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

Ageing Well

Falls Prevention – Scheme ref no 1.1

ANNEX MISSING

Localities Commissioning – Scheme ref no. 1.2

ANNEX MISSING

Support to Live at Home

Disabled Facilities Grant – Scheme ref no. 2.1

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, with Staffordshire Housing delivering 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 district councils retail the mandatory duty to award DFGs, and rely upon this funding to meet that duty.

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

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Lichfield	421
Newcastle-under-Lyme	654
South Staffordshire	431
Stafford	570
Staffordshire Moorlands	654
Tamworth	224

This funding allocation is based in part upon historic funding bids and does not necessarily reflect relative need or meet current demand. Work is being undertaken to establish the need for adaptations and consider the funding requirement and appropriate allocations.

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 multiagency steering group.
The steering group is also working on streamlining and standardising procedures across the County.

Adult Social Capital Grant – Scheme ref no. 2.2

ANNEX MISSING

Scheme ref no. 2.3

Scheme name

Technology Enabled Care Services (TECS) and Assistive Technology

What is the strategic objective of this scheme?

People living in Staffordshire will be supported to manage and improve their health and well-being through Technology Enabled Care Services

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?

A range of projects and interventions is currently being designed.

The delivery chain

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

All of the health and social care commissioners across Staffordshire and Stoke-on-Trent, along with the NHS Trusts and major housing providers, have come together to establish a single coordinated programme, hosted by University Hospital of North Staffordshire (UHNS).

At present, 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 Assistive Technology 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, such as Staffordshire Fire and Rescue Service.

The evidence base

Please reference the evidence base which you have drawn on

-

The TECS programmes is currently collecting the necessary evidence base to direct its next steps.

Investment requirements

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

The contribution of the CCGs and County Council across Staffordshire, drawn from the BCF pool, will amount to £840k annually. In addition, £508k will continue to be devoted to Assistive Technology. Additional contributions, amounting to some £2m annually, will be made by the other partners.

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 proportion of people who reach a point of crisis that requires emergency admission to hospital, admission to a care home, or GP call out.
- Increased ability to respond quickly to an emergency or react to deterioration in health at home.
- Increased opportunities for self-purchase by people who have concerns and want to take early action to monitor changes or protect their independence.
- Increased number of people living as independently as possible and carers feeling reassured.

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?
A TECS Programme Board has been established, bringing together all of the partners. This provides oversight of, and direction to, a series of project groups and is supported by five advisory groups, which ensure the approach is firmly based on perspectives from service users, clinicians, information management, workforce, and quality management.
What are the key success factors for implementation of this scheme?
The next steps of the programme are dependent upon the final success of a bid for national funding to enhance the local contributions.

Integrated Community Equipment Service (ICES) – Scheme ref no. 2.4

Scheme ref no. 2.4

Scheme name
Integrated Community Equipment Service (ICES)
What is the strategic objective of this scheme?
Providing aids and equipment so that people with disabilities or recovering from healthcare interventions can remain 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?
Health and social care prescribers across all acute and community providers have access to a catalogue of aids and equipment, from which they can draw down items suited to support the needs of people who are either finding it difficult to remain living independently at home or who are about to be discharged from hospital. Items may be provided on a permanent basis or for a limited time, to support rehabilitation. Once ordered by a prescriber, items are delivered to a set of agreed timescales to the user's home. Servicing, repair and maintenance, and replacement of consumables is undertaken while the equipment is in use. When no longer required, items above an agreed value are collected, cleaned and refurbished wherever possible, and recycled for further use.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
During 2012/13, all of the CCGs and both upper tier Local Authorities across Staffordshire and Stoke-on-Trent undertook an open procurement to bring together a range of separate services provided by different organisations into a single new service. The contract, secured by Medequip, came into operation on 1 April 2013. The service is commissioned by Staffordshire County Council, operating through a s75 agreement with the CCGs across the county, and a collaboration agreement with the s75 arrangements between the CCG and City Council in Stoke. The work is governed by a joint Board.
The evidence base Please reference the evidence base which you have drawn on -

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£4.809m
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
Reports indicate that the ICES is delivering more equipment more quickly to customers, resulting in: • greater user satisfaction, • reduced hospital & care home admission/readmission • earlier hospital discharge • reduced unit cost for items of equipment
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?
A full cost benefit realisation will be completed by the end of September 2014 to demonstrate the full impact. This will be considered by the ICES Board, which will agree actions to be taken by the commissioning team, hosted by the County Council.
What are the key success factors for implementation of this scheme?
S75 agreement across Staffordshire and Collaboration Agreement with Stoke, monitored by ICES Board.

Support to Live at Home Voluntary Sector Day Services (North Staffs) – Scheme number 2.5

Scheme ref no. 2.5
Scheme name
Support to Live at Home Voluntary Sector Day Services (North Staffs CCG), Approach & Moorlands Homelink
What is the strategic objective of this scheme?
To enable elderly people including those with dementia to remain in their own home and to live as independently as possible.
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 support the cross economy transformation programme which aims to deliver comprehensive multi-agency community-based care and support for people with frailty, complex needs and/or long term physical and mental health conditions. **Approach** Approach provides specialist day care for older people with mental health needs or dementia. As part of a wider provision of day care in North Staffordshire, Approach is contracted to provide 15 places each week within its day care provision in the Newcastle area. Each group provides a structured programme and group sizes are kept small so that everyone has plenty of help and support. Approach aims to deliver services that focus on outcomes based on improving the quality of life of the

services user and their family, through the promotion of well-being (both physical and mentally) using individualised person centred care plans and support mechanisms

Moorlands Homelink

Moorlands Homelink supports older people of the Staffordshire Moorlands who are excluded through poor health, loneliness and isolation by providing opportunities for socialisation and inclusion which allow them to feel included and supported in their own communities while living at home.
The service provides information and advice enabling people to access appropriate services and benefits.
Day care is provided in a number of locations throughout the Moorlands for older people who are frail either mentally or physically to provide stimulation and carer relief.

Through these services, service users and their carers will have reduced feelings of isolation, be stimulated and motivated, encouraged to care for themselves and maintain independence and feel less anxious and depressed.

This will reduce dependence on health services and help prevent the need for admission to hospital.

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

The services are commissioned by North Staffordshire Clinical Commissioning Group and provided by 3rd sector organisations: Approach and Moorlands Homelink.

