accessing the service who are no longer in a caring role are encouraged to become volunteers to support the service and help it to grow.
Total	**£16,234,000**	

We need to add in here a commitment to undertake an evaluation and identify potential areas we'd want to invest in next year (ie what to roll forward and what to stop or do new)
Egs
Occupational Therapy within SSOTP
Dementia Initiatives to reduce crisis
Hospital Discharge Assessment Capacity

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

The lead Commissioner is the Commissioner for Care within Staffordshire County Council and the County Commissioner for Older People and Market Development.
The majority of these initiatives will be delivered through existing providers and contract arrangements reducing the need for time intensive procurement exercises and ensuring whole year performance benefit from the investment.
List Providers
SSOTP – Assessment and Care Management, and delivery of reablement services
etc

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

Contained within table above does this need rewriting into this section?

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

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

Insert final performance matrix for s 256 fudning

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

There are established mechanisms with our main delivery partner SSOTP, we will be using these mechanisms to monitor the achievement of outcomes and where delivery is through another provider this will be embedded within the contract arrangements.
Staffordshire has a mature history of joint commissioning with our CCGs and we will embed the monitoring and evaluation of these initiatives within out joint working arrangements.

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

Success Factors

1. More people are safely supported to stay at home following an acute admission.
2. More people supported to live at home with reduced ongoing needs.
3. Reduction in referral to assessment completion timescales.
4. Reduction in the timescales from completed assessments to start new packages of care.
5. The number of people admitted into a residential or nursing home for the first time following and acute admission reduces
   People experience an improved quality of life as a consequence of helath and social care intervention

Scheme ref no: 1.2
Scheme name
Frail Elderly - Admission avoidance and delayed discharges 'Stemming the flow' – Cannock Chase and Stafford and Surrounds CCGs (South West) 'Partnering working for LTCs'
What is the strategic objective of this scheme?
The majority of users of NHS and social care services are older people, many experiencing frailty, often with complex needs and multiple long-term conditions. Present service configurations and their focus on specific health conditions do not always serve these people well, and they can become stuck in high-level services for want of a more coordinated approach to addressing their needs. Often, the experience of services for this cohort of users can be negative and disempowering. However, acute sector services do offer a level of safety and certainty to people with complex needs who are in crisis. Across Staffordshire the pattern of services for the Frail Elderly is currently unsustainable, with a model that leads to an inappropriate high use of acute hospital services. A transformative model of service provision is required to reduce avoidable acute hospital admissions and reduce excess hospital length of stay. Informed by patients and the public innovative service models are being developed, these will see the provision of an anticipatory care service at scale and pace. For patients this will mean that they will have greater control of their own treatment and care and access to appropriate and timely support from professionals in the community. This approach will offer patients a new and different approach to the current service models. This approach aims to empower patients, families and carers to self-manage to prevent crisis and maintain personal independence, it aims to improve the experience of timely hospital discharge and improve after care support to enable people to recover and live life to the full. For the South West of the county, the Stemming the Flow scheme provides a model for Out of Hospital Care that can enable the safe and sustainable reduction of bed capacity and provide the assurance required by acute providers to down size their operating capacity as per the recommendations of the Trust Special Administrator (TSA). Similarly, a revised approach is in development for people with **Long Term Conditions**. In the south of the county, innovative outcome-based service specifications (co-produced with service users) are in development. New models of LTC management will provide high quality clinical and social care interventions to empower patients, carers and families to maximise independent living. They will provide individual choice and control, actively support individuals to maintain optimal levels of functioning, self-care, adopt healthier lifestyles,

adapt to disease progression and manage any decline in health/ independence.

Overview of the scheme

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

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

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

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

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

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

For LTCs, drawing on the Kaiser Permanente triangular model of care, the LTC service will incorporate the following elements:

- risk profiling
- individual care plans where the patient contributes and takes ownership of their goals
- integrated teams including multidisciplinary and multi-agency (health, social care and voluntary sector) management
- delivery of ongoing patient education and behaviour change programmes
- case management
- remote monitoring
- self-management tools including the use of health coaching and telehealth technologies

- proactive planned care
- personal health budgets/ Direct Payments
- rigid quality criteria (ref Francis report)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By definition outcomes will be measurable and set within contracts with providers. Agreed

[1] Reference about North Staffs Hub model see SSOTP

targets and timescales will be monitored, issues arising will be escalated and a collaborative approach will be used to develop remedial action plans.

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

Patient safety and good quality care is the top priority of all work streams. Non-Elective Admissions are an indicator that highlight system failure to manage patients effectively in their community. Therefore the key success factor for the Frail Elderly and LTC programmes of work would be a reduction in Non-Elective Admissions. Each programme has set objective which aim to contribute to the overall success factor. The key objectives specific to the Frail Elderly and LTC schemes are detailed below:

The main benefits (outcomes) from implementation of the "Stemming the Flow" model are:

- The holistic needs of the patients are met;
- Safe and effective, integrated services, with improved quality and productivity;
- Sustainable and appropriate alternative care provision for patients who historically went to Mid-Staffordshire Foundation Trust (MSFT);
- Enhanced effective working relationships between frontline staff across all disciplines;
- The best care for the population served;
- Cost savings;
- Evidence based outcomes.

