Staffordshire Better Care Fund

Version 05 09/09/14

Staffordshire County Council

Cannock Chase Council

East Staffordshire Borough Council

Lichfield district council www.lichfielddc.gov.uk

Newcastle Under Lyme Borough Council

South Staffordshire Council

Stafford Borough Council

Staffordshire Moorlands District Council

Tamworth Borough Council

NHS
Cannock Chase Clinical Commissioning Group

NHS
North Staffordshire Clinical Commissioning Group

NHS
Stafford & Surrounds Clinical Commissioning Group

NHS
East Staffordshire Clinical Commissioning Group

NHS
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group

Staffordshire Better Care Fund

Introduction

This document has been developed by the partners to the Staffordshire Health and Wellbeing Board.

The people of Staffordshire need a new model of person centred coordinated health and social care. At the moment too many people spend too much time in health and care institutions that risk them losing their independence. In Staffordshire we have started the journey to this new model of care and the pooling of budgets with partners through the BCF will provide us with the next step. This will move us towards a transformation of health and social care which will focus on prevention, early intervention and integrated care as far as possible based around the home.

Staffordshire also needs to make this journey of transformation because we are one of the eleven 'national challenged' health economies. Alongside the needs of the public this economic background makes a further compelling and urgent case for change. The Health and Wellbeing Board recognised these pressures some time ago and the changes required have been clearly documented in the Joint Health and Wellbeing strategy.

To achieve this transformation we as partners must work much better together, to change behaviours. We must strengthen our population's capacity and desire for personal responsibility, independence, choice and control.

The current fragmented care does not maximise the effectiveness of the public sector purse. Our joint work means we will be able to much better use the assets that exist within service users, their carers and their communities to improve the capacity to better self-manage and maintain independence.

As a significant part of this journey, the Better Care Fund planning continues to be a work-in-progress, which aligns locally with plans for a wider-scale integrated commissioning and with the NHS 2- and 5-year plans. As we develop more detailed work plans and align our commissioning to meet agreed targets and population outcomes, we will continue to work through ongoing consultation with key stakeholders including local people, the voluntary and community sector, primary, acute and community health providers, and our social service teams.

It is recognised that the BCF and integrated commissioning work will evolve and change as we develop more detailed plans for individual schemes and service delivery areas.

As our move to integrated care is rapid, there are some areas where we have clear aspirations to commission jointly. However, plans in different parts of Staffordshire are not unified, reflecting the diversity of our population and service provision. We

embrace this variation, whilst remaining very clear in terms of the outcomes we want to deliver for local people.

The Better Care Fund has a focus on Older Adults at a national policy level, which is covered in this plan. Our plan covers broader parts of the population and includes some children's mental health services, prevention initiatives, and carer support and equipment services. In these cases, there is a clear link between interventions and a reduction in reliance on acute or long term care. This provides us with an opportunity to take full advantage of the good work already done to date in recent years around integrating resources and commissioning activity across these areas.

A number of supporting documents have been included which provide further background detail.

Contents

Appendix 1: BCF plan submission template

Staffordshire County submission

1. Plan Details

a) Summary of plan

Local Authority

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

Clinical Commissioning Groups

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

Boundary Differences

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

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

Final sign-off 11th September 2014

Date submitted:

19th September 2014

Minimum required value of BCF pooled budget	2014/15	£16,234,000
	2015/16	£56,108,000
Total proposed value of pooled budget	2014/15	£16,234,000
	2015/16	A minimum of £56,108,000 with likely total pooled budget being in excess of £150,000,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group 	Stafford and Surrounds CCG
By	Dr Anne-Marie Houlder
Position	Chair of Stafford and Surrounds CCG
Date	xxxxx

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

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

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

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

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

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

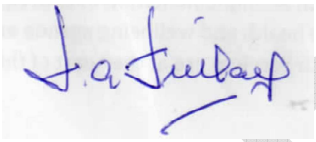
Signed on behalf of the Council 	East Staffordshire Borough Council
By	Councillor Dennis Fletcher
Position	Deputy Leader (Built Environment)
Date	xxxxxxx

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

Signed on behalf of the Council 	Newcastle-under-Lyme Borough Council
By	Councillor Gareth Snell

Position	Leader
Date	xxxxx

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

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

Signed on behalf of the Council 	Staffordshire Moorlands District Council
By	Councillor Gillian Burton
Position	Cabinet Member for Communities
Date	xxxxxx

Signed on behalf of the Council	Tamworth Borough Council

By	Councillor Daniel Cook
Position	Leader
Date	xxxxxx

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

Signed on behalf of the Health and Wellbeing Board	Staffordshire Health and Wellbeing Board
By	Johnny McMahon
Position	**Co-Chair of Health and Wellbeing Board**
Date	xxxxxx

Section 2: Vision for health and social care services

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

The vision for the health, social care and associated services of the future for Staffordshire are set out in the Joint Health and Wellbeing Strategy (Doc2) "Living Well in Staffordshire" 2013-18. At the basis of this strategy is an emphasis on preventative approaches which reduce dependency on the NHS and social care by preventing crises, and which increase people's resilience and independence: ambitions that have been consistently expressed in processes of engagement conducted with those that use services. Continuing as we are is not an option, with a predicted funding gap (by 2018) of £292m in Staffordshire if nothing were to change.

Activity will focus on community and preventative services reducing the level of activity and the impact of costs on acute and NHS services and on on-going social care services, such as residential care. Coupled with this will be whole system efforts to maximise those factors that promote strengthened personal responsibility and independence amongst the population, facilitated through greater community cohesion. Districts and Boroughs have a key role in addressing the underlying determinants of health and independence as part of this strategy.

We want our population to feel able to take control of their own health and wellbeing so a large part of this plan focusses on what we can do to build on principles of self-management, engaged communities and patient activation.

Our aim is to address the following priority areas:

1. **Increase life expectancy** for all, and bring it in line with the rest of the country.
2. **Reduce health inequalities**, and close the gap between those most and least advantaged.
3. Properly **support people with long-term conditions** and/or complex needs to live independently.
4. Ensure that **people experiencing mental ill-health get equal access** to physical health and social care services.
5. **Improve mortality/survival rates for people with long-term conditions and cancer**.
6. Ensure that all NHS, social care and associated services are of a **high standard of quality and safety**, and deliver outcomes that improve people's lives.

In addressing these priority areas, we aim to create a place which:

1. Supports people to ***feel safe and well in their own homes***, through helping people to be a part of their local community and be supported to access a range of support solutions to ***maximise their independence*** for as long as possible.