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 following documents and locally commissioned reports have been used to develop the programme these are:

- Older People and Emergency Bed Use, The Kings Fund, 2012
- The Health and Social Care Act (2012) sets out an explicit focus on the importance of integrated care.
- EICST/Mott, Capita and ATOS overview of the urgent care and community service offers
- Fit for the Future Business Case
- Everyone Counts
- Public Health Indicators/demographic change
- Data developed through participation with the LTYC project
- No Health without Mental Health
- NHS Constitution
- Health and wellbeing profile North Staffordshire 2012
- Keogh Report
- Cross economy modelling overseen through the Cross Economy Leaders Group
- Dementia 2012: A National Challenge
- Alzheimers Society dementia hospital research
- The NHS Outcomes Framework 2014/15

Like most of the country, North Staffordshire is experiencing a continuing rapid increase in the proportion of older people in the population. This increasing proportion of older people in the population will make increasing demands on health and social care services. Positive, proactive approaches to service development providing individualised support can help ensure that psychical and mental health are sustained as long as possible, that people live at home as long as possible and that crises and unnecessary use of intensive services are minimised.

Approach adopts the Tom Kitwood social care model which forms the basis of a person centred approach to improving quality of life and the physical and mental well-being of people using our services

Moorlands Homelink have undertaken monitoring of client admissions to urgent care over a 6 month period which showed only 4 admissions from 438 clients. These people were able to return to the service post admission through discharge planning.

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

Contribution to BCF outcome metrics:

- More patients supported to remain in their home
- Reduced admissions to long term care
- Reduced non-elective admissions to acute care

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?

Local service evaluation to measure the impact of this service on the key outcomes

Regular contract performance meetings.

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

1. More people supported to live at home.
2. The number of people admitted to long term care
3. Number of non-elective admisissions
4. People experience an improved quality of life.

Carers

Carers Services

Scheme ref no. 3

Scheme name

Carers (Inc. Carers Breaks, Mental Health Carers Support and Information for Carers) (need to include dementia carer cafes)

What is the strategic objective of this scheme?

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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)

Dementia Carer Cafes are also made available to carers in order to achieve the following outcomes:

- 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

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- 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.

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.

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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

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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.Error! Bookmark not defined.**
- **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.Error! Bookmark not defined.**
- 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.Error! Bookmark not defined.**

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.Error! Bookmark not defined.**
- 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.Error! Bookmark not defined.**

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

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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.

Frail Elderly

Social Care Transfers – Recurrent Funding (S256)

Discharge and reablement – scheme ref no. 4.1

Scheme ref no. 4.1
Scheme name:
Discharge and Reablement
What is the strategic objective of this scheme?
To support the delivery of the Joint Health and Wellbeing Strategy Vision for People in Staffordshire

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and the County Council's 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?

The funding will be used to protect a range of services connected to respite, hospital discharge, and reablement:

- Hospital Discharge Teams - 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.
- Hospital Discharge Service (Age Concern) - 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.
- Integrated Community Intervention - 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) - Specialist social work and therapy input to get people home and ensure they recover as much independence as possible
- Enablement Flats - 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.
- Independent Sector Beds for Respite / Intermediate Care - 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.
- Great Wyrley CSU (Respite Beds) - This 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

The delivery chain

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

These services are commissioned through the County Council, with the majority delivered through existing providers and contract arrangements reducing the need for time intensive procurement exercises and ensuring whole year performance benefit from the investment.

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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 schemes involved in this area have shown over an extended period that they make a significant contribution towards keeping people in their own homes and reducing the number and duration of non-elective hospital episodes.

As one example, in 2013/14 the Great Wyrley CSU was used by 139 people for a total of 3,720 nights. The usage of the unit is split between Cannock CCG residents (70%), South East Staffs and Seisdon CCG residents (15%) and Stafford & 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.

Investment requirements

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

Hospital Discharge Teams - £1.854m
Hospital Discharge Service (Age Concern) - £30k
Integrated Community Intervention - £4.226m
Enablement Teams (LIS) - £4.672m
Enablement Flats - £22k
Independent Sector Beds for Respite / Intermediate Care - £843k
Great Wyrley CSU (Respite Beds) - £653k

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

5. More people are safely supported to stay at home following an acute admission.
6. More people supported to live at home with reduced ongoing needs.
7. Reduction in referral to assessment completion timescales.
8. Reduction in the timescales from completed assessments to start new packages of care.
9. The number of people admitted into a residential or nursing home for the first time following and acute admission reduces
10. People experience an improved quality of life as a consequence of health and social care intervention
11.

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?

The key requirement for success is for all parties, commissioners, SSoTP and providers alike, to develop and adopt a new approach to ensuring individuals are able to remain living independently in the community. This will involve a shift of mindset away from a focus on determining the inputs of care – in terms of a certain number of visits per week, each lasting a given duration – towards an emphasis on outcomes – in terms of individuals facilitated to maintain the greatest possible level of independence.

Market Development and Domiciliary Care - scheme ref no. 4.2

Scheme ref no. 4.2

Scheme name

Market Development of Domiciliary Care

What is the strategic objective of this scheme?

To support the delivery of the Joint Health and Wellbeing Strategy Vision for People in Staffordshire and the County Council's 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?

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 domiciliary 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 joint project team is working to transform service delivery to focus on outcomes, rather than just task and time, and in the meantime to secure short-term solutions to maintain stability of the market.

The delivery chain

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

Domiciliary services are commissioned by Staffordshire County Council, through its s75 arrangement with SSoTP. Under this arrangement, SSoTP holds the budget for all placements and either calls off care from contracts held by the County Council or secures care directly through its own contracting functions. In order to avoid conflicts of interest, it has been agreed that SSoTP will not provide domiciliary care, other than where the level of acuity is such as make full integration of the health and social care aspects essential.
Domiciliary care is provided through a large number (up to 100) of independent and third sector organisations, operating across the full spectrum of size and scope. In accordance with the principles of choice and control encapsulated in the Care Act, the County Council is seeking to promote and develop this market, to support the availability of a wide range of providers able to offer responsive and high quality services to Staffordshire people, in ways that accord with the specific needs and wants of individuals.

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

Current interventions to support the domiciliary market are based on analysis of the ability of the market to meet demand, complemented by extensive engagement with service providers and with SSoTP as the micro-commissioner. In addition, approaches and experience is being drawn from national exemplars and programmes, as well as from other Local Authorities directly.

