Staffordshire Better Care Fund

Introduction

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

Our first BCF plan (submitted in September 2014) was developed at a time when our local health and care economy was under extreme pressure. These pressures have continued.

The partners have always recognised that – as the BCF plan is a key plank of our system transformation – it is very important to get it right. We believe that given our context, we applied ourselves well to the first iteration of our plan. It expressed our ongoing planning activity – and genuine commitment to joint working - well.

However, the first version of our plan needed further work. This is largely because:

(a) it was not sufficiently direct about the challenges we face as a local health and care economy

(b) the development of the BCF plan coincided with an in-depth review of our NHS economy

(c) Given this context we were unable earlier in 2014 to commit sufficient resources to developing it to the required standard.

As a consequence:

(d) it was not sufficiently grounded in evidence and analysis

(e) It was not specific enough about what would change by when.

We have used the last 4 months as an opportunity to pause, reflect, and take stock. We have renewed our shared commitment to integrated working (which includes better co-ordination across the CCGs, as well as stronger engagement between the CCGs and Council). Since submitting our initial plan, we have:

Adopted the completion of a robust plan as a top priority for both the CCGs and Council (in spite of apparently competing pressures);

Confirmed our commitment to joint working (in principle) and pulled together (in practice) – so that our plan is understood and owned by all the key agencies (including all 5 CCGs, and all the NHS providers) across our area;-

- Worked to collate and articulate the evidence-base for what we are doing
- Grappled further with all agencies' financial challenges – and addressed the protection of Social Care directly
- Agreed how the budget will be managed, and how risks/gains will be shared
- Focussed on a step-by-step approach – identifying the most important changes that can and should be delivered quickly
- Worked to ensure that the conditions identified as needing to be addressed from our first plan are met.

Staffordshire has been identified as one of the eleven 'challenged' health economies nationally - this is clear evidence that we are facing a steep financial and service delivery challenge, with a compelling and urgent case for change. The Health and Wellbeing Board recognised these pressures some time ago and the fundamental systemic changes required have been clearly documented in the Joint Health and Wellbeing Strategy.

The "Support for Planning" report and recommendations reinforced the need for change, setting out a financial gap in the health sector of £230 million by 2018 if no change occurred. This taken alongside the challenges in Social Care means the system as a whole is facing a financial gap of circa £400 million by 2018.

The key schemes adopted in this revised BCF submission are underpinned by an agreed Frail Elderly Pathway across the whole of Staffordshire (including Stoke-On-Trent), completed in the autumn of 2014.

Alongside the above there is an agreed strategy for the joint commissioning of services and pooling of budgets, and the first of these for Learning Disabilities will be in place by the 1st April 2015. These arrangements facilitated through the Better Care Fund discussion give an opportunity to transform the system to focus on prevention, early intervention and integrated care in the community.

However the significant challenges that lie ahead are much more than financial ones. It is about all partners working together to share and manage risk. It requires organisations to focus together, and work with the population to strengthen their capacity and desire for personal responsibility, independence, choice and control.

The above will be supported by measures designed to maximise the effectiveness of the "Staffordshire Pound" to deliver both greater community-based resilience, including care delivery where required, and a wider health and social care economy which is safe, strong and sustainable for the people of Staffordshire.

This Better Care Fund plan is a living document which continues to evolve as relationships develop and joint commissioning becomes the norm not the exception. This submission now aligns totally with the CCG financial recovery plans (FRPs), the County Council's medium term financial strategy (MTFS) and the Staffordshire and Stoke-on-Trent five year plan.

There is still significant work to be undertaken with Providers to ensure they are fully aligned. It is clear from discussions and the evidence of significant systems pressures that they have a shared desire to reduce the number of unplanned emergency attendances / admissions. However, all partners accept we have yet to put in place the systems and processes to make this a reality. Subject to approval of this plan the next three months will be focused on this element.

The partners also realise there is a significant challenge in engaging with the population and enabling them to take control of their own lives and conditions. This will not be achieved by the Better Care Fund alone but will link to other strategies (for example the expansion of Personal Health Budgets). 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 sectors, primary, acute and community health providers, and our integrated social care teams.

In many respects there is a high level of consensus about some of the solutions, in particular the need to facilitate people taking control of their lives. We plan to do this by shifting our offer, giving people the right tools and providing joined up support and care coordination to those people who need it, and this is now reflected in the schemes outlined in section 2.

The delivery of a system which has service and financial sustainability going into the future will not be achieved through the BCF alone. We know from modelling work carried out using the available LGA (Local Government Association) and NHS toolkits that there are significant opportunities to change provision whilst increasing quality and reducing cost. This modelling is providing a focus for further investigation into opportunities locally which may not yet have been considered. For example the CCGs in the County have identified efficiencies of £49.5m in 2015/16 by reducing inappropriate and ineffective interventions in both planned and unplanned care.

Work will continue to identify further opportunities for more efficient use of the "Staffordshire Pound".

Our aspiration is for many more areas of work to be integrated between Health and Social Care; however there is still significant work to be undertaken to achieve this goal. There are many reasons for this including the fact that plans in different parts of Staffordshire are not unified, reflecting the diversity of our population and service provision. Whilst embracing this variation we have to achieve better co-ordination, and remain very clear about the outcomes we want to deliver for local people. Our guiding principle is that we will do things once for the system as a whole, unless there are good reasons for things to be done at a more local level. This approach will be overseen through the governance structures developed since the "Support for Planning" report. Below the Health and Well Being Boards there will be a Joint Transformation Board (JTB) representing Commissioners / Providers / County, City and District Councils. There will also be a pan-Staffordshire Commissioning Congress and Local Transformation Boards. All are in the early stages of being established.

The Better Care Fund has a focus on Older Adults at a national policy level, which is reflected in this plan. Our plan is more ambitious and does focus on prevention initiatives, 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.

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

Document	Document Title
Staffordshire Health and Wellbeing Board Joint Strategic Needs Assessment	JSNA 2014 SUMMARY DRAFT
Staffordshire Health and Wellbeing Board Strategy "Living Well"	Health-Wellbeing-Strategy-Staffordshire-2013
Conversation Staffordshire	Final Report Public and Stakeholder Engagement

	on Health and wellbeing Strategy
Staffordshire BCF Risk Log	Staffordshire BCF Risk Log 09 01 15
Staffordshire BCF Milestone Plan	Staffordshire BCF Timescales 09 01 15
Staffordshire BCF Risk Share Principles draft document	BCF risk share paper - sept 2014 v3
Frail Elderly Strategy	Staffordshire-Frail-Elderly-Care-draft-strategy-v5-Oct-2014

Our Shared Commitment

As partners we are totally committed to delivering a BCF plan which reflects our joint aspirations but also demonstrates we understand the challenge. We have developed an implementation plan for the next three months, designed to get us ready for implementation from April 2015.

We are committed to:-

- Tackling our challenges by working more closely together, it should be noted that all partners now realise our joint success or failure is closely intertwined
- Staying focused on improving the experience of local people
- Being ambitious for our communities
- Realising efficiencies which are shared, and protecting partners
- Being evidence based in our decision-making
- Ensuring the planned changes in the BCF are successfully delivered
- Effectively managing the work plan over a period of time to ensure success.