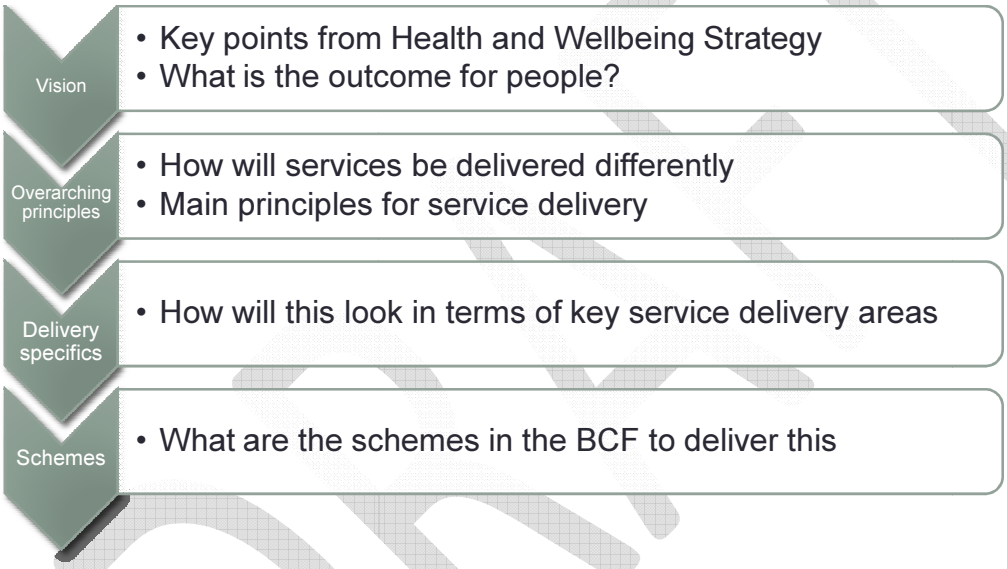
2. Empowers people to make their ***own choices*** and have ***control over their own lives***

3. Ensures that individuals are treated with ***dignity, fairness and respect***

4. Supports people to receive the ***right care at the right time***

5. ***Promotes self-care*** where safe and practical

This submission addresses the following points:-



1. What difference will this make to patient and service user outcomes?

The vision for people in Staffordshire is set out in the Joint Health and Wellbeing Strategy. This is what we aspire to deliver for our citizens:

Living safe and well in my own home

I will live in my own home and remain part of my local community as long as possible. I will be able to access support solutions that are built around my ongoing home life and independence, taking account of my housing needs. I feel safe in my local community and my community is supportive of everyone, especially those who are most vulnerable.

Living my life my way, with help when I need it

I will have control over my own life and be able to make choices about what happens to me. Information, advice and guidance will be readily available to me and will help me draw on the support I need. If I am particularly vulnerable, local services will be aware of this and will offer me targeted support early, to help me manage my situation well.

Treating me as an individual with fairness and respect

I will be treated as an individual, with respect, dignity and fairness, and as an expert in my own experience. I will receive support to a high standard and I will be able to feed my views easily to the Health and Wellbeing Board and to services, and my views will be listened to and acted on.

Making best use of taxpayers' money

I will be confident that public money is being spent well, and that I get quality, and value for money services locally, whether the services I receive are provided by the NHS, the Council or private and voluntary sector organisations.

This vision is fully consistent with the three outcomes that have subsequently been adopted through the Staffordshire Strategic Partnership:

1. *The people of Staffordshire will:*
    1. *Be able to access more good jobs and feel the benefits of economic growth*
    2. *Be healthier and more independent*
    3. *Feel safer, happier and more supported in and by their community*
2. What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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

1. People will be supported at their lowest point of dependency
2. Better-coordinated treatment, care and support will be available for people in the place which is right for them, with an emphasis on keeping people in their communities building on local assets.
3. The local health, social care and housing economy will develop comprehensive generalist community-based care and support for people with frailty, complex needs and/or long term physical and mental health conditions, complemented by specialist input as required. Central to this will be robust, flexible domiciliary care capacity.
4. As we help people to avoid crises, we will expect to see resource presently committed to non-elective urgent care services in the acute sector shift to fund community-based activity.
5. People will be supported to take control of their health and wellbeing, and of the services that support them.
6. Services will be commissioned smartly and where possible for outcomes rather than activity-based targets

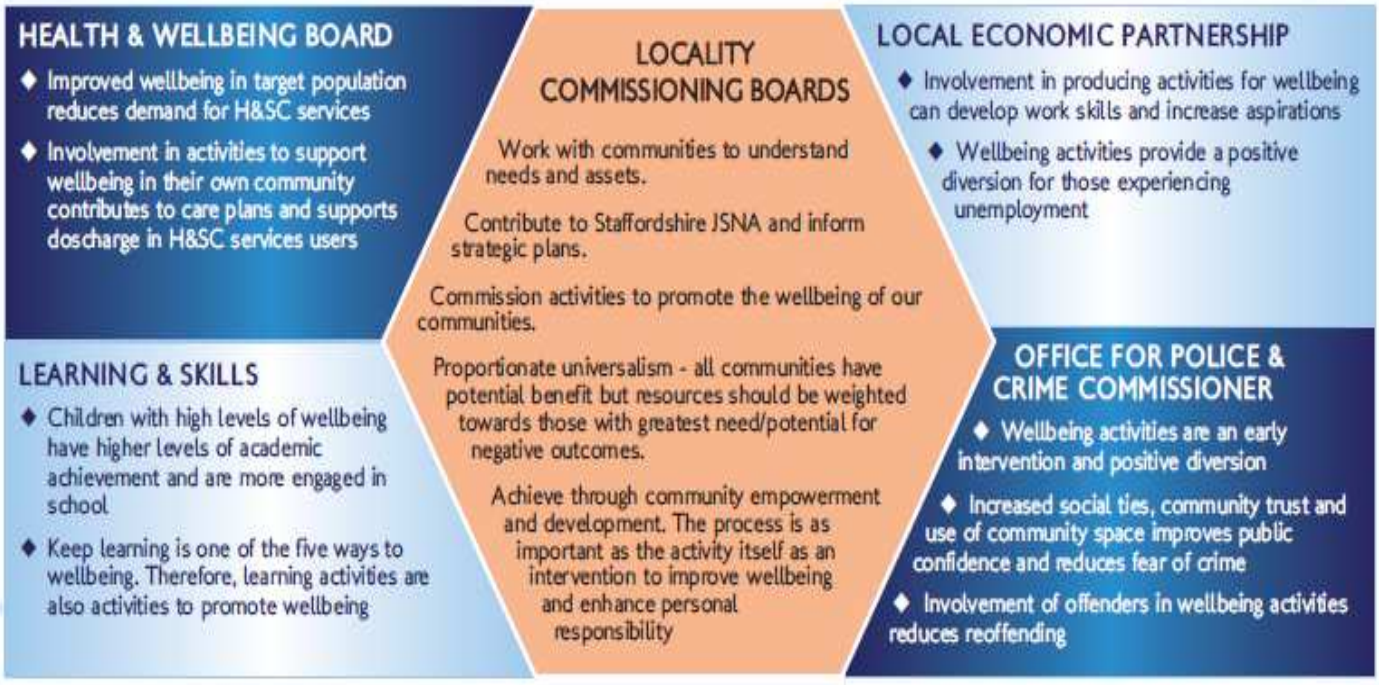
7. It is estimated that preventative health and care services delivered in the community save £4 for every £1 spent.