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Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£1.8m in additional funding to enable care providers to support packages that involve relatively short visits.
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 domiciliary care market will remain viable, with fewer providers failing financially, better quality of care available, and service users placed more easily with providers, thereby facilitating early discharge from hospital and reductions in the number of crises that might require non-elective admission.
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?
A joint project group, bringing together key staff from the County Council and SSoTP has been formed and is actively reviewing the position and is engaging with providers and other partners to identify options for the future and the impact of actions taken.
What are the key success factors for implementation of this scheme?
The key requirement for success is for all parties, commissioners, SSoTP and providers alike, to develop and adopt a new approach to ensuring individuals are able to remain living independently in the community. This will involve a shift of mindset away from a focus on determining the inputs of care – in terms of a certain number of visits per week, each lasting a given duration – towards an emphasis on outcomes – in terms of individuals facilitated to maintain the greatest possible level of independence.

Implementation of the Care Act - scheme ref no. 4.3

Scheme ref no. 4.3

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

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		• 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 Forrest-Davies, Plus Representatives from SSOTP, Mental Health (Mark Cardwell, Andy Oakes) and Independent Futures (Jeanette Knapper)	1. Refresh the Practice Manual 2. Approach to Personalisation 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	1. Review current Safeguarding practice against provisions in the act 2. Make Recommendations for Practice and Market quality including

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	Representatives from SSOTP, Mental Health and Independent Futures	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

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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.**

Frail Elderly - Admission avoidance and delayed discharges & SSoTP Community Frail Elderly (Stafford & Cannock CCG) - scheme ref no. 4.4

Scheme ref no: 4.4

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

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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.

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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.

[1] Reference about North Staffs Hub model see SSOTP

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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 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.

Frail Complex – Intermediate Care (South East & Seisdon CCG) - scheme ref no. 4.5

Scheme ref no. 4.5
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.

Frail Elderly – Cross Economy Transformation Programme "Big Tickets" (North Staffs CCG) - scheme ref no. 4.6

Scheme ref no. 4.6

Scheme name
Cross Economy Transformation Programme "Big Tickets"

What is the strategic objective of this scheme?

At the core of this approach is **comprehensive multi-agency community-based care and support** for people with frailty, complex needs and/or long term physical and mental health conditions. This care and support will feature community health, adult social care and associated services in one coherent offer. It will be delivered under the leadership of General Practice, will be premised upon case management, which will coordinate a range of inputs to provide greater stability to people who may otherwise become overwhelmed by their circumstances, and recourse to acute sector/urgent care services.

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 CEPT programme has 3 key work streams these are:

1. Integrated Locality Care Teams (ILCTs) and Intermediate Care

ILTCs are fundamental to this care and support. In 2014/15, 2,400 people within North Staffs will be being actively case managed through ILCTs.

This supportive community service will be complemented by Intermediate Care. Joined-up Intermediate Care services are a key service component to ensure people stay healthy and independent for longer, and prevent them from being unnecessarily admitted to, or becoming 'stuck' in inappropriate acute sector services for want of the right community solutions.
In 2013/14 North Staffordshire CCG (in conjunction with Stoke on Trent CCG invested in the consolidation of, and staffing of Intermediate Care services.
Social care reablement is at the heart of a programme of modernisation and redesign with a shift in focus from bed to community based provision. A more effective approach to review and better integration with the NHS intermediate care service has led to greater efficiency and improved outcomes for the customer. Overall numbers through the service have increased, the customer journey has reduced and outcomes have improved with greater numbers of people leaving the service with no need for ongoing care and the majority, in the main, leaving with a reduction in care required.
Phase two (2014/15+) will see the alignment of social care Intermediate Care/reablement services with the NHS activity under the Better Care Fund, and the consequent development of a single admission avoidance/discharge hastening pathway. This will continue to shift the community service emphasis from being on discharge, to being on admission avoidance.

2. Frail and complex

The CETP model specifies a multi-agency specialist frail and complex MDT and 'directorate' that works across acute, community and primary care, delivering continuity of care throughout the patient journey. This frail and complex approach will work in conjunction with the ILCTs and Intermediate Care service and provide support to GPs and community services from consultant geriatricians and specialist workers.
The fully-fledged Frail Complex capacity will be mobilised in 2014/15. The support will

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

3. **System coordination / capacity 'hub'** –

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

The CETP will deliver a reduction in non-elective admissions across the Northern Staffordshire local health economy of 4,300 in 2014/15, increasing to 11,900 in 2015/16. Based on 40 % of this, the reduction for North Staffordshire CCG will be 1720 in 14/15 increasing to 4760 in 2015/16.

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

Commissioners
Cross Economy Transformation Programme is commissioned locally via North Staffs and Stoke CCGs

Lead Providers of the relevant services are listed below:

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ILCT – SSOTP
Intermediate Care and Re-ablement – Provided by SSOTP & Staffordshire County Council
Frail & Complex – SSOTP
Capacity Hub - SSOTP

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 following documents and locally commissioned reports have been used to develop the programme these are:

- Intermediate Care - Halfway Home
- National Audit of Intermediate Care
- Older People and Emergency Bed Use, The Kings Fund, 2012
- The Health and Social Care Act (2012) sets out an explicit focus on the importance of integrated care.
- Integrated care for patients and populations: Improving outcomes by working together. A report to the Department of Health and the NHS Future Forum, Kings Fund, 2012
- EICST/Mott, Capita and ATOS overview of the urgent care and community service offers
- Fit for the Future Business Case
- District Nurse Review
- Everyone Counts
- West Midlands Quality Review – LTC
- Francis Report
- Public Health Indicators/demographic change
- Data developed through participation with the LTYC project
- No Health without Mental Health
- NHS Constitution
- The Operating Framework for the NHS in England 2012/13
- Health and wellbeing profile North Staffordshire 2012
- Pilot results -ILCTs 2012
- Keogh Report
- Cross economy modelling overseen through the Cross Economy Leaders Group

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

Contribution to BCF outcome metrics:

- Reduce numbers of acute and sub-acute hospital admissions by increasing the number of patients cared for in a home-based intermediate care setting
- More patients safely supported to stay at home during acute illness/crisis.
- More patients supported to remain in their home following an intervention
- Reduced admissions to long term care
- Shorter lengths of stay within the acute and community trust setting, thereby contributing to reducing delayed transfers of care
- Reduced numbers of re-admissions within 30 days for patients

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?

A framework of KPIs and outcome measures to be measured by both Provider and Commissioner has been developed.

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Acute Trust SUS data and Social Care nationally reported indicators will be used to monitor some of the LHE desired outcomes.

Local service evaluation and audits will be completed to measure the impact of this service on the key outcomes listed above.

The programme of work is supported by the Cross Economy Transformation Team. There are weekly meetings to monitor progress on the Big Tickets and the impact on activity. This feeds in to monthly contract performance meetings.