The outcomes of the partnering working for LTCs will be split into four key components:

- Patients are enabled and empowered to manage their long term condition;
- Clinical measures, detailing how the health outcomes of our population are improving, proving that the model is delivering effective care and support;
- Support to carers and families, acknowledging the key role carers and families provide to patients;
- Communication, to ensure that providers work collaboratively and maximise the opportunities of integration.

Scheme ref no. 1.3

Scheme name

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

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

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

What is the strategic objective of this scheme?

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

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

This service is currently out to tender.

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

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

Overview of the scheme

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

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

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

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

The Service shall support individuals aged 19 years and over.

The delivery chain

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

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

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

The evidence base

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

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

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

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

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

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

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

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

Local anticipated outcomes:

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

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

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

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

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

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

Scheme ref no. 1.4

Scheme name

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

What is the strategic objective of this scheme?

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

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

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

Overview of the scheme

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

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

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

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

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

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

The End of Life Strategy was approved at the CCG Board and is being mobilised through an Accountable Care Partnership arrangement. This covers both South East Staffordshire and Seisdon Peninsula localities and includes local hospice representation, acute hospitals, Staffordshire & Stoke on Trent Partnership NHS Trust and the CCG.

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

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

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

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

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

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

See Expenditure Plan.

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

Local anticipated outcomes:

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

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

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

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

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

- Successful delivery of the End of Life Strategy

Scheme ref no. 1.5

Scheme name

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

What is the strategic objective of this scheme?

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

Overview of the scheme

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

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

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

The delivery chain

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

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

- East Staffordshire CCG
- South East & Seisdon Peninsula CCG

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

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

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

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

Investment requirements

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

Impact of scheme

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

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

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

Feedback loop

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

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

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

Scheme ref no. 2.1

Scheme name Disabled Facilities Grants

What is the strategic objective of this scheme?

Adapting homes so that people with disabilities can remain living safely at home within their communities.

Overview of the scheme

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

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

The Disabled Facilities Grant (DFG) is a mandatory means tested grant funded by central and local government and administered by separate District Councils in order to help people who have been assessed as needing major adaptations to their property because of their disability, so that they can lead healthy, independent lives at home. DFGs are the statutory responsibility of district and borough councils

Grants cover 'simple' large scale equipment such as stair lifts and hoists, and 'complex' adaptations involving surveyor/architectural drawings e.g. level access showers, ramping, or extensions.

Ultimately the grant is one of the key services through which independence and wellbeing is promoted and maintained, reducing pressure on acute and community based services, preventing unplanned admissions and delayed discharges, delivering improved outcomes for customers and their carers. Similarly to integrated equipment services, the speed and efficiency of adaptation through DFGs is crucial.

The delivery chain

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

Further analysis of social care records shows that people who have received a major adaptation and subsequently need residential care, on average enter residential care at the age of 81.5, compared to 70.1 years of age those who haven't. (can the saving for this be quantified?) Furthermore, those who haven't received a major adaptation stay in residential

care for 6.5 years on average, compared to 2.4 years for those who have. This not only highlights a clear improvement in outcomes for people receiving major adaptations, but also demonstrates that a 4.1 year saving in care costs of nearly £50k. Using the proportion of older people currently living in residential care as a conservative benchmark would equate to an additional saving of around £270,000 annually.

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

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

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

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

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

Cannock Chase	414
East Staffordshire	436
Lichfield	421
Newcastle-under-Lyme	654
South Staffordshire	431
Stafford	570
Staffordshire Moorlands	654
Tamworth	224

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

DFGs provide a number of benefits which include the following.

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

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

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

following personal outcomes

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

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

Participation agreement and new HIA contract in place and delivery will be monitored by a multi agency steering group.

MISSING ANNEX DOCUMENTS FOR SCHEMES 2.2 – 2.6

Scheme ref no. 2.7

Scheme name:

Prevention and Treatment of Acute Illness in Children and Young People (reducing emergency admissions in CYP)

What is the strategic objective of this scheme?

To support and empower children, young people and families (CYPF) to stay healthy, manage illness and recover quickly.

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

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

This is a whole system approach with 3 main components:

- Staying healthy (responsibility of the wider partnership)
- Identifying risk of illness – risk due to medical and wider social issues
- Empowerment and support to deal with the crisis and prevent re-occurrence (treatment – "right team, right time, right place, least risk")

The target group is any child or young person at risk of or suffering from acute illness/injury registered with a GP in southern Staffordshire. It is a family-based approach.
The initial focus of work is:

- To develop and implement a respiratory pathway to include self care, primary care, community care and acute care.
- Implement a targeted pilot project to reduce asthma admissions
- Upskilling primary care to deal with childhood illnesses
- Review the prevention role of maternity services

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

Local Area Team – Primary Care and health visitors
CCGs – enhanced primary care functions
ES CCG – BHFT
CC CCG – RWT (post-MSFT)

SAS CCG – UHNS (post–MSFT)
(associate commissioner for HEFT)
SAS CCG – SSOTP
SESSP CCG - SSSFT
SCC – School nurses, public health services, family support services

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

Prevention:
- Breastfeeding initiation (11/12) and prevalence at 6-8 weeks (12/13) lower in all districts
- Excess weight in reception children: Cannock Chase, Lichfield and South Staffs higher than England (12/13).
- Teenage pregnancies – higher in Tamworth than England (2012).