The Staffordshire Health Economy has been one of the eleven national areas identified as challenged as part of the Intensive Support for Planning work. A report has been produced which talks about the need to focus on frail elderly pathways as a large part of the quality and sustainability challenge. Our ambition for Integrated Commissioning across Staffordshire means investing in an ambitious programme of work to integrate our commissioning in a number of areas. They include:

Ageing Well
Support to Live at home
Carers
Frail Elderly
End of Life

The BCF is not a vehicle for delivery of all of our plans for integrated commissioning, but has been designed to focus on the last three of these areas i.e. carers, support to live at home and frail elderly. In addition we have developed plans around 'Aging Well' to recognise that we require support to keep people well and out of the health and social care system for as long as possible.

In parallel to our work on integrated commissioning, we have been working collectively on strategic change led by district councils to develop the concept of locality based commissioning. This focusses on wellbeing and devolves down the commissioning to



support community asset to the district and borough partnerships; the role of locality commissioning boards is demonstrated in the diagram below:

Provider organisations were not involved in depth in the development of the Health and Wellbeing Strategy; however, they have expressed agreement with the general principles.

Frail Elderly Strategy

A key enabler to the delivery of the vision for Health & Social Care is the development of a Staffordshire wide '**Frail Elderly Care'** Strategy. This drafted Strategy has been developed with health economy partners and sets out agreed fundamentals for Frail Elderly Care, recognising the diversity of the populations we serve and allowing for different operating conditions and challenges that each commissioners faces. This drafted Strategy is about securing a sustainable and effective health and social care system which is both local and responsive to the needs of our populations.

This strategy draws together the work underway to transform Frail Elderly Care across Staffordshire and ensure a continuum of care aligned to the ambitions set out within our Staffordshire Health & Wellbeing Strategy.

The Health and social care economy are committed to the NHS England mission of high quality care for all; that Commissioners are striving for parity for mental health; and that the Commissioners respond to and seek to promulgate the best practice guidance from the Royal College of Physicians, the British Geriatrics Society and Kings Fund.

Fundamental 1:	Elderly Care should be a whole system approach where all elements of the system link by design and work together to proactively support the patient anticipating, planning and delivering for their needs;
Fundamental 2:	There should be timely, proportionate and appropriate communication between all those involved in a person's care and support that always engages the person and their carer(s) where the ability to provide for excellence in a person's care is enabled by access to information;
Fundamental 3:	That irrespective of where people present in the system, they have access to an appropriate and rigorous assessment of their needs, that this assessment is trusted and informs the diagnosis of their health, social care and wider well-being needs and that they are able to access treatment and care services in the setting appropriate to their assessed needs promptly without unnecessary transfers of their care and without unnecessary admission to hospital;
Fundamental 4:	That the quality of care received and the experience of individuals should not be adversely affected by where they normally reside, the time their care is needed, the place where their care is delivered, or by the person or organisation delivering their care;
Fundamental 5;	There is a requirement for case finding and case management that navigates people through to the services they need that leads to achievement of outcomes, these outcomes being determined by screening and assessment processes that inform the care plan and the actions taken to deliver care;

Fundamental 6: An emphasis on prevention and support for living well, including after episodes of illness or where an individual's well-being has been compromised, is essential and at all times individuals should be supported to achieve optimal recovery, their best level of reablement, rehabilitation, and confidence; and

Fundamental 7: Preserving dignity, respect and privacy for all must be at the heart of our model of care and by design we should eliminate health inequalities.

The strategy outlines a continuum of care, summarised below:-

The Continuum of Care												
Prevention	Empowering Self-Care and Education	Support at Home	Enhanced Services at Home	Managed crisis and planned responses to need	Step Up	Acute services including admission where necessary	Manage Discharge effectively avoiding readmissions	Step Down	Enhanced Services at Home	Support at Home	Empowering Self-Care and Education	Community and Voluntary Sector support
An integrated delivery system involving public health, community and voluntary sector, primary care, community service, acute and secondary care services and the patient .												

Detailed work is ongoing to identify the best vehicle and footprint to commission this holistic pathway.

Section 3: Case for Change

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

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

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

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

The result is an increased demand for elective NHS, non-elective NHS and social care services. A 'do nothing' option would result in a massive increase in the need for services, be unaffordable (an estimated deficit in excess of £400m by 2018/19) and lead to system collapse. The scale of change required is dramatic. It has been estimated that this will involve a shift of £200m currently spent in acute hospitals and residential social care (equivalent to 400 beds) to be used to support more effective preventative services in the

community. This cannot simply involve a shift in the geographical location of services, doing in the community what used to be done in hospitals. Instead, what is required is a major redesign of the very nature of the care system, doing different things in the community so that needs are met effectively which in turn means there is less demand for bed based acute hospital and residential social care services.

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

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

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

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

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

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

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

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

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

Activity and costs of Frail Elderly

- During 2012/13 there were around 35,100 non-elective (unplanned) admissions to people aged 65 and over making 43% of all non-elective admissions but 60% of non-elective admission costs. Around 24,200 of these admissions were to people aged 75 and over and 10,600 to people aged 85 and over. Admission rates for people aged 65 and over in Staffordshire are higher than the national average, in particular for strokes and hip fractures.
- The number of delayed transfers of care from hospital per 100,000 population in Staffordshire has increased slightly 9.8 per 100,000 in 2011/12 to 10.2 per 100,000 in 2012/13 (not statistically different). The proportion of delayed transfers in Staffordshire that were attributable to social care is higher than the England average.
- During 2012/13 there were around 1,095 permanent admissions to people aged 65 and over to residential and nursing care homes, the rate being similar to the national average.
- In 2012/13 more older people (aged 65 and over) who were discharged from hospital to intermediate care / rehabilitation / reablement were still at home after 91 days (86% compared with 81% across England). The proportion at home at 90 days does reduce with age with around 90% of Staffordshire's residents aged 65-74 being at home 90 days after discharge compared with 82% of people aged 85 and over.
- Non-elective spells, elective spells and residential care admissions are all increasing.
    - Non-elective spells are predicted to increase at a rate of 2.4% per year
    - Elective spells are predicted to increase at a rate of 13% per year
    - Permanent admissions to residential care are predicted to increase at a rate of 4.2% per year.