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

The Vision for the CETP programme is within three years we will be:
• Supporting people to live independently in their own homes
• Giving people the best support when they need it most
• Helping people to stay well
• Working better together for the people who we serve
• Using our resources to maximum benefit

The ambition for the Northern Staffordshire LHE is to achieve a system which will see:

- 3,500 people per year leave the acute hospital earlier
- Improved step-down to community (requires 3,266 additional intermediate care places)
- 11,900 Non-elective admissions to acute hospital avoided
- 25% of NEL admissions avoided amongst the 20 to 69 age group
- 30% of NEL admission avoided amongst the 70+ age group
- Pro-active management of 50,000 people with LTCs
- Improved flow of patients to the right place at the right time through a combination of simplified systems/services, reduced occupancy levels and a capacity hub function.

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NB. The modelling excludes patients outside of Stoke-on-Trent and North Staffordshire.

Reablement Services (North Staffs) - scheme ref no. 4.7

Scheme ref no. 4.7

Scheme name

Reablement and support for Older People(North Staffs CCG)

What is the strategic objective of this scheme?

The funding and investment is considered a *unique and excellent opportunity to forge better integrated working between health and social care systems, for the benefit of patients, service users and carers.* Key to achieving this are Joint working arrangements and these will ensure appropriate development of re-ablement capacity in councils, health services, and the independent and voluntary sector

Co-ordinated Services will deliver care closer to home, support to recovery and self-help and prevention

This scheme supports flow through the system by facilitating hospital discharge, reduced length of stay and delayed discharges..

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 supports the cross economy transformation programme which aims to deliver comprehensive multi-agency community-based care and support for people with frailty, complex needs and/or long term physical and mental health conditions.

The main elements of this scheme are:

Support for hospital discharge

Additional social care assessors ensure that assessments can be undertaken in a timely fashion contributing to reduced length of stay and reduction in delayed discharges. This capacity is required to cope with the increased throughput. Referrals have increased by an average of 15 per week in Q1, although it is planned that the assessors will become more proactive, working from the point of admission rather than waiting for referrals.

Transition / step down beds

It is recognised that there is the need for some transitional support for people who no longer need to be in hospital but cannot yet manage in their own home. 12 beds are commissioned to provide a further period of 24hr nursing support so that patients can be discharged from hospital but still receive further assessment if required and a period of rehabilitation to maximise independence and support return to home if possible.
The key aims of the transitional support is to support flow across the local health economy, reduce length of stay in acute, provide a better environment for the multidisciplinary assessment of patients and to enable patients to achieve optimal functioning after a period of rehabilitation.

The beds are supported by a wrap-around team including OT, social work, rehab support worker and physiotherapy.

The expectation is that patients will be discharged from the transition beds within 4 weeks.

Stay at Home Scheme

This team supports people with dementia to secure timely discharge from acute and community hospitals and to return home from residential and nursing care settings. A full screening assessment is undertaken enabling the team to suggest solutions which will enable people to leave hospital quicker and to support rehabilitation in the community.

The scheme can help prevent inappropriate admissions to residential care, provides care closer to home and increases independence. The team make use of assistive technology to reduce 24 hr care through lifestyle monitoring such as “Just Checking”

Brighton House

Brighton House provides a range of rehabilitation services for up to 26 people including enablement, assessment and respite. The service is available to people over 50yrs who are medically stable and can be maintained in the community, those who are deemed to be at risk of admission to long term care and people who may benefit from a short term programme of enablement. The service is supported by the Community Intervention Service (CIS). Therapeutic activities and assistive technologies are used to support people with their progress.
In 2013/14:
94% of admissions were from hospital
13% were re-admitted to hospital
66% returned home
21% admitted to long term care

Community Services for Older People

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- to develop and maintain community services for older people
- to enable older people to regain and maintain daily living skills and optimise their independence, dignity, health and well being
- to contribute to the improvement of throughput and capacity across a range of older peoples services; namely domiciliary care, in house rehabilitation / re-ablement and specialist provision for older people with dementia

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

Social care assessors and wrap around care -commissioned by North Staffs CCG provided by SSOTP
Transition beds are commissioned by North Staffs CCG provided by the independent sector.
Stay at Home is jointly commissioned by North Staffs CCG and Staffs County Council and provided by SSOTP
Brighton House is jointly commissioned by North Staffs CCG and Staffs County Council and provided by SSOTP
Community Services for Older People are commissioned by Staffordshire County Council from SSOTP, voluntary sector and private sector organisations.

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 following documents and locally commissioned reports have been used to develop the programme these are:

- Older People and Emergency Bed Use, The Kings Fund, 2012
  - The Health and Social Care Act (2012) sets out an explicit focus on the importance of integrated care.
  - EICST/Mott, Capita and ATOS overview of the urgent care and community service offers
  - Fit for the Future Business Case
  - District Nurse Review
  - Everyone Counts
  - Francis Report
  - Public Health Indicators/demographic change
  - Data developed through participation with the LTYC project
  - No Health without Mental Health
  - NHS Constitution
- Health and wellbeing profile North Staffordshire 2012
- Keogh Report
- Cross economy modelling overseen through the Cross Economy Leaders Group
- Dementia 2012: A National Challenge
- Alzheimers Society dementia hospital research

Local evaluation has shown:
65% of patients in transition beds stay less than 4 weeks
61% of patients were discharges home
Of the 91 people supported by the stay at home scheme over a 12 month period, only 3 were admitted to long term care.

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

Impact of scheme

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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
Contribution to BCF outcome metrics: • More patients supported to remain in their home following an intervention • Reduced admissions to long term care • Shorter lengths of stay within the acute and community trust setting. A specific target is difficult to set as trim points and long stay payments vary according to speciality. Targets will need to align with current and future Cross Economy Transformation plans for length of stay • Delayed transfers of care Delayed transfers of care per 100,000 of the population aged 65 and over will be maintained at or below 3.5%. A further percentage reduction in delayed transfers of care is critical to accommodate reduction in acute capacity and the aim is to work proactively in reducing delayed transfers of care to <1% • Reduced numbers of re-admissions within 30 days for patients
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?
Local service evaluation and audits will be completed to measure the impact of this service on the key outcomes Monthly contract performance meetings.
What are the key success factors for implementation of this scheme?
12. More people are safely supported to return home following an acute admission. 13. More people supported to live at home with reduced ongoing needs. 14. Reduction in referral to assessment completion timescales. 15. Reduction in the timescales from completed assessments to start new packages of care. 16. 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 health and social care intervention

Frail Elderly – General Practice Plus (South East & Seisdon CCG) - scheme ref no. 4.8

Scheme ref no. 4.8
Scheme name
General Practice Plus- South East Staffordshire & Seisdon Peninsula CCG
What is the strategic objective of this scheme?
The vision of South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group is to transform general practice to become the centre of local healthcare. To build community services into the practice team so that there is seamless care for patients and clear lines of accountability.