Treatment
- Hospital admissions due to injury: 0-5yr and 0-15yr high in Cannock Chase and Stafford (13/14).
- Unplanned admissions due to alcohol-specific conditions (0-18yr) – high in Cannock Chase and Stafford (08/09 – 10/11)
- Hospital admissions due to asthma (0-19yr) higher in Staffordshire (12/13)
- Hospital admissions for asthma, diabetes and epilepsy (0-19yr) higher in Cannock Chase and East Staffs (13/14) (and previously in Stafford 12/13)
- A&E attendances (0-4) very high in Lichfield and Tamworth (13/14)

The current evidence base will be used to design each element of the programme.

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

See spreadsheet

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

- Reduced unplanned admissions for asthma, diabetes and epilepsy in under 19s
- Reduced emergency admissions for children with LRTI
- Improved identification of CYP at risk of illness and reduced risk
- Improved access to quality information, advice and guidance on health issues and services for CYPF
- Increased confidence and ability of parents/carers to deal with illness in CYP
- Increased primary care practitioner confidence and ability to deal with illness in CYP

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

- Unplanned admission rates, potential for clinical audit
- Feedback from parents
- Feedback from practitioners

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

Acute provider engagement
Community provider engagement

Primary care engagement. Resource to upskill primary care Working across the whole system through a local network approach Resource shift from acute care to community Communication with parents / carers Wider partner engagement (particularly with higher risk families)

Scheme ref no. 3
Scheme name
Carers (Inc. Carers Breaks, Mental Health Carers Support and Information for Carers)
What is the strategic objective of this scheme?
The strategic objective of the Carers Scheme is to jointly commission improved outcomes for carers through a Whole Carers System Redesign, which includes the re-commissioning of Carers Breaks and wider universal carers support. Staffordshire's JHWS Living Well in Staffordshire places an emphasis on working together to jointly support carers, "We also need to do more to support carers." The Health and Wellbeing Outcomes Framework within the Strategy identifies the following Specific aim and Indicator: Enhancing quality of life for people with long term health, care and support needs – Carer reported quality of life. Improved outcomes for carers will have a positive impact on improved health and wellbeing outcomes for carers, which will have a positive impact on reduced non elective admissions, delayed transfer of care and admission to residential and nursing homes. The **Staffordshire Carers Partnership (SCP)** was established February 2014 to provide strategic direction, governance and accountability for Carers outcomes in Staffordshire. Healthwatch Staffordshire are currently leading independent Carers engagement activities on behalf of the SCP (see Appendix A – Support for Carers: Interim Report). The SCP provides the strategic direction for the Staffordshire **'Carers Whole System Redesign'**, which is set out within the **SCP Framework** (see Appendix B – SCP Framework). The SCP Framework is not a static document and will evolve as the Partnership develops. The SCP Framework will replace the Joint Commissioning Strategy for Carers (2011-16) once formally agreed by SCC Cabinet and CCG Boards (September 2014) The SCP is accountable to the Health and Wellbeing Board, and formally reports to the Integrated Commissioning Executive Group (ICEG). The SCP will also be the mechanism for reporting progress on the Carers Schedule within for Integrated Commissioning (IC). The SCC Commissioning Manager for Carers and Wellbeing is jointly appointed across both People (Community Wellbeing Team) and Public Health to maximise on improved health and **wellbeing outcomes** for Carers, which is now a statutory of the **Carer Act**: *"Local authorities **must promote wellbeing** when carrying out <u>any</u> of their care and support functions in respect of a person"* Care Act Guidance (2014) This also ensures links within the SCC Community Wellbeing Team, who are the commissioning leads for **Information, Advice and Guidance**, which is part of the Universal Carers Offer currently undergoing Whole System Redesign and also a statutory responsibility of the **Care Act:**

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

Care Act Guidance (2014)

Overview of the scheme

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

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

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

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

Source: Census 2011

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

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

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

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

- **Integrated Commissioning** (IC) for Carers health and wellbeing outcomes with **CCGs** through the **Better Care Fund** (BCF)
- Modernisation of the **Staffordshire Carers Journey** and **Carers Outcomes Framework**

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

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

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

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

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

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

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

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

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

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

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

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

Carers Breaks and wider Universal Carers Support is currently delivered by two main local carers voluntary and community sector organisations:
- North Staffs Carers Association (NSCA)
- Carers Association Southern Staffordshire (CASS)

The SCP works across two levels
- Governance and Strategic Direction (meets quarterly)
- Task and Finish / Project Groups / Work Streams

There are five core Work Streams that report the SCP Governance Group quarterly:
- Young Carers
- Engagement, Co-production and Insight
- Care Reform
- Health and Wellbeing / Life Outside of Caring
- Information, Advice and Guidance / Carer Awareness and Recognition

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

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

Key Stakeholders who form the membership of the SCP at both levels include:
- Carers
- Heathwatch Staffordshire
- SCC Commissioning Managers
- CCG Commissioning Leads
- Stoke on Trent City Council Carers Commissioning Lead
- Voluntary and Community Sector Providers
- SSOTP
- Mental Health Trusts
- Independent Futures
- Families First
- Housing
- District Representatives
- Staffordshire Police
- Staffordshire Fire and Rescue
- Job Centre Plus
- Local Pharmacy Committees