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

We are well placed in Staffordshire in that we have made good progress in integrating provision. We know we have much more to do. We will continue to implement our plans to use integration of systems, process teams and budget to:

Simplify care services by breaking down organisational and administrative barriers, so that people can access the right care at the right time (our approach to integrated commissioning is the means to deliver this)

Coordinate service delivery enabling earlier and faster delivery of more effective care in cooperation with GP practices, community health, mental health, acute providers and the 3rd sector

Align our approach to prevention , self-care and support for people, their families and carers to increase the individuals and family/carers' capability to manage care needs

Commission responsive and intensive community based services supporting people and their families /carers to manage their needs at the least invasive level as possible (our approach to managing risk is key to delivering this)

Understand individual needs by personalised care planning and effective case management in primary /community care, linked to effective proactive case finding and early intervention

Use workforce changes and training to fundamentally shift the culture of staff delivering health and social care.

Section 4: Plan for Action

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

In order to achieve our ambitions around the BCF, we will focus in the following areas.

Programme
Ageing Well
Support to Live at Home
Carers
Frail Elderly
End of Life

A series of initiatives have been identified to help us achieve against these headings. This is consistent with the narrative in the CCG two and five year strategies and the local authority plans.

The delivery of whole-system transformational change will only be achieved if a range of coordinated developmental programmes are instituted to ensure that key enablers to service delivery also transform to meet the challenges of the future. Programme management will be employed to this end, and a programme management office set up for the purpose.

It is likely that the Better Care Fund will be overseen by a new Joint Executive Board which will be a subgroup of both the Staffordshire and Stoke on Trent Health and Wellbeing Boards.

In terms of milestones key dates are:-

- Joint Executive Board established October 2014
- BCF Delivery Plan finalised November 2014
- Frail Elderly Strategy finalised December 2014
- Providers agree joint pathways for community hospitals December 2014

Each of the individual initiatives will have detailed project plans and an overarching progress report will be developed for the Joint Executive Board.

Where clear project methodology is not in place, risks on a per scheme basis will be developed during 14/15 as part of the development of individual projects. Agreement has been reached on existing activity (funding) which is being transferred to the BCF, and what activity this will translate to in order to deliver against BCF targets and vision (see BCF doc8). Work remains to clarify – where not already developed – additional/new activity to deliver the BCF vision.

Finance leads and commissioner leads have been agreed for each scheme, and meetings are taking place on a bi-weekly basis to agree detailed financials and commissioning plans.

Further sub-groups have been set up as follows:

- Metrics
- Modelling
- Care Bill
- 7-day working

These groups are being tasked with working up the detail to support the BCF vision, reporting along programme management lines.

Considerable work is being undertaken around the governance arrangements which need to underpin any integrated commissioning arrangements.

8. Please articulate the overarching governance arrangements for integrated care locally

In order to meet these challenges, strategic commissioning must focus upon whole systems of activity, and adopt methods that will guarantee coherent service delivery. Use of new methods of commissioning (e.g. 'capitated' budgets, prime providers for specific pathways, the encouragement of alliances or consortia of complementary provision, etc.) alongside the reemphasis of the centrality of General Practice in the future model of care, are essential prerequisites of a whole system solution to the issues of the moment.

Over the next five years, the BCF will enable more consolidated commissioning of better services and support for people, with consequent improvements in service effectiveness and qualitative outcomes.

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

Current arrangements are that the HWB has overarching responsibility for the achievement of the BCF plan, with executive responsibility delegated to the co-chairs of the Integrated Commissioning Executive Group. This is a mature group, with well-established working relationships, whose membership reflects that of the HWB with representation of senior officers from Councils, CCGs, Public Health, Police Commissioner and HealthWatch.

For delivery of the Better Care Fund Plan, it is likely that the Joint Executive Board which sits beneath both Staffordshire and Stoke on Trent Health and Wellbeing Boards will take overall responsibility for assuring delivery. :

One of the key gaps in terms of the existing arrangements for coordinated delivery is the lack of providers on the HWB. This will be addressed and the Joint Executive Board will include both commissioners and providers and develop mutual accountability.

Any decisions affecting the delivery of local services (CCG aligned) will be agreed by local commissioning and finance committees/board as appropriate to enable partners to exercise their statutory duties before final sign off at the Health and Wellbeing Board. Commissioners must clearly understand arrangements and key personnel at locality level to ensure local delivery opportunities are co-ordinated and maximised.

It is expected that in addition to the overall scrutiny of delivery the JEB will : -

1. Identify services, funding and strategic objectives where a PAN CCG/county approach or a locally specific CCG approach is required as appropriate
2. Oversee the implementation of the projects for review and redesign within geographical areas as appropriate
3. Oversee the co-ordination of appropriate engagement with local patients, clinicians and commissioning networks
4. Ensure quality patient/user care and the best value for services
5. Monitor the performance (agreed outputs, outcomes) and financial aspects at a local/county level
6. Review the effectiveness of the collaboration
7. Establish working groups as appropriate

The governance arrangements for client specific boards are being fully reviewed to ensure the delivery mechanisms are fit for purpose and there is clear delegation.

The BCF will be delivered through a pooled budget under s75 arrangements. Discussions have begun as to how this s75 agreement will be arranged and which organisation(s) will be responsible for holding the fund.

d.) List of planned Better Care Fund Schemes

In terms of our strategic intent, these are the schemes which form the basis of this Better Care Fund submission are currently.

Existing Plans

We will need to develop different solutions for different geographical areas, based on the varying risk profiles and local population needs of those areas.

For this reason, approaches are legitimately being developed for different localities within Staffordshire. The BCF is not a vehicle for delivery of all of our plans for integrated commissioning, but has been designed to focus on the last three of these areas i.e. carers, support to live at home and frail elderly. In addition we have developed plans around 'Aging

Well' to recognise that we require support to keep people well and out of the health and social care system for as long as possible.

Frail Elderly

We have identified as part of the BCF that the need to provide a coherent continuum of care for frail older people is key to delivering better outcomes. Have adopted the following definition of frailty: 'a state of vulnerability resulting from the cumulative decline in physiological systems which occurs progressively over a lifetime'

Our aim is to support people to stay well and independent for as long as possible. The initiatives described in this section represent some of the big transformational changes to shift that balance.