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The objectives that contribute to this vision include:-

- To provide as much care as is safely possible close to home;
- To support fast track access to medical services where required
- To support GPs to develop clinical specialisms to support cohorts of patients in the local community eg ENT, paediatrics, .
- To ensure support for patients and the public to build confidence to manage their own condition.
- One clinical record for a patient so all clinicians, and the patient, understand the plans.

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 South East Staffordshire & Seisdon Peninsula CCG vision for General Practice Plus incorporates five key functions. These include:

1. Supportive Care for the whole family from cradle to grave

2. Advice, support and guidance to help people prevent or delay the onset of long term conditions and/or illness

3. A focus on the Proactive Management of Long term conditions(LTCs)

4. An urgent response in times of patient's perceived need

5. A key co-ordination role in the care of frail older people

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

The CCG and membership will develop and deliver the General Practice Plus vision.

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

Over the past few years, the NHS has seen unprecedented change, not least in general practice. Demand on the NHS is growing with the local population ageing at a greater rate than the national average. This increase in demand is coupled with an increase in the populations' expectations, with patients wanting more holistic, coordinated care with faster access to both routine and urgent care. Whilst general practice has often been sited as the 'answer' to these challenges, the ability for general practice to increase capacity is limited within current arrangements, with year on year funding decreases and significant workforce challenges for both nursing and

medical staff (Deloites 2013).

Local clinicians and the community have highlighted the need to respond to these challenges and develop a much more sustainable solution with its heart in primary care. Multiple stakeholders have suggested that this solution should closely align (or integrate) with community services which will wrap around the practice wherever appropriate and possible. This change will see a corresponding shift in resources from acute settings. This solution has been defined as 'General Practice Plus' (GPP).

Call to Action: Improving Primary Care and the local drafted Primary Care Strategy both support a transformational change in primary care, which our General Practice Plus vision starts to articulate.

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:

- Coordinated proactive care for patients with long term conditions and frailty leading to a reduction in:-
  - ✓ Hospital admissions
  - ✓ Reduction in outpatient attendances in hospital settings
- Increased integration of services and support with GPP- including third sector leading to an increase in:-
  - ✓ Team approach to care- the right person to deliver the care.
  - ✓ Community support
- People taking more control over their own health
- Sharing of good practice and skills within localities.
- Transfer of resources to primary care from secondary care

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?

Patient & Carer feedback
Provider Contract monitoring
Measurement of the success of the cross economy frail elderly strategy.

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

- Successful delivery of the General Practice Plus Strategy.

Scheme ref no. 4.9

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

Dementia Care Services - scheme ref no. 4.10

Scheme ref no. 4.10

Scheme name

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

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.

South East & Seisdon CCG are looking in particular at developing existing services into a new multi-disciplinary dementia service which has close links with GP services but supports the person from diagnosis through to end of life, providing outreach into the community.

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
- Stafford and Surrounds CCG
- Cannock Chase 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?

Activity and outcome measures will be formulated and fed back to commissioners via contract monitoring mechanisms and outcomes reporting.

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. 4.11

Scheme name

Implementation of the Care Act

What is the strategic objective of this scheme?

The Care Act 2014 represents the most significant change in the legislative basis of adult social care since the modern system was established in 1948. While many of the principles enshrined in the legislation simply put onto a statutory footing services and approaches that have long been in place within the County Council, there are many changes to the detail of these, while there are also many new requirements, such as the introduction of Care Accounts.

Effective implementation of the Care Act will enable adult social care services across the county to be more focused on prevention and on reducing the need for care through adopting an approach based on empowering the service user. Success here will reduced demand for non-elective hospital services and facilitate faster and more effective discharge from hospital.

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 touches almost every aspect of the delivery of adult social care. This will require all policies to be reviewed, with many being significantly amended, while operational staff will need to be trained in their new / revised functions, supported by updated IT systems, and service users, their carers and advocates will need to be informed of the changes and their enhanced responsibilities.

The delivery chain

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

Adult social care services are commissioned by Staffordshire County Council from four separate providers:

- Through a s75 arrangement with SSoTP, for Older People and people with Physical Disability / Sight Impairment
- Through s75 agreements with SSSFT and CHC, for people with Mental Health issues
- Through an SLA with Independent Futures, the County Council's in-house all-age service for people with lifelong disability

Under these arrangements, SSoTP and IF hold the budgets for all placements and either call off care from contracts held by the County Council or secure care directly through their own contracting functions. The two Mental Health Trusts either provide care directly or use their own contracts. Frontline staff in all of these organisations, as well as the County Council itself, will require training and support to deliver their new / revised duties.
In addition, there are several hundred independent and third sector organisations that provide care to Staffordshire people. While less directly affected by the changes in the Care Act, these will have significant impacts upon the way in which they operate. In particular, because the Act brings self-funders more closely into the statutory system, providers serving that part of the market may experience particular implications.

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 draws from nationally identified best practice. In implementing the legislation locally, significant efforts will be maintained to draw from national and regional guidance and to adapt this to the specific local context of Staffordshire.

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£2.179k of revenue costs for one-off transition £700k of capital costs for IT system changes
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
Effective implementation of the Care Act will ensure that the adult social care system is fit for purposes, based on a philosophy of prevention, empowerment and a person-centred approach. This will facilitate the availability of services that reduce demand for hospital and long-term residential care, while enabling rapid discharge from hospital with the minimum of ongoing care needs.
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?
A project group, addressing the full range of strands affected by the Care Act and bringing together key staff from the County Council and all of the providers, especially SSoTP, has been formed and is actively reviewing the position. Each strand is engaging with providers and other partners to identify options for the future and the impact of actions taken.
What are the key success factors for implementation of this scheme?
The key requirement for success is for all parties, commissioners, micro-commissioners (SSoTP, SSSFT, CHC, and IF) and providers alike, to develop and adopt a new approach to ensuring individuals are able to remain living independently in the community. This will involve a shift of mindset away from a focus on determining the inputs of care – in terms of a certain number of visits per week, each lasting a given duration – towards an emphasis on outcomes – in terms of individuals facilitated to maintain the greatest possible level of independence.