Andrew Donald
Chief Officer for Stafford & Surrounds and Cannock Chase CCG's

Andrew Burns
Director of Finance and Resources

Joint Senior Responsible Officers for the Better Care Fund

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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 8th January 2015

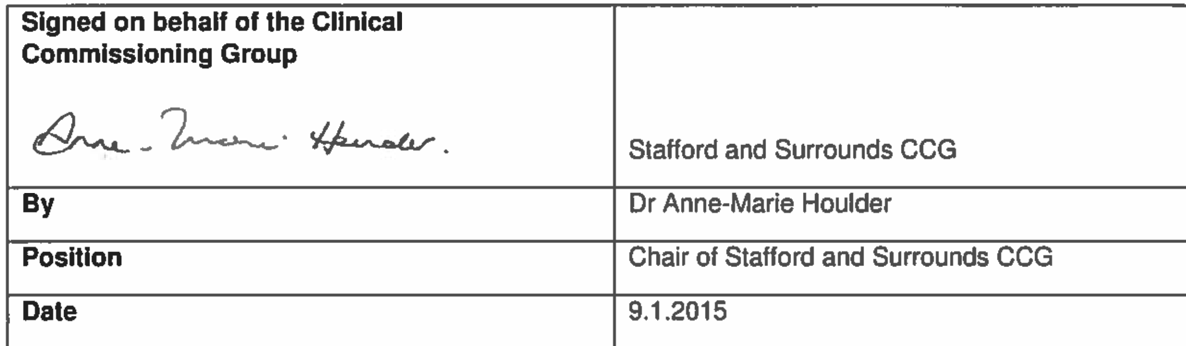
Date submitted:

9th January 2015

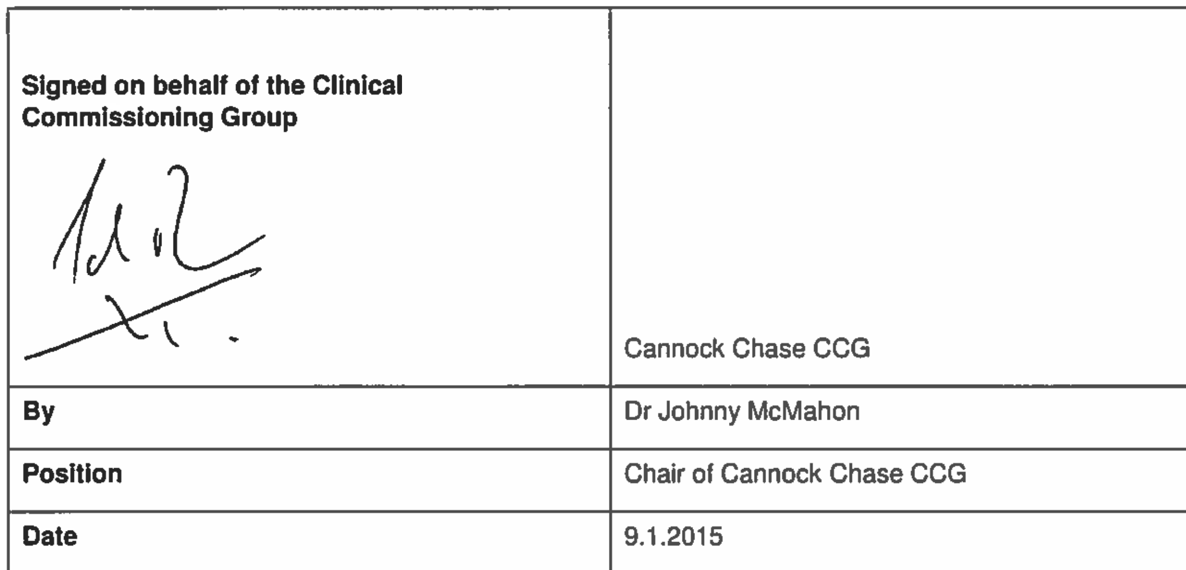
Minimum required value of BCF pooled budget	2014/15	£16,234,000
	2015/16	£56,108,000
Total proposed value of	2014/15	£16,234,000

pooled budget	2015/16	A minimum of £56,108,000 with likely total pooled budget being in excess of £104,738,000

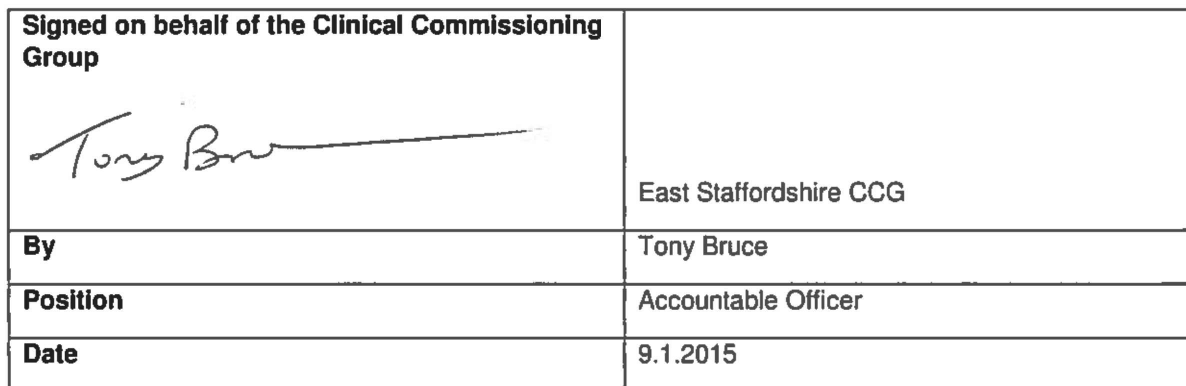
b) Authorisation and signoff



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	9.1.2015

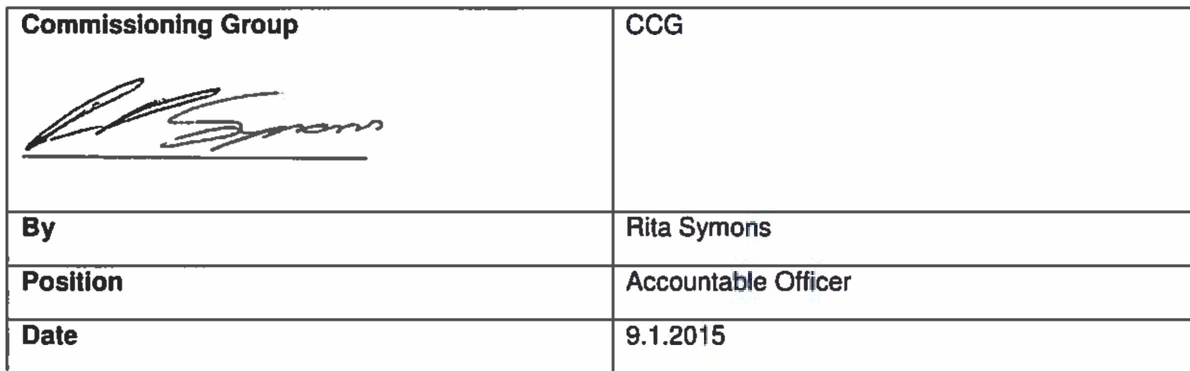


Signed on behalf of the Clinical Commissioning Group	Cannock Chase CCG
By	Dr Johnny McMahon
Position	Chair of Cannock Chase CCG
Date	9.1.2015

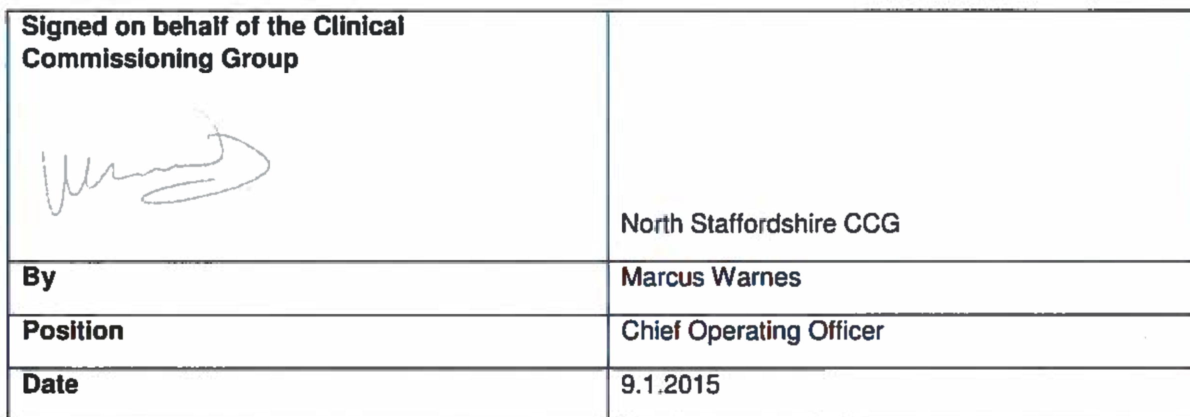


Signed on behalf of the Clinical Commissioning Group	East Staffordshire CCG
By	Tony Bruce
Position	Accountable Officer
Date	9.1.2015