The evidence base

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

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

- Carer-related reasons for admission to nursing or residential care are common, with carer stress the reason for admission in 38% of cases.**Error! Bookmark not defined.**[1]
- **Commissioning breaks, training, information and emotional support for carers** could reduce the overall spending on care by local authorities by more than £1bn a year.
- Providing carers with **breaks, emotional support and access to training** can significantly

delay the need for the person receiving care to go into residential care.**Error! Bookmark not defined.**[1]

- A longitudinal study of 100 people with dementia found a 20-fold protective effect of having a co-resident carer when it comes to preventing or delaying residential care admissions. Further studies have confirmed that where there is no carer, the person receiving care is more likely to be admitted into residential care.**Error! Bookmark not defined.**[1]

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

- Carers who do not feel prepared or sufficiently supported are one cause of delayed transfers of care which can cost the NHS £150m per year.**Error! Bookmark not defined.**[1]
- In 2010, The Carers Trust published 'Out of Hospital' to make recommendations to help to reduce delayed transfer in care:
    - include identification, recording and referral of carers in hospital discharge policy;
    - collect clinical audit data on the numbers of carers identified and the impact of providing carer support on patients and hospital, e.g. improved patient experience of discharge, increased hospital efficiency;
    - health commissioners should agree carers' standards as part of the contract with hospital trusts;
    - health commissioners should actively participate in local strategic and developmental work on carers issues, e.g. local carers' strategy.

Non Elective Admissions

- Admission or readmission to hospital by a person with a long-term condition can be an indication that the carer is no longer able to care, often due to the strain of caring causing physical or mental ill health, or that discharge planning is poor and the carers is not involved as an expert partner in care. One study found that problems associated with the carer contributed to readmission in 62% of cases.**Error! Bookmark not defined.**[1]

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

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

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

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

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

Qualitative feedback from carers identified the following feedback in terms of access to information

advice and guidance:

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

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

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

Carers Conversation - Carers Engagement

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

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

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

Investment requirements

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

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

Impact of scheme

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

Vicky – We are in the process of developing a Carers Outcomes Framework (see table 1 / figure 1 below)

But I'm not sure how we could directly evidence the financial impact of supporting Carers using the

BCF metrics??

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

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

Key Success Factors for the Carers Scheme include:

- A Carers Whole System Redesign, through an 'Integrated Commissioning Approach' which includes the re-commissioning of Carers Breaks and wider Universal Carers Support across Staffordshire.

- The alignment of the Carers Whole System Re-design with the Care Act, with a focus on improved Carers Pathways, Information Advice and Guidance, Wellbeing and Prevention.

- A 'Co-production Approach' to Carers Commissioning, through ongoing engagement with Carers and Providers to inform the development of the Carers Outcomes Framework and Modernised Carers Service Specification.

- A strong 'Partnership Approach' through the Staffordshire Carers Partnership (SCP) with buy in from all partners. Improved outcomes for carers will be achieved through re-commissioning and modernising Universal Carers Support in Staffordshire. However the SCP will enable the greater influence to improve links between partner agencies as well as aligned and improved carers pathways.

Scheme ref no. 4.1

Scheme name: Primary Care Mental Health/IAPT

What is the strategic objective of this scheme?

The aim of this service is to provide evidence based psychological therapy service for the local population, to increase wellbeing and mental health resilience.

Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life.

The objective is to reduce the impact of poor mental health across a number of conditions.

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

The services provide a range of therapies to support the patient's needs. These will include

- CBT High intensity
- Mindfulness
- Self help groups
- Therapeutic groups
- Psycho educational groups
- Individual Counselling

- Integrative Counselling
- Inter personal Therapy
- EMDR

Current services target:

- Care Cluster 1: Common Mental Health Problems (Low Severity) - This group of service users has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms

- Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need) - This group of service users has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms

- Care Cluster 3: Non-Psychotic (Moderate Severity) - This group of service users have moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

- Care Cluster 4: Non-Psychotic (Severe) - If the Step 4 psychological therapist **is the lead clinician** and the service user does **not require multi-disciplinary case/care management and/or other co-morbidities (e.g. borderline personality disorder) are not the primary focus of treatment**, then these more complex and severe cases could also be treated within the Psychological Therapies Services (Adults). This group of service users is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

There is growing evidence that supporting the psychological and mental health needs of people with long-term conditions more effectively can lead to improvements in both mental and physical health.

Interventions from mental health can be adapted and integrated within chronic disease management frameworks or rehabilitation programmes designed to support people in managing their condition. A growing evidence base suggests that more integrated ways of working with collaboration between mental health and other professionals offer the best chance of improving outcomes for both mental health and physical conditions (Fenton and Stover 2006; Yohannes *et al* 2010). There is also evidence that the costs of including psychological or mental health initiatives within disease management or rehabilitation programmes can be more than outweighed by the savings arising from improved physical health and decreased service use (Howard *et al* 2010; Moore *et al* 2007). The box overleaf summarises some of the research evidence.