End of Life

Macmillan End of Life (Stafford & Cannock) – Scheme Ref no. 5.1

Scheme ref no. 5.1
Scheme name
End of Life/Cancer/Palliative Care (Stafford and Cannock)
What is the strategic objective of this scheme?
In relation to End of Life Care Services there are three key aspects for the Programme within the Region: • To improve the identification of people approaching the end of their lives to ensure they receive the care and support they need; • To improve the patient experience and quality of care for patients at end of life, their families and carers; • To improve patient choice at end of life • To reduce the fragmentation of care provision so that there is seamless, integrated and personalised care, when and where people need it, so that no patient or carer will get lost in a complex system.

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?

N.B. Cannock Chase CCG and Stafford and Surrounds CCG are the only two CCGs that are placing this scheme under the BCF. In addition, the only financial element of the Cancer/End of Life programme that is being attributed to the BCF pot is the funding attributed to local hospices and Marie Curie. In so doing the CCGs recognise that by co-ordinating the palliative care / hospices element of end of life care, health and social services can work more effectively to ensure patients nearing the end of their life are supported in their choice of preferred place of death. In so doing the number of patients being supported to dye at home will increase, this in turn will have an impact on the proportion on non-elective admissions being experienced by patients in their final weeks. .
The National End of Life Care Programme (*what we know now 2013*), tells us that

- nationally across England people average around 2.1 hospital admissions in the last 12 months of life
- Approximately 78% of people will be admitted to hospital at least once in their last year of life.
- People from most deprived quintiles are more likely to die in hospital. 61% of people in most deprived quintile die in hospital compared with 54% of people in least deprived quintile (2007-2009)
- Hospital was the least preferred place of death in all regions except for the North East, where care homes are the least preferred.
- People think that dying in the preferred place of death is an important priority. Across the country, ranking 'Dying in preferred place' as the number one care-related priority' varied by region from 29% to 43%.
- There is variation between people's preferred place of death and actual place of death.
- The gap between a preference for a hospice death and actual deaths in a hospice is highest for older people accounting for on average 30 bed days.
- Admission rates are highest in young age groups

Locally, our patients are telling us that if they could, they would prefer to die at home with their family around them.
Evidence shows us that this is not happening:
Local Picture – Place of death
Cannock Chase, Stafford & Surrounds, North Staffs, Stoke on Trent

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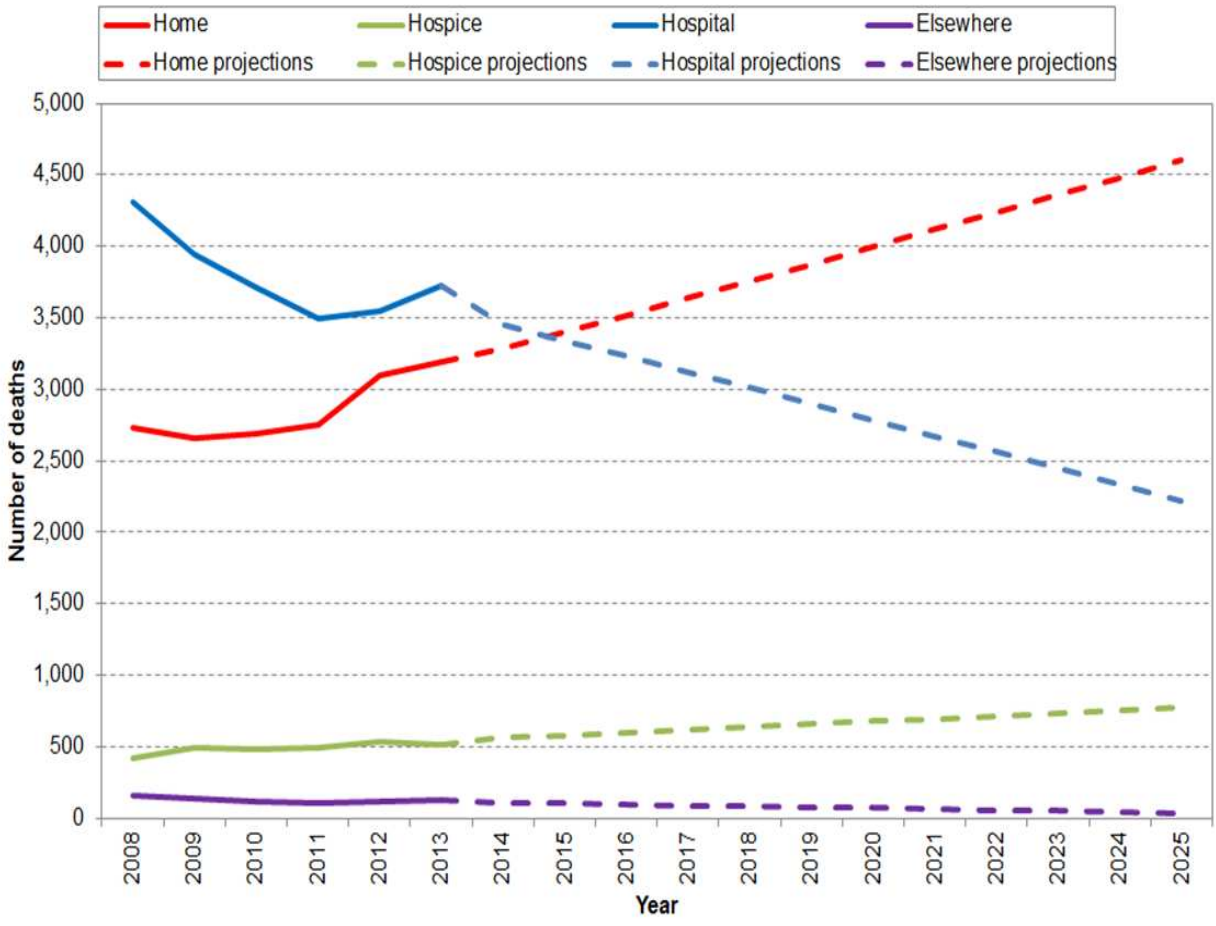
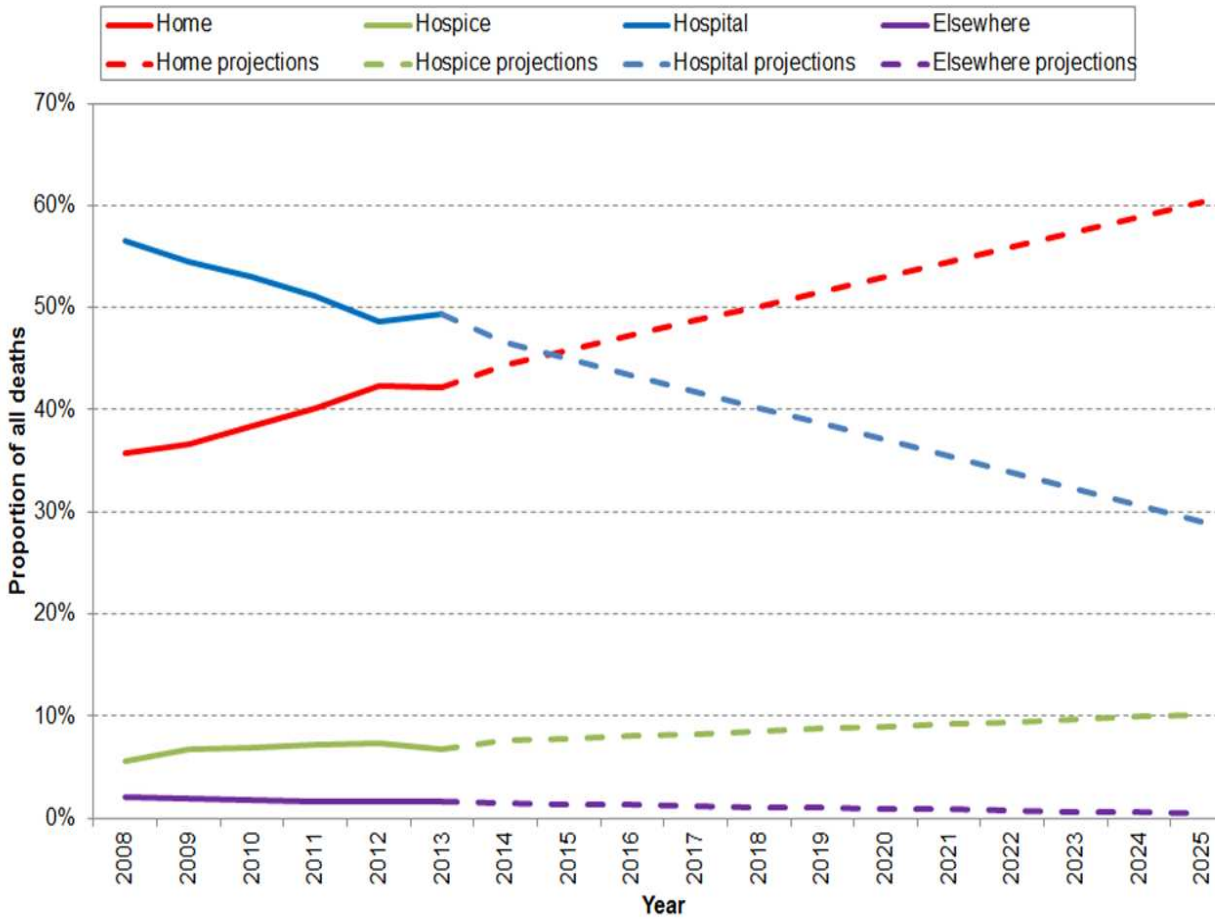
	2012 actual	2013 provisional	2015	2020	2025	Percentage change between 2013 and 2025
Number of deaths						
Home	3,092	3,186	3,399	3,996	4,605	45%
Hospice	539	514	581	677	774	51%
Hospital	3,543	3,728	3,340	2,786	2,214	-41%
Elsewhere	118	125	102	70	38	-70%
All deaths	**7,292**	**7,553**	**7,421**	**7,529**	**7,631**	**1%**
Proportion of all deaths						
Home	42%	42%	46%	53%	60%	43%
Hospice	7%	7%	8%	9%	10%	49%
Hospital	49%	49%	45%	37%	29%	-41%
Elsewhere	2%	2%	1%	1%	0%	-70%
All deaths	**100%**	**100%**	**100%**	**100%**	**100%**	**0%**