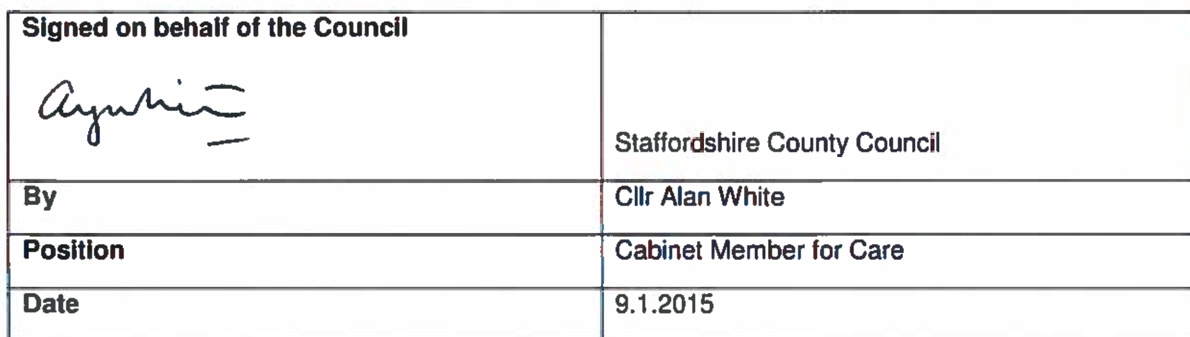
Signed on behalf of the Clinical	South East Staffordshire & Seisdon Peninsula



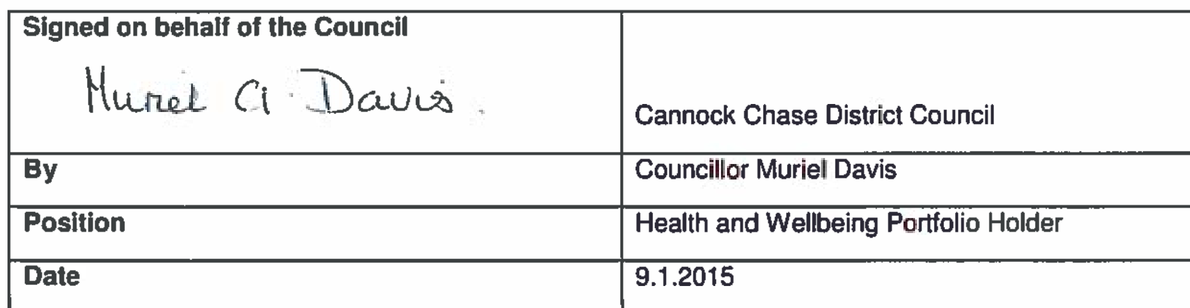
Commissioning Group	CCG
By	Rita Symons
Position	Accountable Officer
Date	9.1.2015



Signed on behalf of the Clinical Commissioning Group	North Staffordshire CCG
By	Marcus Warnes
Position	Chief Operating Officer
Date	9.1.2015

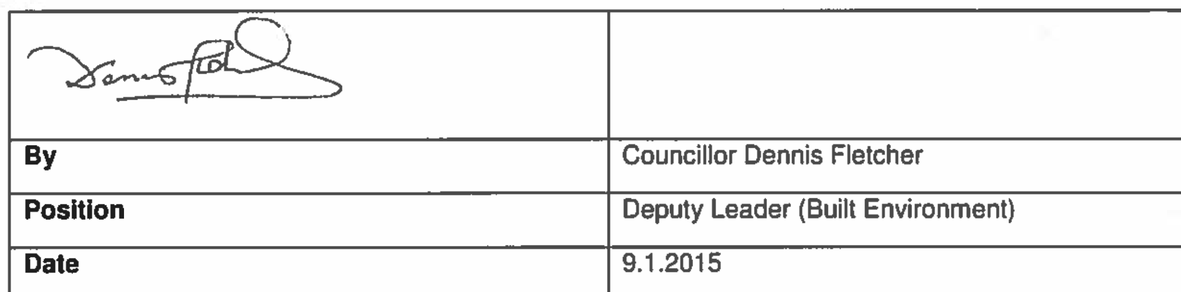


Signed on behalf of the Council	Staffordshire County Council
By	Cllr Alan White
Position	Cabinet Member for Care
Date	9.1.2015

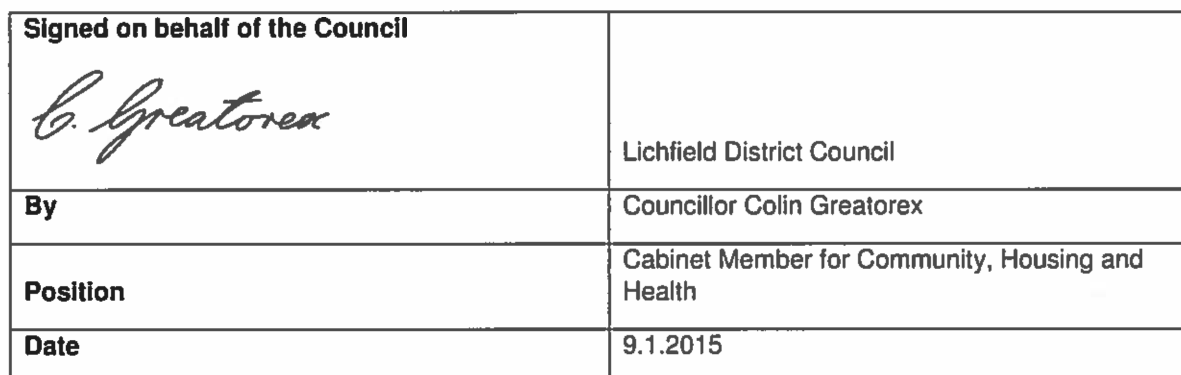


Signed on behalf of the Council	Cannock Chase District Council
By	Councillor Muriel Davis
Position	Health and Wellbeing Portfolio Holder
Date	9.1.2015

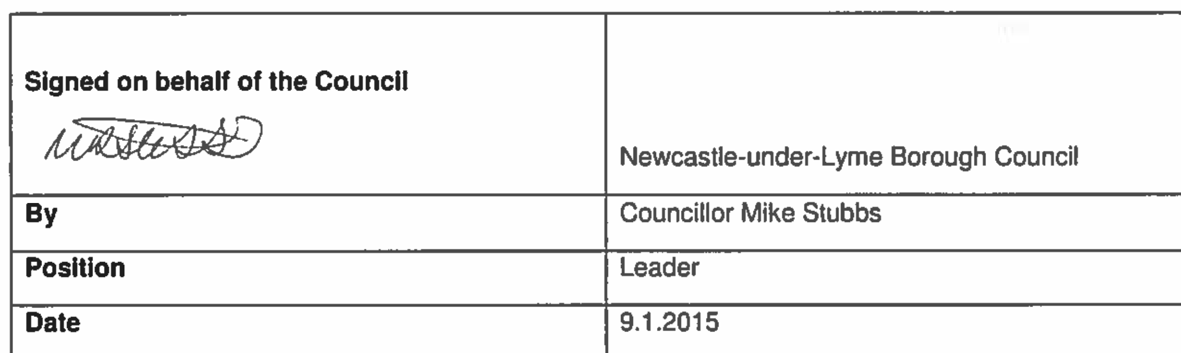
Signed on behalf of the Council	East Staffordshire Borough Council



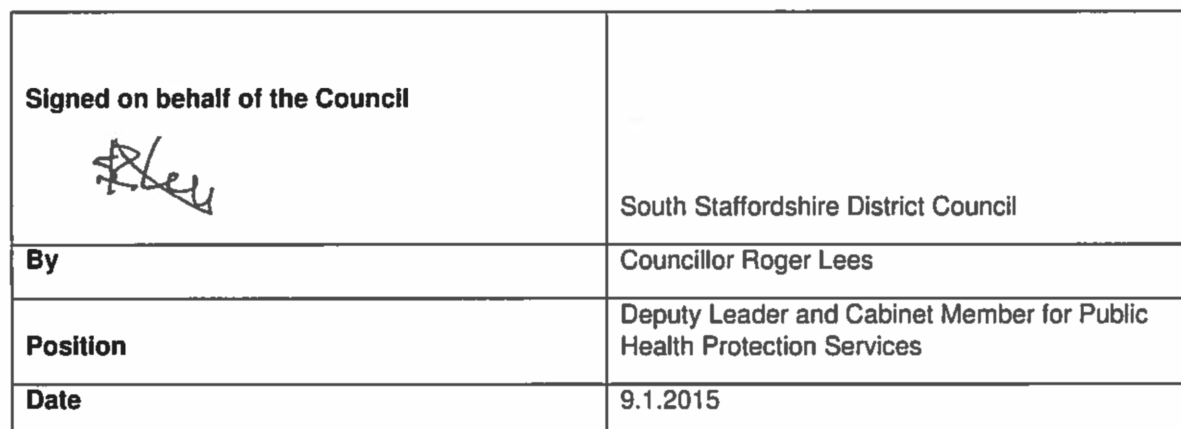
By	Councillor Dennis Fletcher
Position	Deputy Leader (Built Environment)
Date	9.1.2015