Ageing Well

[Lucy Enter narrative here]

Scheme	Projects	Scheme Ref:
Ageing Well	Falls Prevention	1.1
	Locality Asset and Capacity Building	1.2
Support to Live at home	Disabled Facilities Grant	2.1
	Adult Social Care Capital Grant	2.2
	Technology Enabled Care Services (TEC) and Assistive Technology	2.3
	Integrated Community Equipment Service (ICES)	2.4
	Support to Live at Home Voluntary Sector Day Services	2.5
Carers	Carers Breaks	3.1
	Mental Health Carers Support	
	Carers Information	
Frail Elderly	Social Care Transfers – Recurrent Funding (S256)	
	Discharge and reablement	4.1
	Market Development and Domiciliary Care	4.2
	Implementation of the Care Act	4.3
	Frail Elderly - Admission avoidance and delayed discharges & SSoTP Community Frail Elderly	4.4

	(Stafford & Cannock CCG) Frail Complex – Intermediate Care (South East & Seisdon CCG) Frail Elderly – Cross Economy Transformation Programme "Big Tickets" (North Staffs CCG) Reablement Services (North Staffs) Frail Elderly – General Practice Plus (South East & Seisdon CCG) Frail Complex – End of Life care (South East & Seisdon CCG)	 4.5 4.6 4.7 4.8 4.9
	Dementia Care Services	4.10
	Care Act Implementation (Revenue Funding)	4.11
End of Life	Macmillan End of Life (Stafford & Cannock)	5.1

Wider Plans

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

Joining Up our Transformation Plans

Staffordshire health and social care economy has no financial flexibility and all organisations are in deficit. That means there is very little flexibility to divert money in terms of cash investment. We now have the recommendations of the KPMG report and there are suggested areas of savings. In addition, we have had a small task group further reviewing the evidence around other initiatives we could implement to create financial headroom.

They are:-

	Estimated Saving
Continuing Health Care	£2m
Expanding falls prevention	£3m
Patient Activation	£1m
Capitated Budgets for frail elderly and MSK	£2m
Shared decision making for surgery	£1m
Changing criteria for adult social care	£1.5m

Developing extra care housing options	£1m
Increasing access for IAPT	£1.5m
Stroke prevention	£1m
Increasing uptake of flu vacs	£0.5m
Disinvestment	£1.5m

We are doing further work up on these proposals and will seek agreement to monitor progress as part of the overall Joint Executive Board.

[enter text here about Integrated Commissioning and wider context]

Plans to protect social care

[Rita to enter list of things]

Section 5 Risks and contingency

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

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

10. Risk Log

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

Risk	Risk rating/ Likelihood	Mitigating Actions	Owner	Timeline
High level of savings required across the health and social care economy (c.£45m) in	High	Implementation of KPMG recommendations. Further work has been done to		

2015/16 are unachievable		identify savings plans to create financial headroom. Develop a whole system service and financial transformation programme, which addresses the challenges facing each of the partners. Some elements of this plan may be focused on specific parts of the system, building on existing change initiatives. Review good practice from elsewhere, including LGA value cases and outcomes of Anytown modelling to identify opportunities for greater impact.		
CCGs and providers are unable to deliver plans to reduce hospital emergency admissions leading to inability of the system to make savings intended through the plan	High	Good programme management in place. Work to develop strong resilience plans to ensure delivery.		
Money going into BCF already tied up in mainstream services, therefore cannot fund additional activity	High	Plans already in place for re-commissioning of services at lower cost which will fund expansion of preventative / community investment.		
Potential impact of Mid-Staffordshire NHS Foundation Trust changes where redesign is focused on maintaining financial viability of the Hospital rather than supporting changes set out in BCF	Medium	Gradual transformation with staged approach to investing in preventative options. MSHFT changes invest in acute care. Negotiation on new contracts with Hospitals agreeing caps on intake numbers and shared risk with Hospitals on overspends.		
Lack of clear national guidance on the following	High	To be raised with national team LAT		

may prevent signatory partners gaining sufficient assurance to develop s75 agreement(s). *11.* Arrangements for (S75) budget pooling. *12.* Establishment of reasonable local improvement trajectories and targets. *13.* Mechanism for determining 'failure', apportioning responsibility, and withholding resource.		following submission of 4/4 BCF.		
National benchmarks/baselines upon which performance is to be premised may present unrealisable trajectories/targets for local health economy/CCG areas. (See appended metrics document)	Medium	LAT to support the development of locally relevant trajectories/targets where applicable.		
Lack of progress against BCF plans leading to not meeting targets and achieving benefits across the system as a whole	Medium	Robust approach to Programme Management. Development of principles around 'rules of engagement' between all partners for the BCF. This will include the development of a number of risk sharing agreements which will clearly articulate the impact of not achieving the deliverables in the BCF Plan. Any		

		risk sharing will include clear lines of responsibility and accountability against performance within the Plan.		
Challenge of delivering 7-day working	Medium	Expand 7 day working group in north to the South. Pick up in Joint Executive Board. . With regard to third party social care provision, steps to expand the ability of the system to extend the times during which assessments can be carried out will be built into wider work to redesign the sector.		

Contingency plan and risk sharing

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

Section 6 Alignment

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

Locality Based Commissioning

The Health and Wellbeing Board has identified three approaches to achieving the Health and Wellbeing strategy: 1) Influence, 2) Integrated Commissioning (which was described earlier) and 3) Locality based commissioning.

Locality commissioning boards (LCBs) are being developed on a district footprint, generally hosted by the district/ borough council. All strategic commissioning organisations are represented on the LCB and are committed to the principle of pooling/aligning resources. Work has already commenced in all districts using resources identified by public health commissioners and the police and crime commissioner. Other county council commissioners, CCG commissioners and district council commissioners are actively identifying resources that can be aligned for 2015/16.

The LCBs are focussing on commissioning and influencing activity that improves wellbeing in their local population. Older people are a target population in all localities and improvement in wellbeing in this group will support them to 1) connect – thus reducing social

isolation, 2) be active – thus improving physical health particularly risk of falls, 3) keep learning – with a focus on self-care, 4) take notice – with a focus on noticing those in their community who need support and 5) give – thus developing community assets to address need.

All this activity will lead to a reduction in demand for health and social care services and support people to feel safe and well in their own communities.

Falls Prevention

Falls are the largest cause of accidental injury, particularly in older people. In Staffordshire it estimated that 55,000 adults aged 65 years and over fall each year, 8,400 call an ambulance, 4,200 attend A&E, 3,400 are admitted to hospital (1,400 with hip fractures), 840 will require a home care package and 140 will require a care home admission as a result. The response to falls cost the health and social care system in Staffordshire an estimated £21 million.

There are plans in development to reduce this demand by 20% (i.e. preventing 680 non-elective admissions and saving the health and social care system £4 million. These plans include reviewing falls services which is included in the frail elderly work stream described earlier. In addition the plans include, through locality based commissioning: 1) increasing physical activity opportunities that promote lower limb strength and balance, 2) improving uptake of NHS England funded eye tests, improving uptake of NHS England funded Medicines Use Reviews and 4) addressing home and outdoor environmental hazards.