The delivery chain

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

Each CCG commissions a Primary Care Mental Health/IAPT service to a different service specification, there are a number of providers in the delivery chain including South Staffs and Shropshire NHS Foundation trust and Third Sector providers. Care pathways for people with chronic disease or Long term conditions are commissioned by each CCG with a different set of providers. A coherent delivery chain to achieve the stated objectives will be required to be developed.

The evidence base

Please reference the evidence base which you have drawn on

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

Available data suggest that the indicative benchmark rate for common mental health disorders is **17.7%,** or 17,700 per 100,000 of the population aged 18 years and older (National Institute for Clinical Excellence).

For a standard population of 100,000 around 79%, or 79,000, will be aged 18 or older. Of this population 17.7%, or around 14,000, will have a common mental health disorder.

Service capacity should be locally defined, but it should assume that around 15%, or 2100 per 100,000 population, of those aged 18 or older, will need access to treatment at steps 2 or 3 each year.

Chronic disease and long term condition management – people with 2 or more long term conditions are 7 times more likely to have depression (Talking Therapies: a 4 year plan of action).

Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.

This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.

Research evidence consistently demonstrates that people with long-term conditions are two to three times more likely to experience mental health problems than the general population. Much of the evidence relates specifically to affective disorders such as depression and anxiety, though co-morbidities are also common in dementia, cognitive decline and some other conditions. There is particularly strong evidence for a close association with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders.

- Depression is two to three times more common in a range of **cardiovascular diseases** including cardiac disease, coronary artery disease, stroke, angina, congestive heart failure, or following a heart attack (Fenton and Stover 2006; Benton *et al* 2007; Gunn *et al* 2010; Welch *et al* 2009). Prevalence estimates vary between around 20 per cent and 50 per cent depending on the conditions studied and the assessment approach used, but the two- to threefold increase compared with controls is consistent across studies. Anxiety problems are also common in cardiovascular disease (Goodwin *et al* 2009).
- People living with **diabetes** are two to three times more likely to have depression than the general population (Fenton and Stover 2006; Simon *et al* 2007; Vamos *et al* 2009). As observed for cardiovascular disease, prevalence estimates vary but the proportionate increase is consistent (Anderson *et al* 2001). There is also an independent association with anxiety.
- Mental health problems are around three times more prevalent among people with **chronic obstructive pulmonary disease** than in the general population (NICE 2009). Anxiety disorders are particularly common; for example panic disorder is up to 10 times more prevalent than in the general population (Livermore *et al* 2010).
- Depression is common in people with **chronic musculoskeletal disorders** (Sheehy *et al* 2006). Up to 33 per cent of women and more than 20 per cent of men with all

types of arthritis may have co-morbid depression (Theis *et al* 2007). For example more than one in five people over the age of 55 with chronic arthritis of the knee have been reported to have co-morbid depression (Sale *et al* 2008).

There is also evidence for higher than usual levels of mental health problems among people with other conditions, including asthma, arthritis, cancer and HIV/AIDs (Chapman *et al* 2005; Sederer *et al* 2006).

Increased service use

Given the significant impact on prognosis, it is unsurprising that co-morbid mental health problems also substantially increase patients' use of health services for their physical problems. Depression, for example, is associated with an increase in rehospitalisation rates in cardiovascular disease – for patients with chronic heart failure the emergency admission rates are two to three times higher (Himelhoch *et al* 2004; Jiang *et al* 2001; Fenton and Stover 2006)

A UK survey found that people with co-morbid mental health problems and diabetes experienced more hospital admissions and GP consultations for physical complaints (Das-Munshi *et al* 2007). International studies report similar findings, for example that the presence of mental health problems increases risk of admission by 2.8 times, causes slight increases in length of stay, and doubles the use of outpatient services (Krein *et al* 2006; Vamos *et al* 2009).

There is also evidence of increased service use in COPD. For example, COPD patients with co-morbid mental health problems have more than 50 per cent more acute exacerbations per year (Laurin *et al* 2009), experience higher rates of hospitalisation, and in one study spent twice as long in hospital as those without mental health problems (Yellowlees *et al* 1987).

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

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

A number of health economic outcomes including:
o Reduction of hospital admissions, and within each, hospital bed days
o Reduction of crisis team episodes
o Reduction in medication spend with lowered doses following improved functioning
o Reduction in DLA spend
o Increased return-to-work, or return-to-work-related-activity
o Increased completion of episodes of secondary care, transfers back to primary care
o Increase in general physical health (decrease in smoking, obesity following increase in psychological wellbeing

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

New metrics will need to be agreed with provider organisations in terms of data collection for all providers in the delivery to chain to ascertain effectiveness in contributing towards the reduction of avoidable non-elective admissions as this has not been previously captured. Develop Local CQUINs which incentivise the use of WRAP plans in **all** patients seen in the community.