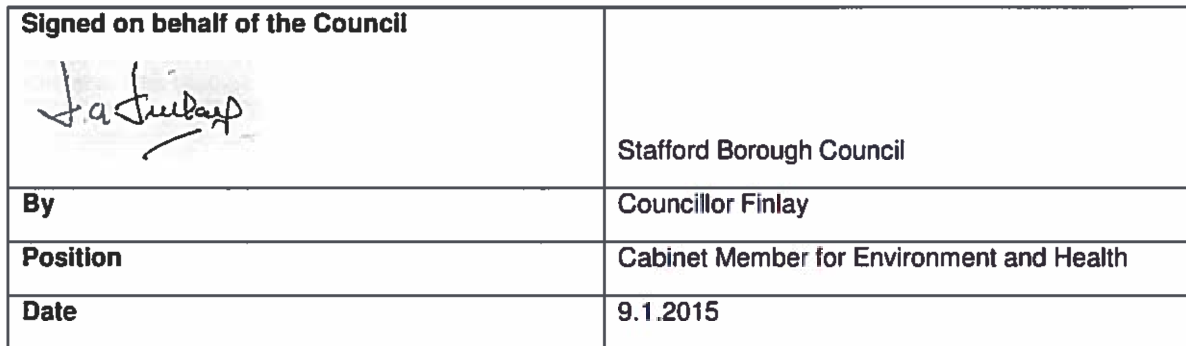
Signed on behalf of the Council	Lichfield District Council
By	Councillor Colin Greatorex
Position	Cabinet Member for Community, Housing and Health
Date	9.1.2015



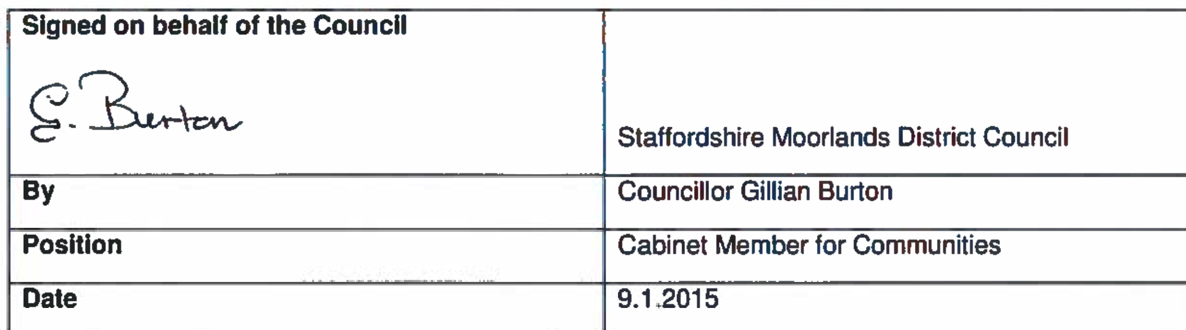
Signed on behalf of the Council	Newcastle-under-Lyme Borough Council
By	Councillor Mike Stubbs
Position	Leader
Date	9.1.2015



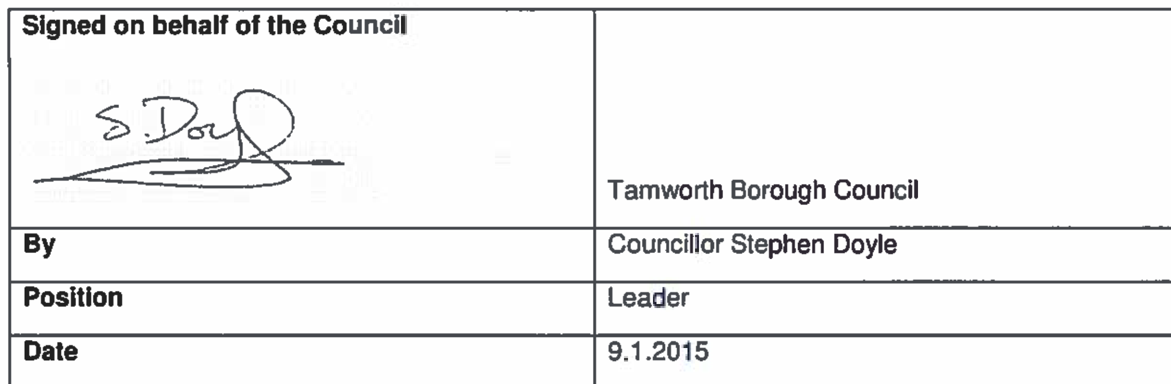
Signed on behalf of the Council	South Staffordshire District Council
By	Councillor Roger Lees
Position	Deputy Leader and Cabinet Member for Public Health Protection Services
Date	9.1.2015



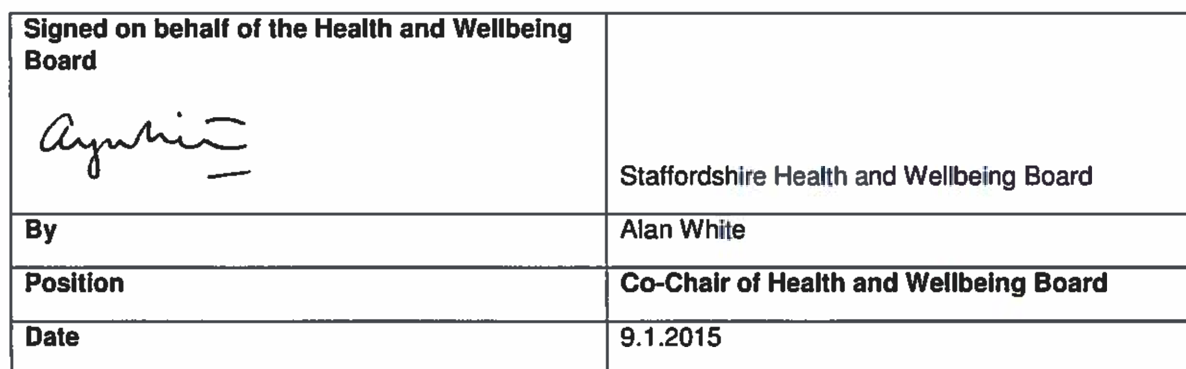
Signed on behalf of the Council	Stafford Borough Council
By	Councillor Finlay
Position	Cabinet Member for Environment and Health
Date	9.1.2015



Signed on behalf of the Council	Staffordshire Moorlands District Council
By	Councillor Gillian Burton
Position	Cabinet Member for Communities
Date	9.1.2015

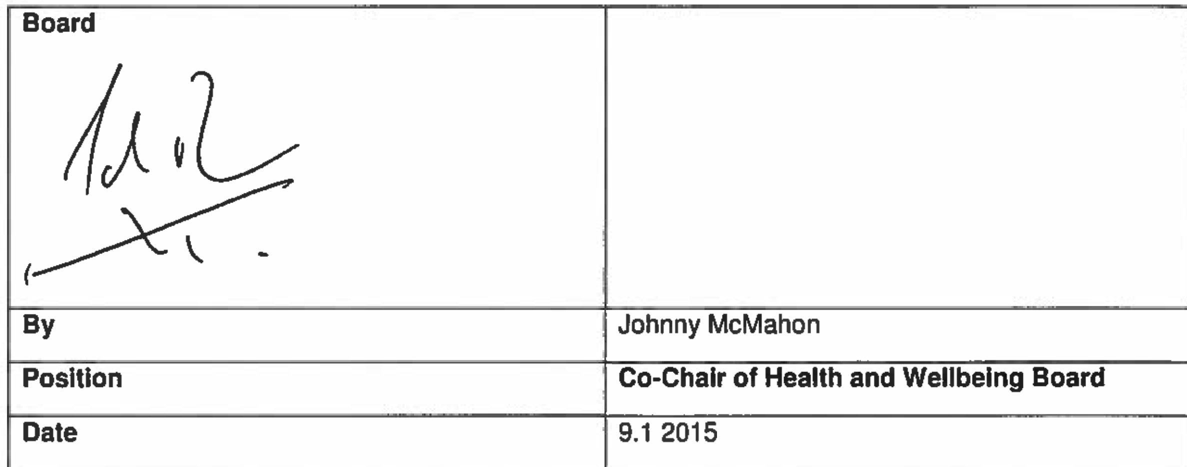


Signed on behalf of the Council	Tamworth Borough Council
By	Councillor Stephen Doyle
Position	Leader
Date	9.1.2015



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	9.1.2015

Signed on behalf of the Health and Wellbeing	Staffordshire Health and Wellbeing Board



Board	
By	Johnny McMahon
Position	**Co-Chair of Health and Wellbeing Board**
Date	9.1 2015

Section 2: Our Vision for Health and Well-Being

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

"Staffordshire will be a place where improved health and well-being 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."