Mental Health

It is estimated that an average of £3,500 is spent per year on a person with a long term condition and 12-18% of this is linked to poor mental health. It is estimated that 93% of the older adult population with depression also have a long term condition.

Psychological therapy services have been commissioned in Staffordshire to meet 15% of population need per year. However, this resource is underused by adults aged 65 years an over, where only an estimated 6% of need is met each year.

Access to psychological therapy services is being reviewed to improve access for older adults. It is anticipated that the redistribution of psychological therapy capacity will support an additional 2,250 adults aged 65 years and over to receive psychological therapy. It is anticipated that 1,125 (50%) will move to recovery. This will lead to savings of between £418k and £628k a year due to reduced demand for NHS long term conditions services. It should also reduce demand for adult social care services estimated at approximately £300k. A total saving of nearly £1 million.

Business cases are also being progressed to develop lower level psychological support which could also contribute to reducing the impact of mental health on needs relating to long term conditions.

Alcohol

Over 50% of alcohol related admissions in Staffordshire are in adults aged 65 years and over. Alcohol and Drugs commissioning is completely integrated in Staffordshire with resources from Staffordshire County Council, the CCGs and the police pooled and a single responsible integrated commissioner. Services have been redesigned and implementation of the new model started in July 2014.

Alcohol related admissions have been on an upward trajectory over the last 10 years. The impact of the redesign is yet to be realised but recent data suggests the trend is slowing down.

A reduction in alcohol related admissions in adults aged 65 years and over will directly contribute to the Better Care Fund outcomes. In addition, it indicates a change in behaviour which will have much wider positive implications on demand for frail elderly services.

Stroke Prevention

Strokes can be prevented through better identification and treatment of Atrial Fibrillation (AF). In 2013 only 37% of people with AF who had a stroke were on anticoagulation. A plan has been developed to increase the numbers on anticoagulation to 93% which will prevent between 64 and 77 strokes in Staffordshire.

The plan include: 1) proactive identification of people in AF through NHS Health Checks and opportunistically during flu vaccination clinics 2)systematic implementation of new NICE guidelines which will increase the proportion identified as high risk and the proportion that receive anticoagulation (as opposed to aspirin) 3) review of patients who are not optimally managed on warfarin for consideration for new oral anticoagulants.

The business case has yet to be improved as an investment of approximately £2 million is required. However, it is estimated that preventing 64 strokes would lead to savings of over £5 million for the health and social care systems.

Housing

There has been significant investment in recent years in Staffordshire in Extra Care Housing and Flexicare Homes. A number of these schemes have been recently been completed and the impact of these on demand for NHS and Adult Social Care services should be seen over the next few years. It is estimated that the impact on demand for NHS is over £2k per unit.

There are further opportunities that are starting to be explored including: 1) identifying NHS properties that can be developed into housing schemes, 2) proactively identifying potential tenants and supporting decision making, 3) developing focussed support for dementia, 4) developing short term step down opportunities as part of current schemes.

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

The Staffordshire Health and Wellbeing Strategy has identified frail elderly, support to live at home, carers and end of life care as four of it nine key priorities. This has influenced the development of the Staffordshire and Stoke NHS 5 year plan, the individual CCG 2 year operating plans and Staffordshire County Council's Strategic Plan.

These plans have all been presented to the Health and Wellbeing Board and taken through a process of challenge to assure the Health and Wellbeing Board that they align and contribute to the Health and Wellbeing Strategy.

The interventions described in the CCG 2 year operating plan and the 5 year strategic plan will achieve the 3.5% reduction in non-elective admissions required in this Better Care Fund submission. However, they will not bridge the £15 million financial gap. Therefore, this submission has identified additional transformation change both in the Better Care Fund schemes and the aligned initiatives that will bridge this gap.

With your plans for primary co-commissioning

Co-commissioning of services by the Local Area Team and the 5 Staffordshire CCGs will develop a strong sustainable Primary Care service over the next five years. This will consider different ways of commissioning additional primary care either through using current providers or opening up the market and considering alternative suppliers in effort to stimulate improved quality, reduced variation and achieve financial sustainability

Our plans for primary co-commissioning involve six change programmes:

1) "At Scale Work stream" Where appropriate we will explore the shift to working at greater scale through networks, federalisation or mergers. This will involve:

a. Collaboration between groups of practices and other providers, this may include community nursing services and GPs with extended clinical roles, workforce flexibility and sharing of back office functions.
b. Community services will be collocated with GP services Practices will offer more community services e.g. dietetic services, podiatry and outreach services dependent on GP skills (e.g. minor surgery and complex contraceptive services). This will require consideration of the current estates utilisation.

The Primary Care Joint Commissioning Board will work to ensure there is both capacity and capability across the federations. Where appropriate we will look to achieve economies of scale in administrative and business functions of practices.

2) Improved Access We will explore innovative approaches to improving access to general practice services. We will look to support the changes to the urgent care system to make 7/7 working a reality across the whole system

3) Workforce We will build on existing good work and look to address the workforce problems facing general practice in Staffordshire and neighbouring Shropshire. The General Practitioner community and health centre teams face great challenges ahead where there are a high proportion of GPs leading up to retirements (often earlier at 55yr) and some areas are historically difficult to recruit new staff. A higher ratio of women who may prefer part-time due to childcare arrangements could possibly impact on resourcing. The CCGs, LMC and AT are taking a proactive stance on recruitment and retention including bursaries for relocation to the area, re-starter schemes , innovative training posts etc

A new way of thinking about how 7 day accessible Primary Care services will be delivered, including greater roles for practice nurses allowing them to use a broader range of skills. There will be opportunities for new roles and ways of working to ensure sufficient capacity is available across the network to deal with the increasing demand. This needs to be sustainable and does take some time to implement as often training programmes take a year or more.

The profile of practice administration and support services will need to be redesigned by a modernised practice management approach. This will in turn minimise the demands on clinician time but will require a flexible and experienced set of practice managers as part of the federated approach.

4) Unwarranted Clinical Variation We will look to systematically identify and address the systemic and clinical causes of variation and significantly improve the poorest practices.

5) Pharmacy, Optometry and Dentistry We will look to these professions to play a greater role in treating minor ailments; empowering patients with long term health conditions to manage their own health more effectively; improving the efficiency across the whole system. It is envisaged that this programme will be intrinsic to the primary care at scale solution, and it is recognised that the inter-dependency of these clinical specialties means they are equal partners in defining and delivering the programme of transformation.

6) Infrastructure This programme will look to develop a coherent primary care estates strategy. We will look at the estates and IT infrastructure across the health economy and identify actions required to ensure that these key components enable the delivery of the changes identified within the other programmes. We will ensure that estate is fit for purpose and that have compliant disability access fulfils statutory requirements for clinical environments (CQC).