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

Measurement is essential to understanding whether a service is effective and meeting the needs of patients. Ensure that psychological care provision (in all its forms from all professions) is included in routinely collected data which can be used to feedback to teams and to illustrate how the service is improving.
Psychological care is delivered through a network of professions and organisations with different methods of psychological support. The local pathway of care, its structure, roles and methods of referral should be clearly communicated to all who need to access the services.
Psychological care needs to adopt a joined up approach with health, primary care, mental health and physical health, social services, and the voluntary sector all working together.
IAPT workers will need training and on-going supervision by relevant professionals with experience of working with physically ill patients, such as clinical health psychologists. IAPT teams will need to accept referrals from long-term conditions teams as well as GPs, and where they have not already done so will need to expand their referral criteria to include older people, among whom co-morbidities are particularly common.

Scheme ref no. 4.2

Scheme name: Mental Health- Psychiatric Liaison/RAID

What is the strategic objective of this scheme?

Liaison psychiatry services are an essential component of effective care in acute hospitals. liaison psychiatry services – which support the mental health needs of patients with co-morbid physical and mental disorders aim to improve care by:
• improve physical and mental health outcomes
• decrease length of stay
• reduce readmissions
• reduce healthcare costs for patients with unexplained symptoms
• reduce psychological distress.

Emergency departments have 50,000-60,000 attendances each year. They represent the largest proportion of work for liaison psychiatry. Severe Mental illness is estimated to be the primary cause for attendance in 5% of occasions and this can be the first time patients contact a health professional.
Prevalence of Mental Illness among those that self harm can be as high as 90% and episodes of self-harm are high in the younger population, especially girls aged 15-16. Self-harm is a risk factor for suicide with rates being 100 times higher in those that self harm than the general population. National Audits found that Less than 42% of staff in A&E have been trained to use NICE bio-psychosocial assessments. Patients who do not get this evidence based assessment repeat self harm more often and have higher risk of suicide.

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

Liaison psychiatry services provide mental healthcare to people being treated for physical health conditions in general hospitals. Patients with both mental and physical health problems often have poorer health outcomes and it can be more expensive to treat them. Liaison psychiatry services can improve care and bring cost savings by allowing patients to

be discharged earlier if their mental health needs are addressed and by reducing rates of readmission. An effective liaison psychiatry service therefore can improve health and save money.
Key features of the RAID model are as follows:
• The service offers a comprehensive range of mental health specialities within one multi-disciplinary team, so that all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity.
• The service operates 24 hours a day, 7 days week. It emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards.
• The service aims to meet the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia.
• The service provides formal teaching and informal training on mental health difficulties to acute staff throughout the hospital.
• The service puts an emphasis on diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards.

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

South East Staffordshire and Seisdon CCG is lead co-ordinating commissioner for Mental Health, on behalf of East Staffs CCG, Cannock Chase CCG and Stafford and Surrounds CCG. Service is contracted with South Staffordshire & Shropshire NHS Foundation Trust and provided with Mid Staffs NHS Hospital Trust and Burton Hospitals Trust.

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

Very high proportions of people with physical health conditions also have co-morbid mental health problems, including 30 to 65 per cent of medical inpatients. This co-morbidity is associated with a number of adverse consequences, including poorer quality of care for the physical condition, reduced adherence to treatment, increased costs and poorer health outcomes. The economic and financial impact of co-morbidity can be very significant. For example, a US study has shown that healthcare costs for people with diabetes and co-morbid depression are almost twice as high as for people with diabetes alone. A UK study found that people with diabetes and co-morbid depression are seven times more likely to take time off work than those with diabetes alone.
Rates of co-morbidity are particularly high among elderly people in general hospitals, where they account for about two thirds of all occupied beds. Up to 60 percent of these patients have or will develop a mental disorder during their admission, the most common conditions being dementia.
In the case of dementia, a survey carried out in Lincolnshire by the National Audit Office found that patients with this condition were particularly likely to experience delays in discharge and overall more than two-thirds of those with dementia were assessed as no longer needing to be in hospital. Potential savings from quicker discharge were estimated at £6.5 million in the local area, equating to more than £300 million if extrapolated over the whole of England (NAO, 2007).

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

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

Based on an evaluation of RAID a comparison of lengths of stay and rates of re-admission in similar groups of patients before and after RAID was introduced in December 2009, in place of a previous, smaller liaison service, the internal review estimated that cost savings are in the range of £3.4 - £9.5 million a year.
Most of these savings come from reduced bed use among elderly patients.
The top six reasons for referral to RAID were: deliberate self-harm 27.6%; depression 16.2%; cognitive impairment, confusion and dementia 13.6%; alcohol misuse 12.5%; suicidal ideation 10.1%; and psychosis 8.4%.
In terms of follow-up support after discharge from the hospital, 916 of the patients seen by RAID between December 2009 and September 2010 were signposted to services in the community, with the majority of these (71.2%) being to the patient's General Practitioner. A similar number were formally referred to community services after discharge, including 252 to community mental health teams, 207 to home treatment teams and 139 to a RAID follow-up clinic.
A statistical analysis of data on hospital re-admissions, including multiple or repeat re-admissions, among all patients in the control and intervention groups found that, even after taking into account other influences, the likelihood of re-admission was some 70% lower in the RAID sub-group than in the pre-RAID control group.

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

New metrics will need to be agreed with provider organisations in terms of data collection for all providers in the delivery to chain to ascertain effectiveness in contributing towards the reduction of avoidable non-elective admissions as this has not been previously captured.
Local CQUINS can be set up to help all crisis response services identify and manage the top 100 most frequent attenders and promote early intervention in the A&E setting.
CCGs can look to develop patient held records and remote access arrangements to clinical records as this will help A&E doctors and liaison psychiatry services to have full information and provide interventions for physical and mental health.