Local projections on place of death:
Trends and projected number of deaths by location



Trends and projections of proportion of deaths by location



About the project

North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups jointly and on behalf of themselves, and with the support of NHS England, Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England launched the End of Life Care Programme in April 2013.

The Programme is one of the fourteen Department of Health National Integrated Health and Social Pioneer initiatives.

The Commissioners see the appointment of a Prime Provider for End of Life Care Services as an opportunity to modernise and target services that best meet the needs of the local population. Recent engagement sessions with the local population have made it clear that the public want responsive services that are person centred and developed in partnership with the patient, family and carers, delivered in a holistic manner.

The aim of the Programme is to support health and social care commissioners to shift the focus of practice from commissioning acute based care and individual interventions to one that encompasses the whole patient journey, is fully integrated, and puts the patients' needs at the centre of End of Life Care Services across all providers of care.

The vision for the Programme is aligned with and underpinned by the principles outlined in the five-year plan for Staffordshire and Stoke-on-Trent (2014-2019), the Commissioning

intentions of all partners, and the local Health and Wellbeing Strategies. Namely, a vision for an integrated health and social care system which is centred on individual needs more personalised community-based care and support, and one which recognises the wider determinants of health.

Innovation and having a responsive health and social care system across the locality which meets patient and carer expectations is fundamental. The attributes of such a system would be that it:

- is co-designed by the public, personalised to their needs and preferences;
- provides access to services 24/7;
- reflects a modern model of integrated, co-ordinated care between providers and sectors;
- reflects a high quality, innovative and flexible care market resulting in service models designed to deliver outcomes not outputs underpinned by a high quality and a stable workforce;
- results in exemplary end of life care for patients and carers, enabling independence, choice and control;
- exemplifies integrated systems and pathways reflected by the quality of experience of recipients of care; and
- ensures seamless transitions through health and social care systems and improved cross-boundary and partnership working with an infrastructure in place to enable this to happen.

In addition to meeting national requirements for end of life care, there is the expectation that the appointment of a Prime Provider through a long term contract will deliver the following outcomes:

- all patients at end of life have an excellent and equitable experience of care and support, with care organised around them, provided by a skilled and able workforce;
- all patients at end of life receive appropriate and timely care, support (24/7) and access to NHS funding to enable them to live the best possible life and to support people to die in their place of choice;
- integrated care that is centred around the patient with timely access to local services that provide continuity of care where appropriate;
- reduced inequalities and improved early identification of people with progressive illness in order to support their individual needs and wishes;
- increased choice and personalised care and support based on the holistic needs of patients;
- treatment and care for people in a safe environment and protection from avoidable harm;
- where clinically appropriate, the ability for patients at end of life to self-manage or to receive supported management of their condition at home; and
- a single point of contact for all care and support needs, with services that are co-ordinated and responsive to the specific situation.