7) Change in Public Behaviours We will work to support the development of a culture of self-reliance and self-care with our population in Staffordshire. See the right patients at the right time which may be earlier that previously organised by professionals. Change in clinical practice and guidance given to patients, moving from a paternalistic approach to more of a partnering approach so that people may feel

empowered to self management and take control of their care where appropriate. The primary care clinician still needs to assess and treat but should also enhance the focus on providing information and sometimes challenge to existing behaviours, which assists people to navigate the services available.

8) Demand Management - primary care developments to encourage demand management initiatives:

- Increase vaccination uptake in adults aged 65 years and over. In 2013, 70% of adults aged 65 years an over had the influenza vaccination and 66% had the PPV vaccination. If this was increased to the national target of 75% it is anticipated that approximately 200 admissions could be avoided and £850k saved (£600k to NHS and £250k to adult social care).
- Increase referral rates to psychological therapies in adults aged 65 years and over. This is discussed in section 6a).
- Identification of those who could benefit from falls prevention activities. This is discussed in section 6a).

System Wide Enablers and Initiatives:

The following system wide **key enablers and initiatives** will assist in the delivery of our vision for health and social care services:

Findings from the national intensive Support for Planning – early indication of plans for building a more co-ordinated and responsive primary care and community service, supports our plans around Integrated working with multi-disciplinary teams

Frail Elderly Strategy – the drafted Staffordshire Frail Elderly Strategy, sets out the intentions to deliver a more joint up, portable and seamless service across Staffordshire for our frail elderly populations;

Primary Care Strategy – the Shropshire & Staffordshire Area Team drafted Primary Care Strategy, sets out clear objectives for providing pro-active co-ordination of holistic care, which promotes self-care and fast, responsive access to care. The principles in this strategy align with those within our overarching vision for health and social care.

Integrated Commissioning – working collaboratively through the leadership of Staffordshire Joint Health & Wellbeing Board, partners will harness the opportunity of working together to get the best value for money for the people of Staffordshire.

Systems Resilience Plans – sets out the collaborative approaches to understand the system wide pressures and solutions to enable 'systems resilience' within Staffordshire not only focussing on unplanned acute admissions but the planned care system, including Referral to Treatment Times.

A key development in terms of the role of districts/boroughs in developing work around health and well-being is the **review of 'locality working'**, commissioned by the Health and Well-Being Board and led by the a borough council Chief Executive. This review is referred to earlier in this report. In essence, the review found that districts/boroughs were not being

considered as a matter of course when it came to developing strategic approaches to health and well-being and commissioning decisions were being taken that lacked the necessary sensitivity to issues in local areas such as Newcastle under Lyme. The approach which has been agreed, therefore, is for districts/boroughs to be a part of the strategic picture at all times and for both local commissioning approaches to be established at borough/district level and for all agencies from all sectors to be seen as potential providers.

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

The Five Year Plan provides a platform for the strategic leadership to influence and pool resources collectively in order to make step changes towards delivering the vision **for health and social care. This is the same vision as outlined within this plan.**

CCG's are currently in the process of refreshing their two year operational plans including the development of commissioning intentions for 2015/16. These intentions include the integrated intentions laid out with this BCF Plan.

Local Government planning documents are aligned to the Health and Wellbeing Strategy "Living Well in Staffordshire" included in Appendix. The vision of this Strategy "*Staffordshire will be a place where improved health and wellbeing is experienced by all. It will be a good place to live. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as part of strong, safe and supportive communities."*
Is aligned to the outcomes of the Better Care Fund.

Providers will also be refreshing their Integrated Business Plans and will reflect any joint agreements through the Joint Executive Board.

With your plans for primary co-commissioning. The majority of CCGs in the area have expressed an interest to co-commission at Level 2 i.e. actively have joint plans with the Area Team of NHS England but not formally receive delegation to hold primary care contracts. It will be vital that the plans described in this BCF are coordinated with commissioning of primary care. Where there are areas of significant overlap e.g. the DES for long term conditions management, CCGs are working closely with NHS England to align.

Section 7 National Conditions

a) Protecting social care services

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

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

By proactively intervening to support people at the earliest appropriate opportunity and ensuring that they remain well, are actively engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services once people have experienced a crisis. In many cases, this will require a new way of looking at ensuring people's needs are met, with consequent implications for service redesign.

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

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

Funding currently allocated under the s256 transfers from NHS England to the County Council has been used to enable the local authority to sustain the current level of eligibility criteria and hence to provide timely assessment, care management and review and

commissioned services to clients who have substantial or critical needs. In addition, funding has been employed to ensure effective information and signposting is available to those who are not FACS eligible. In Staffordshire, these existing £16m of transfers from the NHS to social care will be continued under the BCF.

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

This level of financial challenge in the system as a whole demands that we identify new solutions that deliver sustainability across all partners. The County Council and the CCGs are therefore actively seeking to draw together their respective financial and transformational planning. The CCGs and the County Council therefore continue to work together to enhance the transformation programme required to meet this significant challenge. This will build upon the initial recommendations recently received through the challenged health and social care system work.

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

At present, the financial pressures on the CCGs, outlined above, are such that it has so far not been possible to identify more than the existing £16m of s256 funding to protect adult social care services. One consequence of this is that the local proportion of the £135m for Care Act duties (£1.9m) has also not yet been identified. Work is being taken forward to develop solutions that address the overall financial issues facing all partners, thereby addressing the question of protecting adult social care.

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

Staffordshire County Council has established a formal change programme to ensure robust and effective implementation of the Care Act. This comprises a range of work streams, addressing all of the strands of service and policy change, supported by a programme office employing full programme management technologies. The programme reports into the

County Council's governance structures and is designed to secure full engagement from all relevant partners. At present, work is underway to identify the key responsibilities and tasks for each work stream, with a set of implementation plans to be developed before the end of September. The plans will set out key tasks, milestones, stakeholders, resources required, risks and issues.

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

The Staffordshire Carers Partnership was established in February 2014 to provide strategic direction, governance and accountability for Carers outcomes in Staffordshire. This includes work on a 'Carers Whole System Redesign' including the modernisation of the Staffordshire Carers Journey, in line with the statutory requirements within the Care Act.

A large scale tender across Staffordshire and Stoke on Trent is currently underway to deliver a co-ordinated and coherent universal service and a specific scheme has been detailed within the Better Care Fund allocation for the delivery. The resources detailed within the attached Annex equate to £692k.