(Living Well in Staffordshire 2013-18"- Staffordshire's Joint Health and Well-Being Strategy)

The basis of the Health and Well-Being strategy is an emphasis on prevention which reduces dependency on NHS and Social Care services by preventing crises and increasing 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 more than £400m across the Staffordshire health and social care system if nothing were to change.

Activity will focus on community and preventative services that reduce the level of demand, and hence the impact of costs, for acute and NHS services and for 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 Borough Councils 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. A large part of this plan therefore focusses on what we can do to build on principles of self-management, engaged communities and patient activation.

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

The Staffordshire Strategic Partnership has identified three overarching outcomes that guide the work of all public service bodies across the county:

The people of Staffordshire will:

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

Within this broader context, our aim for the Better Care Fund is to deliver improvements in both the objective health outcomes for our local population as well as their quality of life.

The priority health outcomes we have identified are:

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

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

- ***Living safe and well in my own home:*** *I will live in my own home and remain part of my local community as long as possible. I will be able to access support solutions that are built around my on-going 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 will be delivered in consideration of the following overarching principles:

- People will be supported to take control of their health and wellbeing, and of the services that support them.

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

Our Priorities for the Better Care Fund (BCF)

To support the above strategy, the BCF has six priorities:-

- Focussing on **frail elderly pathways**, as the core element of our quality and sustainability challenge. There is now a single agreed Frail Elderly Pathway across Staffordshire and Stoke-on-Trent across Health and Social Care as shown below
- Focus on those individuals who are already in the health and care system (e.g. in hospital, or receiving long-term care).
- Prioritising **early intervention** with people who are struggling to maintain their independence.
- **Integrating commissioning** – bringing together our combined commissioning activities and funding for care in community settings in a phased way: the pool will initially total around £104m net.
- **Integrating provision** – reducing fragmentation, duplication, and hand-offs between professionals.
- Developing the concept of **locality-based commissioning**, with District and Borough councils playing key roles.

Public Engagement

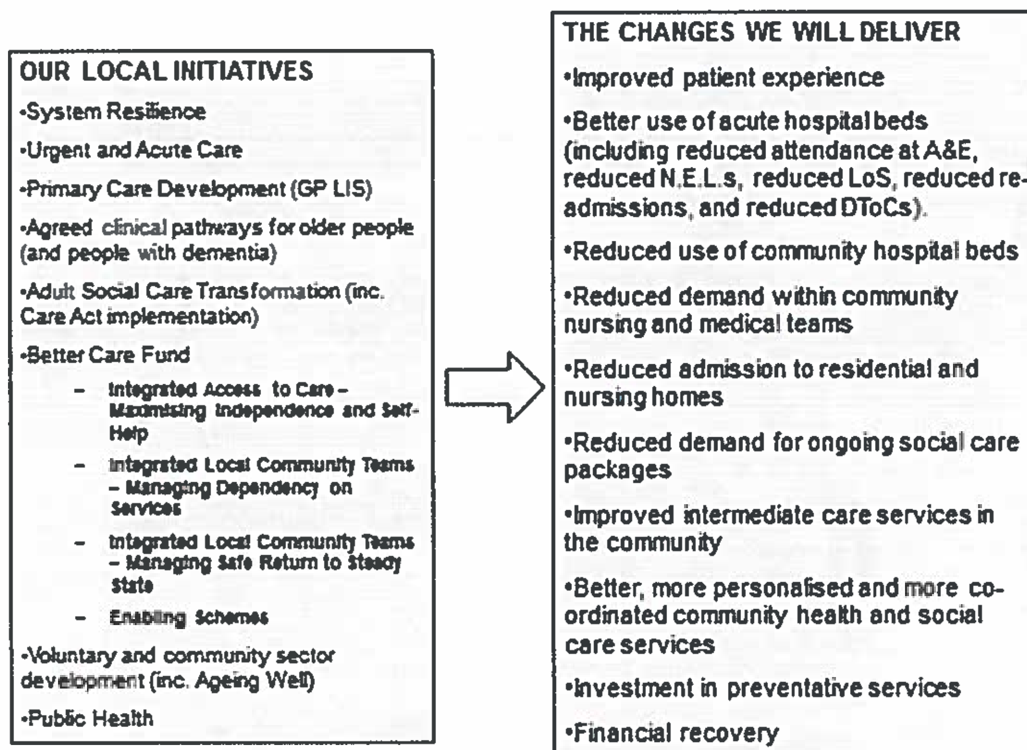
We are confident that our BCF programme and priorities are in line with the priorities of older people and carers in Staffordshire, as expressed in numerous consultation and engagement exercises. Further detail regarding our approach to public consultation can be found in Section 8: Engagement.

The Frail Elderly Pathway – our working model

We have developed a working model that illustrates our new focus on "managing demand", and on using risk stratification to identify patients (within target populations of 50-100,000

people) who should be case managed within multi-disciplinary community teams. This model will be developed in tandem with our work to develop a single approach to risk stratification for Staffordshire (see Section 3, p. 29 below):

Our priorities will be achieved through the BCF alongside our current system-wide work programmes as shown below:-



b) 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?

The Staffordshire Health and Social Care Economy is one of the eleven areas nationally identified as being challenged, as part of the Intensive Support for Planning work. A report has been produced with twenty three recommendations which together will support the delivery of a financially sustainable system by 2018. One of the key recommendations was to focus on the frail elderly population, who are key users of health and care services. This focus would be achieved through a single frail elderly pathway as the core element of the quality and sustainability challenge. In looking at this population group, we are clear that it is not sufficient to consider just those individuals who are already in the health and social care system, whether in hospital or in long-term residential or nursing care. It is equally necessary to consider the wider population of older people who are starting to find it difficult to maintain their independence within the community. Early intervention here, with the effect of reducing avoidable crises, may have the triple benefit of improving not only individuals' quality of life and longer-term health outcomes, but also reducing demand for expensive acute health and social care services.

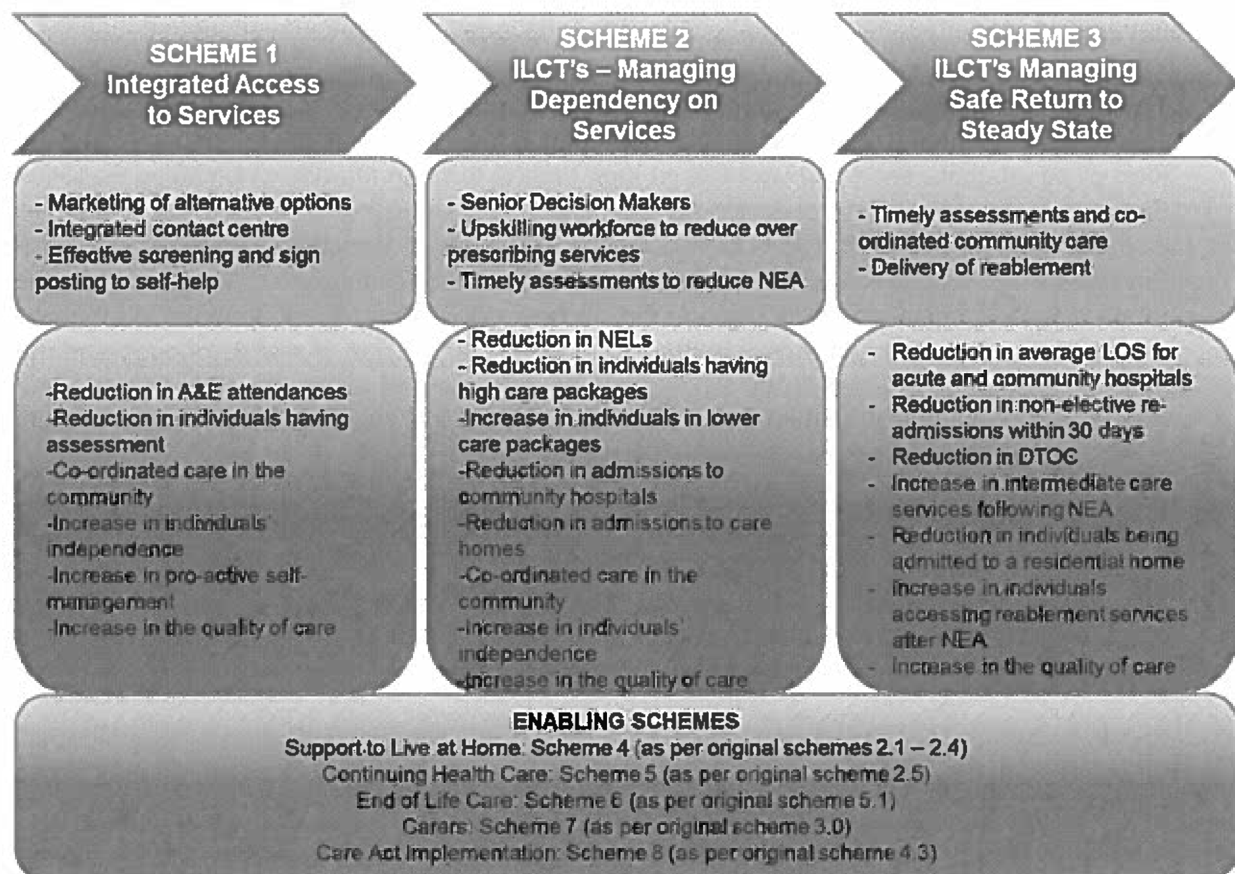
Our ambition for Integrated Commissioning across Staffordshire means investing in an ambitious programme of work covering almost the full range of health and social care functions - such as mental health and sexual health, but also wider areas, such as drugs and alcohol. The role of partners in these areas, such as District and Borough Councils and the Police, is recognised as vital.