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

Engagement processes with family and carers
Strong aligned leadership
Local sponsors to develop shared market target
Culture for service improvement
Need buy in from primary care practitioners and staff
Develop a data model and tools to support reporting and analysis .
Protocols should be developed which promote the use of basic physical health interventions in the A&E setting. Often A&E staff will simply rule out any significant physical health issue and then refer to psychiatry but there is evidence that simple advice could benefit in improving the physical health of people with severe mental illness.

Scheme ref no. 4.3

Scheme name

Emotional Wellbeing and Mental Health (CAMHS)

What is the strategic objective of this scheme?

To provide effective and integrated care to children and young people experiencing emotional wellbeing and mental health difficulties

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

What is the service? Who will deliver it?

The services offer support from Tier 1 – Tier 3.

Tier 1 - promotion of good emotional wellbeing and prevention of mental ill health

Tier 2 – early and targeted intervention for children with mild/moderate emotional wellbeing and mental health difficulties

Tier 3 – specialist treatment for children and young people with complex and enduring mental health difficulties

The services will be offered to children and young people aged 0-18, and the target audience is from universal (entire population) to targeted audiences (those experiencing difficulties). Vulnerable young people (i.e, Looked After Children, Young Offenders, and Children In Need) comprise a high proportion of the referrals.

Prevalence data

	Tier 1
Staffordshire	25,580
North Staffordshire	5,805
South Staffordshire	19,775

	Tier 2	Tier 2 referrals 14-15
Staffordshire	11,940	1,510
North Staffordshire	2,710	785
South Staffordshire	9,230	725

	Tier 3	Tier 3 referrals 14-15
Staffordshire	3,155	3,733
North Staffordshire	720	1,078
South Staffordshire	2,435	2,655

The services are delivered in the community, and comprise of clinical and non-clinical buildings. Routine appointments are usually offered between 9am-5pm, although services

do offer routine appointments beyond these hours. Out of Hours Service is delivered by Tier 3 Providers, and Crisis Intervention delivered by Adult Mental Health Providers.

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

Commissioning
Staffordshire County Council –Tier 1 and 2 services
South Staffordshire Clinical Commissioning Groups – Tier 3
NHS England – Tier 4

Providers
South Staffordshire and Shropshire NHS Foundation Trust (Tier 3)
North Staffordshire Combined Healthcare Trust (Tier 3)*
Voluntary, Community and Social Enterprise Sector Providers (Tier 2 and some Tier 3)

Roles and Responsibilities

South East Staffordshire and Seisdon CCG lead on childrens' commissioning for all of South Staffordshire CCG's.

South Staffordshire has an integrated childrens' commissioning team (across CCG's and LA) and lead commissioning role has been assigned for the leadership and development emotional wellbeing and mental health.

***Unsure of North Staffs CCG their plans to contribute to BCF**

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

Emotional Wellbeing and Mental health continues to be highlighted as a priority both nationally and locally.

Half of those with lifetime mental health difficulties experience symptoms by the age of 14, that one in ten children under 16 years have a mental health difficulty, and that self-harming in young people is becoming more common, occurring for example in 10-13% of all 15-16 year olds. (Mental Health Foundation, 2006)

Locally the Staffordshire, Children and Young People Survey (2013) found that 53% of those asked wanted to know more about how to manage emotions and feelings.

We know that referrals to Tier 3 and Tier 4 services have increased year on year since 2011.

Stakeholder events were held in 2013 to inform the development of an Emotional Wellbeing and Mental Health Strategy for Staffordshire. Common identified themes for the strategy to address was "Clarity on national and local commissioning of services", "better information sharing and communication between health, education and social care and "clearer pathways between services".

The above evidence would suggest that an integrated budget for Emotional Wellbeing and Mental Health for Children and Young People would be an important process to help to achieve success in some of these areas. Adopting this level of commissioning would mean that LA and CCG's commit themselves to discussions on commissioning needs and

intentions in a collaborative way. Thus reducing the risk of creating gaps in service delivery, and duplicating commissioning. It would mean that the entire population from Tier 1 to Tier 4 is considered and decisions are not made in isolation for just Tier 1 or Tier 2 need. More integrated service delivery pathways would be a reflection of this integrated commissioning arrangement.

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

SCC contribution = **£458,701** (CAMHS Budget SC0440)

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

The following outcomes have been identified as part of the Emotional Wellbeing and Mental Health Strategy development.

- More children and young people accessing emotional wellbeing advice, support and signposting from universal services, schools and colleges
- More children and young people are supported to maintain good emotional wellbeing, difficulties are noticed earlier and appropriate services are available
- Reduction in lifelong distress as a result of poor mental health
- Children and young people can access age appropriate Tier 4 placements close to their home
- Children and Young People are supported within the community wherever possible
- Efficient care pathways for vulnerable groups of children and young people to allow quicker access to support
- Efficient care pathways for young people who need emotional wellbeing and mental health support beyond the age of 18.