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

Staffordshire County Council had originally assumed that the existing s256 funding of £16m would be carried forward from 2013/14, along with an additional £15m from the NHS £1.9bn transfer in 2014/15. Further, it was assumed that there would also be additional funding received, whether through the BCF or directly, to cover Care Act implementation. As has been noted above, the financial pressures on the CCGs have to date meant that neither of these two funding streams can yet be identified. This leaves the County Council with a shortfall, compared to its budget forecasts, of £16.9m.

b) 7 day services to support discharge

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

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

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

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

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

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

In Staffordshire, the following arrangements apply.

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

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

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

c) Data sharing

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

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

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

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

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

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

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

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

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

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

d) Joint assessment and accountable lead professional

The health and social care system has traditionally been focused on the provision of community services through direct interaction between patients / service users and professional staff, whether district nurses, care assistants, or therapists, to name but a few. The underlying philosophy has been that things need to be done for or to citizens if they are to be able to remain living at home, rather than enter institutional care. It is increasingly recognised, however, that this model of care is not only extremely expensive but can also have the unintended consequence of reducing people's ability to manage their own lives. The result can be that they are more dependent upon the care system, thereby facing worse health outcomes, experiencing a reduced quality of life, and requiring greater expenditure still. Across the Staffordshire health and social care system, we are convinced that there needs to be a major shift in culture and approach.

Rather than direct provision of care be seen as the default, we want to move to a position where our population expects to take maximum personal responsibility for their own lives, seeking care only when absolutely necessary. We recognise that many people find themselves struggling to cope as they get older or their health declines. In such situations, we want it to become the norm for people to make maximum use of technology to assist them in maintaining independence within the community. The population we serve are increasingly looking to such solutions to support them to better coordinate their health, care and wellbeing as part of their everyday lives. This may take the form of adaptations and improvements to their homes through the use of Disabled Facilities Grants and the Home Improvement Agency, the use of equipment through the Integrated Community Equipment Service to help them continue to undertake normal household functions when they are

disabled or recovering from a crisis, or through drawing on the wide range of technological solutions through the Technology Enabled Care Services programme to help their carers support them remotely, making maximum use of mobile phones and the Internet.

These approaches together support our goals to reduce admissions and readmissions to hospital and long-term care among older people, as well as support people of all ages to take greater responsibility for their own health and wellbeing and that of their families. We can build them into the increased adoption of personal health and care budgets to improve person-centered outcomes and support self-care.

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

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

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

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

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

- Coordination of resources around individuals with multiple chronic disease from one single health or social care professional. Thus recognising the growth in numbers of these individuals and the limitations of traditional 'single disease specific' strategies.
- Reducing the impact of these individuals on acute care resource through prevention (admission avoidance) and slowing of disease progression.
- Potential efficiencies in the delivery of care, particularly against a back drop of rising demand from an ageing population and increase in multiple chronic disease prevalence.

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

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

The local health economy in the north is developing an integrated risk stratification tool that will support the work of the integrated locality care team and the delivery of the LTC Year of

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

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

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

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

Alongside a range of performance measures

- Percentage of care plans in place
- Percentage of individuals seeing a reduction in risk score
- Percentage of individuals/carers reporting they are confident in managing their own health
- Percentage of individuals reporting an improvement in quality of life
- Percentage of individuals achieving goals set
- Admission avoidance

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

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

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

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

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

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

Section 8 Engagement

a). Patient, service user and public engagement

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

CCG's have developed models of 'patient engagement' which supports the local planning processes and strengthens the prioritisation of commissioning decisions. Local district patient groups and Patient Councils have been established with many reporting into governance arrangements within CCGs.

Local evidence through 'Call to Action' events have supported the vision for a new Health and Social Care vision and the transformation required.

As the recent report of the Francis Inquiry makes clear, the voice of the local population must be at the heart of our debates, just as our communities must be at the centre of everything we do. The experience at Stafford Hospital is especially powerful in this respect and we are united in our commitment to ensure that we avoid such failures in care affecting Staffordshire's people ever again. In order to strengthen the voice of people who use services, in 2012 we established a new organisation called Engaging Communities Staffordshire (ECS).

Building on the experience and expertise of the Local Involvement Network (LINk), ECS goes beyond the remit for HealthWatch to become a centre of expertise and knowledge about the people of Staffordshire. It has a key role as an independent organisation to collate and challenge all the available information about how people experience health and social care services, undertaking new research where necessary and drawing on this to present a clear and persuasive contribution to the debate.

Through its full membership of the Health and Wellbeing Board through its role as the provider of Staffordshire's HealthWatch, ECS provides a powerful connection with the people of Staffordshire, ensuring that their voice is heard at every stage.

There is a raft of communication mechanisms in place locally that complement the countywide work of HealthWatch, in particular scrutiny through District and Borough Councils and the formal engagement activity undertaken during the summer of 2013 regarding the JHWS. This involved a significant number of members of the public and gathered clear evidence of support for the direction of travel set out in the JHWS.

Public, patient and service user engagement is also embedded in the process which is taking place to co-design service specifications, for example for re-procurement of key integrated service delivery areas of Long Term Conditions and Intermediate Care/reablement.

CCGs and SCC have well developed engagement mechanisms for all client groups.

Within learning disabilities, extensive engagement has been undertaken in developing the *Living My Life My Way* strategy through involving families and people with learning disabilities in shaping the direction of travel. Over 250 people have been involved in the consultation process to improve access to mainstream health services for people with learning disabilities.

HealthWatch has identified Carers Engagement as one of their key priority areas. HealthWatch has agreed to chair the newly established Staffordshire Carers Partnership as an independent voice.

Other robust examples of engagement include the Transforming Cancer and End of Life Programme, work with users on the mental health strategy, and a model of Experience Led Commissioning to fully involve people in the co-design of services for people with Long Term Conditions and Intermediate Care.

The next step in developing Staffordshire's patient, service user and public engagement is to develop ways to change the conversation from 'what can we do for you?' to 'what can you do for yourself?' and 'what can we do to support you to do this?'. This work has started in some areas as part of the Locality Commissioning developments (described in section 6).

b.) Service provider engagement

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

- NHS Foundation Trusts and NHS Trusts
- primary care providers
- social care and providers from the voluntary and community sector

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

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

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

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

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

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

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

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

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

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

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

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

c). Implications for Acute Providers

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

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

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

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

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

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

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

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

UHNS is the main acute provider in North Staffordshire and Stoke-on-Trent. There is direct consistency between the Stoke-on-Trent BCF and the North Staffordshire element of the

Staffordshire equivalent. As patients from Stafford and surrounds recourse to UHNS, strategic planning between that CCG and those in the north will become increasingly integrated.

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

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

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

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

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

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

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

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

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

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

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

Part 1 – Annex 1: Detailed Scheme Description

See Appendix 1

Part 1 – Annex 2: Provider Commentary

See Appendix 2