It is beyond the scope of the Better Care Fund to seek to cover the full range of this integrated commissioning ambition, though we are very conscious of the interdependencies between these areas.

The Better Care Plan has therefore been designed to improve the experience of frail older people in four ways:

- Integrated Single Point of Access – Maximising Independence and Self-Help
- Integrated Local Community Teams-Managing Dependency on Services
- Integrated Local Community Teams- Managing Safe Return to Steady State
- Enabling schemes to support the three above

The BCF Schemes



Given the scale of the change required to achieve integrated commissioning across a system as complex as Staffordshire, it has not been possible to set out the proposals in detail in this plan. However, since our original submission, significant progress has been achieved in agreeing how to work together to combine our commissioning activities and funding for care in community settings into a single aligned budget (initially totalling c. £105m).

The role of District and Borough Councils

In parallel to our work on integrated commissioning, we have been working collectively on strategic change led by District and Borough Councils to develop the concept of locality-based commissioning.

The Districts and Boroughs, rather than being seen as a default for direct provision, want to move to a position where they are seen as leading the commissioning approach to help local people to take maximum personal responsibility for their own lives seeking care when only 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 in 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. Disabled Facilities Grant funding will be safeguarded within the Better Care Fund and should a national Spending Review take place after the General Election which affects the BCF, then that funding will be reviewed accordingly.

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-centred outcomes and support self-care.

The focus therefore of this work is on wellbeing and devolves commissioning responsibility to support community assets to the district and borough partnerships. The work done to date has shown that:

- Local authorities make a significant contribution to the improvement of wellbeing outcomes through the delivery of statutory and discretionary services. These range from strategic/policy decisions to daily transactions/services.

- Local partnerships add value to the above contributions using a variety of methods, funding/resource streams and community engagement and networking tools.
- Statutory organisations across Staffordshire are recognising the value of working through localities for various reasons, including local knowledge, access to networks; community engagement. This has led to the formal recognition of "devolved accountability" as a means of supporting local delivery in a range of outcome focused activities.
- Improved outcomes are evident in those localities where the aforementioned bodies have come together with a shared view upon "what needs to be done". The application of "common sense for a common purpose" helped to remove the often self-imposed barriers to working in collaboration. The result in many cases has been the establishment of delivery or commissioning boards using agreed local frameworks in order to agree solutions; commission services and achieve improved outcomes.

Planned outcomes from the BCF

If the Staffordshire system is successful we believe the experience of "Mrs Smith" and "Mr Jones" will be significantly different in the future as described below.

How we will improve the experience of "Mrs Smith"

Mrs Smith is an 83 year old who lives alone, but is visited regularly by her niece. However, she sometimes feels lonely and isolated. She has a range of long term conditions including COPD, type 2 diabetes and arthritis which are currently self-managed with medication and periodic monitoring and review from her GP. As a result of her arthritis, Mrs Smith struggles to cook for herself. Mrs Smith looks forward to her family's visits, and her goal in life is to carry on living independently at home.

What happened to Mrs Smith in under the current system?

Mrs Smith visits her GP on a regular basis and has presented at A&E three times within a six month period with breathing difficulties due to a chest infection and exacerbation of her COPD. On all presentations to A&E Mrs Smith was admitted into hospital for a period between 5-7 days returning home once the infection cleared and her COPD had been stabilised.

What would happen to Mrs Smith under Scheme 2 – "Managing Dependency on Services"?

As a result of risk stratification, Mrs Smith was identified by the Integrated Local Community Team and her GP as having presented at A&E on several occasions. Mrs Smith was allocated a single case worker who was responsible for working with Mrs Smith to develop a management plan to help her manage her long term conditions and goals. Mrs Smith made contact with her case worker as she was showing symptoms of a chest infection and was having some difficulties breathing. Mrs Smith received a visit from a respiratory specialist nurse in the rapid response team who undertook an assessment which identified that Mrs Smith was experiencing an infection and exacerbation of her COPD. The Respiratory Nurse was able to initiate Mrs Smith with her rescue antibiotics that were installed as part of her management plan and nebulise her. Wrap around support services were organised for a period of two days whilst Mrs Smith was recovering. This provided Mrs Smith with early intervention support that avoided Mrs Smith's condition worsening and being admitted to hospital, as a result Mrs Smith was managed safely in her own home. The team worked with Mrs Smith to help her monitor and manage her long term conditions more effectively, giving her increased confidence and independence. As the team contained both health and social care professionals, it was identified that Mrs Smith was potentially in danger of deteriorating as a result of difficulty in cooking for herself. The team was able to assist Mrs Smith in finding community programmes that

would work well for her. Mrs Smith is now part of a casserole club and attends a local luncheon club; as a result she does not have to worry about how to prepare her meals, feels included within her local community and does not feel lonely.

How we will improve the experience of "Mr Jones"

Mr Jones is a 77 year old grandfather who lives alone, but is visited regularly by his daughter and son-in law. He and his family believe he copes well at home, in spite of his somewhat limited mobility. Mr Jones has arthritis and poor eyesight. As a result of his arthritis and growing frailty, Mr Jones struggles to undertake a number of daily living tasks and receives two times daily domiciliary care visits to assist him. Mr Jones looks forward to his family's visits, and his goal in life is to carry on living independently at home. However, he sometimes feels frightened of what will happen if he has an accident.

What happened to Mr Jones under the current system?

Mr Jones had a fall and was admitted to hospital to be treated for a hip fracture. Following Mr Jones's operation, he was discharged to his local residential home for a period of respite care. During this period Mr Jones did not receive reablement as part of his care package and he therefore became more dependant; as a result, Mr Jones was admitted on a long term basis and subsequently passed away.

What would happen to Mr Jones under Scheme 3 – "Managing Safe Return to Steady State"?

Mr Jones had a fall and was admitted to hospital to be treated for a hip fracture. During his time in hospital, Mr Jones received a co-ordinated health and social care assessment which recognised his strengths and capabilities along with his existing networks of support and his wish to return home to live independently. The outcome of the assessment was short term community reablement support. Upon returning home, Mr Jones received an integrated reablement/intermediate care package, which included input from physiotherapists and occupational therapy which provided some community equipment to support his recovery. Following a co-ordinated review, Mr Jones received a revised maintenance domiciliary care package of one visit per day which improved his sense of independence and wellbeing.

Performance Targets

In this revised version of the BCF plan, we have described and quantified the targets of our whole BCF plan for 2015/16 onwards. Where possible, specific targets (such as unplanned admissions to hospital) have been attributed to each BCF scheme. Our overall approach to measuring success will involve:

- Tracking performance at high level, using a performance framework that has been prepared to support the BCF plan;
- Also monitoring each individual scheme, using bespoke performance measures in each case.