These outcomes relate to the BCF outcomes:

- Avoidable emergency admissions (i.e., self-harm, deliberate overdose)
- Patient/Service User Experience (improved as a result of better ways of working)

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

The scheme will be monitored through an action plan that will be developed in response to the identified priorities, commissioning intentions and outcomes within the strategy. A number of KPI's will be developed in consultation with stakeholders, Providers and service users which will monitor the impact of the scheme.

Data and outcome measurement tools are already in place with Providers that will feed into measuring the success of this scheme. There is some additional data that may be required subject to agreement of the KPI's.

Service user feedback mechanisms are already in place to gain their levels of satisfaction with the scheme.

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

A key success of the programme will be that children and young people have access to the right service, at the right time, delivered by the right professional. This approach should produce some key outcome in terms of reducing the number of children and young people requiring specialist (Tier 3 and 4) support. Bi-proxy indicators may also include more children and young people staying in education, training or employment, a reduction in youth offending, less teenage pregnancies etc. Learning from other areas that have existing joint commissioning arrangements would suggest that this could be possible.

Scheme ref no. 5

Scheme name:

Care Act Implementation Funding (Revenue)

What is the strategic objective of this scheme?

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

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

The overall objectives of the Living Well Outcome Plan are

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

Overview of the scheme

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

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

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

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

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

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

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

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

Work stream	Members	Deliverables
Regulation, Policy and Comms	Ben Odams (Lead), Claudia Brown, Mark Sproston, Andrew Errington, Lee Pardy-McLaughlin and Legal Representative	1. Briefing on the regulations 2. Respond to the Government's consultation 3. Update all of the policies • Contributions and charging • Ordinary residence and continuity of care (needs to include extra care housing) • Prisons and continuity • Eligibility criteria inc carers • Assessment pathway and advocacy (inc tiers of assessment) inc carers • Financial advice • Deferred payments • Prevention • Provider failure • Refresh of direct payments and personal budgets approach • Practice manual • Transitions 4. Review of Delegation 5. Develop a Prevention Strategy 6. A Guide to the Care Act (for County Council Staff, Providers, Service Users etc)
Assessment, Eligibility and Support Planning	Helen Trousdale(Lead),, Jeanette Knapper, Denise Tolsen, Julie	1. Refresh the Practice Manual 2. Approach to Personalisation

	Forrest-Davies, Plus Representatives from SSOTP, Mental Health (Mark Cardwell, Andy Oakes) and Independent Futures (Jeanette Knapper)	3. Self funders, Carers and Walk in 4. Prisoners and Veterans 5. Embed Prevention 6. Transition 7. Deficit Capacity Plan
Insight and Care Markets	Bev Jocelyn (Lead), Shirley Way, Enrique Centeno, Lucy Heath, Esther Jones, Corporate Insight Representative, Other Commissioners.	1. Scope additional demand 2. Risk analysis around Care Markets 3. Refresh the Market Position Statement 4. Engage with the Care Market 5. Use the ELSA data to undertaken a 'map and gap' exercise 6. Deficit Capacity Plan
Finance	Sara Pitt (Lead), Lee Assiter, Chris Aldritt, Julie Edwards-Thompson	1. Complete necessary Financial modelling to support analysis 2. Charging 3. Welfare Reform 4. Modelling Deferred Payments Deficit Capacity Plan
Safeguarding and Quality	Sarah Hollingshead-Bland (Lead), Laura Johnston, Donna Colgrave, Jim Ellam, Commissioning Quality Lead, Plus Representatives from SSOTP, Mental Health and Independent Futures	1. Review current Safeguarding practice against provisions in the act 2. Make Recommendations for Practice and Market quality including How we will monitor quality 3. Deficit Capacity Plan
Workforce: It was agreed that this work stream relies on the work of others so this will be set up later on in the project.	Shirley Way (Lead) Plus Representatives from SSOTP, Mental Health, Independent Futures, Families First, Finance and Legal	1. Training for Provider workforce on Assessment 2. Wider workforce training 3. Organisational Development 4. Capacity Planning a. Care Assessments

		b. Legal c. Financial Services d. Market Workforce 5. Culture and Practice – New ways of working
Prevention and IAG	Nichola Glover-Edge (Lead)	1. Independent Financial Advice 2. Updating Staffordshire Cares 3. Making sure Frontline (inc. Voluntary Sector) know how to use the IAG 4. Tiers of Assessment including Self Assessment
ICT	Jan Cartman Frost (Lead)	1. Care Director 2. Interface with NHS systems for integrated providers.

The evidence base

Please reference the evidence base which you have drawn on

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

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

Investment requirements

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

Impact of scheme

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

Have we got specific outcomes for the project which are separate to the Living Well Outcomes?

Feedback loop

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

The project plan identifies a number of key milestones and critical success factors. The delivery to agreed milestones of both the project and any associated work streams will be monitored through SCC governance routes.

DH is monitoring LAs readiness and implementation through Stock-take submissions and has appointed regional leads through ADASS who are providing guidance and support.

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

Success Factors

1. **Implementation of Mandatory requirements of the Care Act within required timescales to ensure the council meets go live date of 1.4.15 and 1.04.16.**
2. **That the council is not able to be successfully judicially reviewed for non**

compliance.