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The patient cohort

Research by the End of Life Care Intelligence Network (now Public Health England) suggests that on average around 25% of deaths are unexpected. This means that around 75% of people dying should have their end of life needs recognised and provided for in the last year of life and should be on palliative care QOF registers (which record the number of patients who are expected to die within the next six to 12 months).

Locally, there is a great deal of work to accomplish improvement in the recognition of people at end of life:

	2008/09	2009/10	2010/11	2011/12	2012/13	Number an percentag point differe between 200 and 2012/1
Cannock Chase	146 (0.1%)	211 (0.2%)	277 (0.2%)	286 (0.2%)	364 (0.3%)	218 (0.2%)
East Staffordshire	92 (0.1%)	118 (0.1%)	131 (0.1%)	149 (0.1%)	188 (0.1%)	96 (0.1%)
North Staffordshire	186 (0.1%)	295 (0.1%)	421 (0.2%)	509 (0.2%)	533 (0.2%)	347 (0.2%)
Stafford and Surrounds	132 (0.1%)	195 (0.1%)	217 (0.1%)	240 (0.2%)	255 (0.2%)	123 (0.1%)
Stoke-on-Trent	302 (0.1%)	403 (0.1%)	500 (0.2%)	636 (0.2%)	609 (0.2%)	307 (0.1%)
Staffordshire and Stoke-on-Trent CCGs	**858 (0.1%)**	**1,222 (0.1%)**	**1,546 (0.2%)**	**1,820 (0.2%)**	**1,949 (0.2%)**	**1,091 (0.1%)**
West Midlands	**5,489 (0.1%)**	**8,287 (0.1%)**	**10,440 (0.2%)**	**12,705 (0.2%)**	**13,542 (0.2%)**	**8,053 (0.1%)**
England	**53,857 (0.1%)**	**74,907 (0.1%)**	**92,870 (0.2%)**	**113,105 (0.2%)**	**130,233 (0.2%)**	**76,376 (0.1%)**

Source: Quality Management and Analysis System (QMAS) database - data as at end of July, Copyright, The Health and Social Care Information Centre, Prescribing and Primary Care Services.

End of Life Care Services are defined as services for those people "approaching the end of life" where they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

• advanced, progressive, incurable conditions;

• general frailty and co-existing conditions that mean patients are expected to die within 12 months;

• existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and

• life-threatening acute conditions caused by sudden catastrophic events

Definition used by the GMC and NICE End of Life Care Working Group1

Prisons

Nationally, As of March 2010, 85,184 people were being held in prisons across the UK

- Up to 30% of prisoners have learning disabilities
- 48% of prisoners are at or below the reading age of an 11 year old

- 82% of prisoners are at or below the writing age of an 11 year old
- Once offenders have been in prison for 4 or more years, they age twice as quickly as the general population
- People over 60 yrs of age have been identified as the fastest growing group within the prison estate
- Of the prisoners across the UK, 95% are male and proportionately more prisoners are from an ethnic minority
-

Staffordshire has a high prison population with a total of over 4,000 prisoners.
Across Staffordshire & Stoke on Trent there are 9 Prisons:

- Drake Hall (Womens prison)
- Swinfen Hall (Young Offenders – male)
- Werrington Prison (Young Offenders – male)
- Brinsford (Young adult)
- Featherstone (Adult cat C)
- Stafford Prison (Adult male cat C)
- Oakwood Prison (Adult male cat C)
- Dovegate (Adult male cat B)
- Stoke Heath Prison (Adult & young adult male closed cat C)
-

Palliative Care & End of Life provision across the West Midlands comprises of:
1 palliative care cell with 24 hour nursing at Hewell Prison in Worcester
2 palliative care cells with 24 hour nursing at Birmingham Prison (Winson Green) Patients at end of life will use normal inpatient facility if palliative care beds occupied.
Out of hours GP cover provided to all prisons by current out of hours provider
ISSUES: Shortage of 24 hour specialist nursing and palliative care provision

Commissioning partners will work to address the issues around end of life care for our prison population.

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

North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups jointly and on behalf of themselves, and with the support of NHS England, Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England launched the Transforming Cancer and End of Life Care Programme in April 2013.

The providers of adult hospice / Palliative care for Cannock and Stafford are:
Marie Curie
Staffordshire and Stoke and Trent Partnership Trust
St. Giles Hospice
Katherine House Hospice

Douglas McMillan Hospice
Compton House Hospice

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

Building the evidence of such an approach, as well as scope for the programme has been

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organic from extensive public and clinician engagement over the course of a two year period. An external organisation has been commissioned to work with the commissioners to evaluate the Programme in real-time, to enable learning to be applied. The first stage of the work carried out was an insights piece which looked at the range of commissioning models and the risks and benefits for each. As a Pioneer site commissioners are committed to being a part of more of an impact evaluation. Macmillan, as the key strategic partner has committed to commissioning a longitudinal evaluation and impact assessment of the Programme for the lifetime of the contract (10 years).

Evidence that a shift to a more 'Hospice at home based approach to End of Life care' could provide the following efficiencies and improvements in quality of care:
Palliative and end-of-life care can be provided in a range of settings,
including hospitals, hospices, outpatient or community services, and at home. Studies have suggested that palliative and end-of-life care can allow more people to die at home, improve quality of life, reduce pain and other symptoms, and lower the demand for unplanned hospital care
(*Alonso-Babarro and others, 2011; 2012; Barbera and others, 2010; Brumley and others, 2007; Gomes and Higginson, 2006; Gómez- Batiste and others, 2012; Lorenz and others, 2008; Serra-Prat and others, 2001; Shepperd and others, 2011; Tamir and others, 2007; Temel and others, 2010).*

A recent review of funding for palliative care estimated that around 75% of the 470,000 people who die each year in England would benefit from palliative care, while around 90,000 people die each year without access to palliative care
(Hughes-Hallett and others, 2011).

The evaluation of the Marie Curie Nursing Service by the Nuffield Trust showed:
Across all types of hospital activity, people who received MCNS care used significantly less hospital care than matched controls.

People who received MCNS care were much more likely to die at home, less likely to require hospital care and incurred significantly lower hospital costs.

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?

Feedback will be through the End of Life Programme Board and the EoL Programme Implementation Team (Commissioners). An EoL outcomes framework has been developed and will be finalised as part of the process to award the EoL prime Provider contract.

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

By co-ordinating the hospices element of end of life care, health and social services can work more effectively to ensure patients at the end of their journey experience in a planned, coordinated way individuals will be able to choose their preferred place of dying. Patient consultation has demonstrated that there will be a shift away from the current default of the

acute hospital setting to the home or hospice provision reducing the number of non-elective admissions for this patient group in the latter stages of death.

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