Scheme Benefits

At this stage, it would be helpful to explain the basis for the benefit detail included in our Part 2 Template and the variance between Benefits and Metrics information in that document.

The Part 2 template Benefits tab is reflective of the incremental benefits of the BCF schemes above other plans already in place across the Staffordshire health economy. These benefits are delivered by Schemes 2 and 3 and supported by Scheme 1 and the other supporting schemes. Due to the required implementation timescales, there are no 2014/15 benefits recognised in the Benefits tab for the BCF schemes.

The Metrics tabs, including the P4P metric tab, are reflective of the cumulative transformation plans delivering improved performance for Staffordshire. This includes MTFS and FRP plans formed by the council and CCGs, as well as other integrated commissioning projects.

Therefore, the reduction in non-elective admissions recognised in the Benefits tab forms a small part of the overall 3.5% reduction reflected in Metrics tab 5. Equally, the reduction in residential admissions reflected in Metrics tab 6 is not in the Benefits tab as this performance improvement is as a result in non-BCF activity.

Due to the following factors, we have revised the Part 2 Metrics tabs since the September submission:

- More up to date data (Q1 and Q2 actual performance data is now available)
- Additional transformational plans being discussed with providers
- Revised and refined schemes which have made a different local metric more appropriate

As a result of the above, the following changes have been made:

- Residential admissions – the expected performance has improved since the September submission, as the Council is embedding a philosophy of enablement and reablement that will see an increase in independence. This philosophy also underpins BCF Schemes 1, 2 and 3.
- Success of reablement – although we intend to increase the number of individuals appropriately receiving reablement services, we anticipate that this metric will remain static. This is reflective of the high quality of services required to maintain our current good performance, given the higher complexity individuals who will now be in scope for reablement services.
- DToCs – as a symptom of wider issues for our local health economy, there has been recent poor actual performance in relation to DToCs. In particular, there has been a

very substantial increase in demand for domiciliary care, which has overtaken significant increases in capacity. Recognising the need for a joint approach to tackle deep-seated issues in the market, the County Council is supporting the Partnership Trust by working with a neighbouring local authority in regards to workforce development. The council and health providers are also working together to implement plans to improve this performance, including establishing some guaranteed rotas, making better use of the available respite bed capacity, and bringing more providers onto framework contracts from April 2015. There are also plans around collaborative work in hospitals to ensure that health and social care understand the impact of delayed discharge on the patient journey, i.e. early notification to social care, cultural change in terms of dealing with patient choice, as well as managing expectations such that packages of care are better aligned with actual need, based on a default emphasis on personal responsibility, supported through assistive technology.

- Local metric – we have changed our local metric from a measure around falls prevention to monitoring the reduction in A&E attendances, as this better aligns with the work we will be doing as part of existing FRPs, and Schemes 1 and 2.

The benefits and budget associated with each of our proposed schemes is shown in the table below:

SCHEME	BUDGET (£m's)	Reduced NELs	Reduced DTOCS	Reduced Readmissions	Reduced Admissions to community hospitals	Reduced Admissions to care homes	Co-ordinated care in the community	Improved user/patient experience
Integrated Access to Care – Maximising Independence and Self-Help							✓	✓
Integrated Local Community Teams – Managing Dependency on Services	16.960	✓				✓	✓	✓
Integrated Local Community Teams – Managing Safe Return to Steady State	19.168		✓	✓			✓	✓
Supporting Schemes	68.609	✓	✓	✓		✓		

Detailed performance targets (see also Part 2 Template)

As a result of transformational work taking place across the whole of the Staffordshire health economy, of which the BCF schemes form a part, the following changes in performance are expected:

- A 7% reduction in permanent residential admissions of older people, equating to 74 less people per year

- We will maintain our current high rate of success in reablement, despite increased numbers of people being re-abled
- After an increase in DTOCs as a result of market issues, 2015/16 will see a 14% reduction in DTOCs as a result of the full implementation of current plans
- A 5% increase in the percentage of people who use services and carers who find it easy to find information about support, services or benefits
- Prevention of a c5% increase in the total number of A&E attendances.

These targets are aligned with the plans of all relevant partner agencies (see section 6 below).

The Health and Wellbeing Board has overseen the development of the plan, and signed it off at its meeting on January 8th 2015. The Board will ultimately be accountable for the delivery of the plan (see section 4.b).

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.

Our Demographic Pressures

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 **carers**. None of these groups are mutually exclusive and all are predicted to grow significantly.

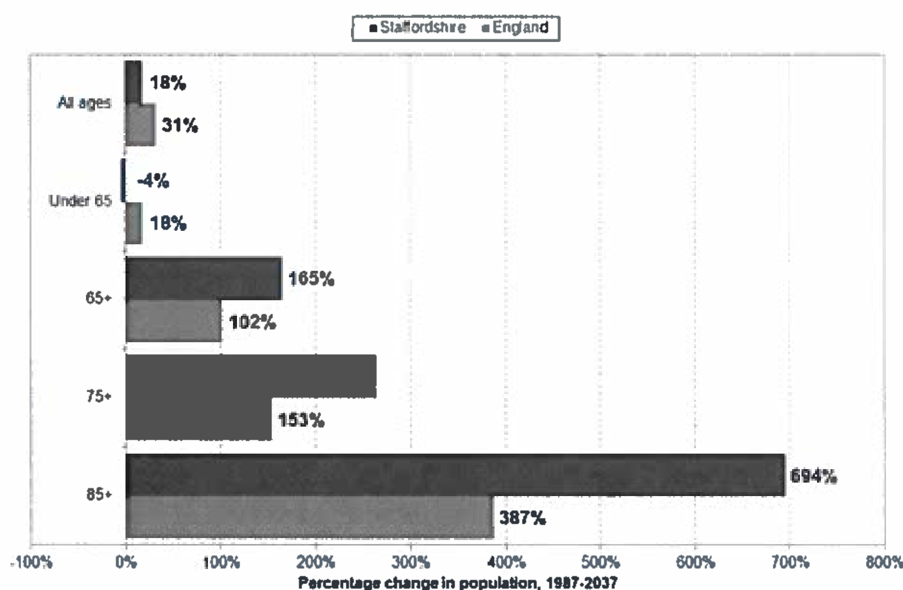
It is estimated in Staffordshire that there are currently 24,000 frail elderly people, 240,000 people with a long term condition (including 11,000 people with Dementia) and 27,000 Carers (of people in receipt of services).

Staffordshire's elderly population is expected to grow much faster than the England average; as an example, the number of people aged 85+ will increase seven-fold between 1987 and 2037. Over the same period, the number of working adults (who may be expected to care for their elderly relatives) will reduce.

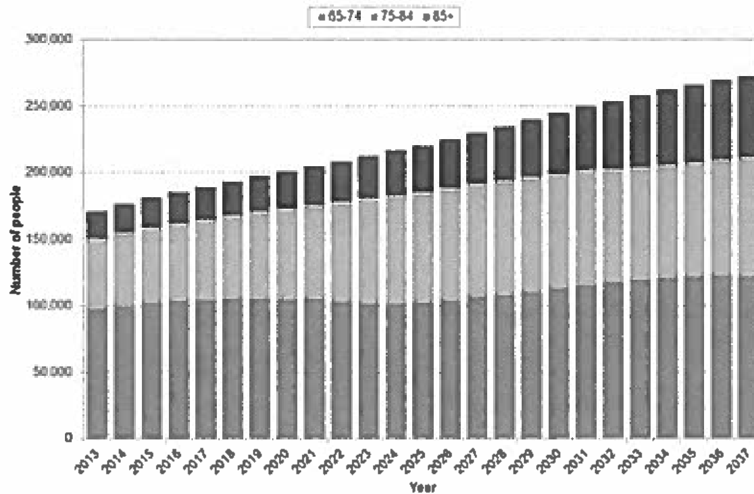
The impact on the care system of this decrease in the working age population will be exacerbated by the improving economic climate, such that people may have less time available in which to provide care to their own relatives and there will be greater employment competition for people who might otherwise enter the care workforce.

Future Change in Population

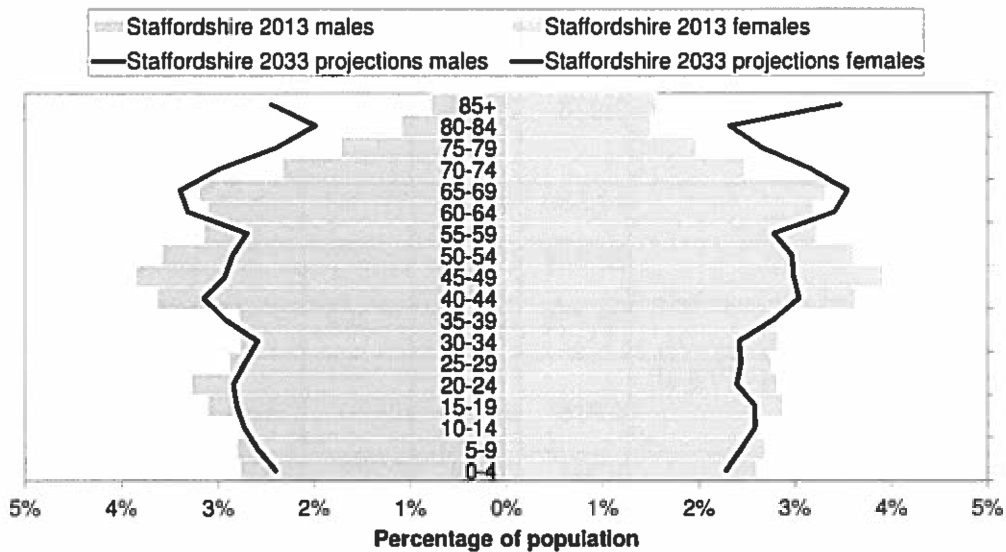
Percentage change by age group, 1987-2037



Staffordshire population projections by age group, 2013-2037



The changing Staffordshire population pyramid



Linked to the increase in the number of very elderly people, Staffordshire is experiencing increases in the number of people presenting with long-term conditions (including dementia). This is exacerbated by an explosion of lifestyle- and obesity-related conditions (e.g. diabetes and heart disease), higher expectations of the public regarding access, safety, and standards of care, and expectations that technological advances in medicine will keep people alive and active longer.

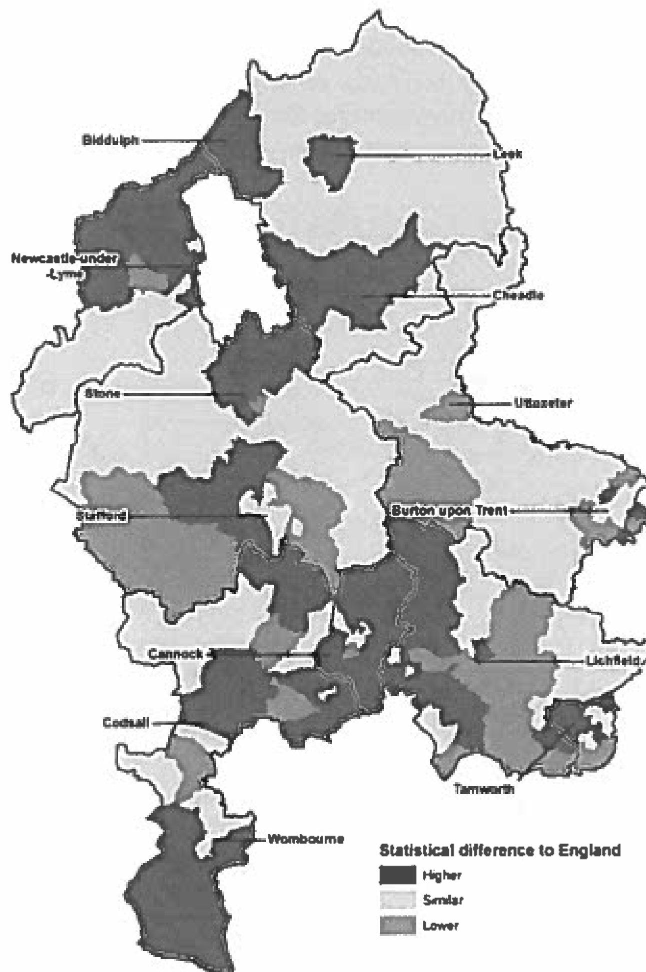
Current and projected numbers of selected health conditions and supported care arrangements for people aged 65 and over in Staffordshire

Supported care arrangements					
	2014	**2015**	**2020**	**2025**	**2030**
Unable to manage at least one domestic task	69,464	71,531	82,471	94,295	106,930
Unable to manage at least one self-care activity	57,079	58,750	67,434	77,037	87,647
Unable to manage at least one mobility activity	31,004	31,969	37,101	42,790	49,366
Health					
	2014	**2015**	**2020**	**2025**	**2030**
Limiting long-term illness	42,622	43,859	50,289	57,772	65,143
Long standing health condition caused by a heart attack	8,599	8,832	9,863	10,947	12,165
Long standing health condition caused by a stroke	4,045	4,161	4,698	5,274	5,862
Long standing health condition caused by bronchitis and emphysema	2,978	3,060	3,400	3,744	4,160
Obese (BMI over 30)	46,583	47,715	51,788	55,649	61,017
Diabetes	22,038	22,604	24,978	27,332	30,348
Incontinence	28,436	29,239	33,002	37,111	41,651
Registrable eye conditions (75 and over)	4,915	5,069	6,170	7,584	8,435
Profound hearing impairment	1,861	1,924	2,229	2,616	3,133

These issues are also associated with significant health inequalities, with mortality rates (and the incidence of long-term illness) being particularly high in those areas of the county that are most deprived.

Self-reported limiting long-term illness, 2011

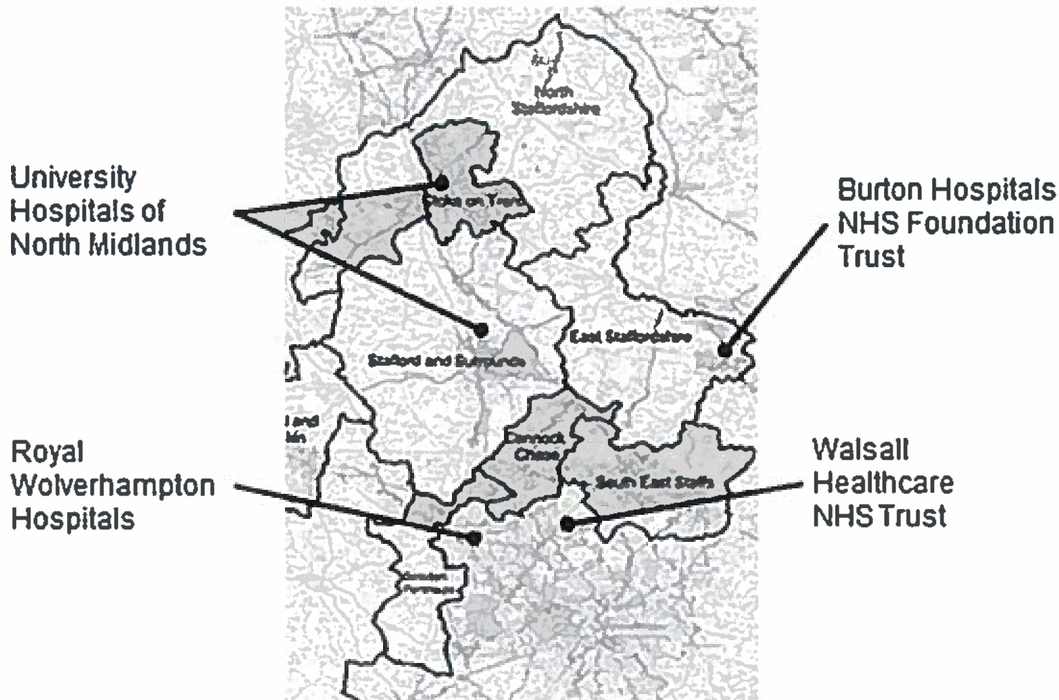
Geographic Variations



The overall 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, 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 - i.e. 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.

Our Organisations

Staffordshire is a complex system which has a large number of provider and commissioning organisations across a large geographic footprint. There are six CCGs, two Acute Providers, an integrated Community Provider and two Trusts which provide Mental Health and Learning Disabilities services (one of which also provides Children's Community Services). There are also significant levels of patient activity outside of Staffordshire boundaries - particularly to the South of the county, where the Acute Trusts covering Wolverhampton and Walsall provide a significant amount of acute provision for Staffordshire residents. In the South East much of the patient activity takes place outside of the CCGs' boundaries.

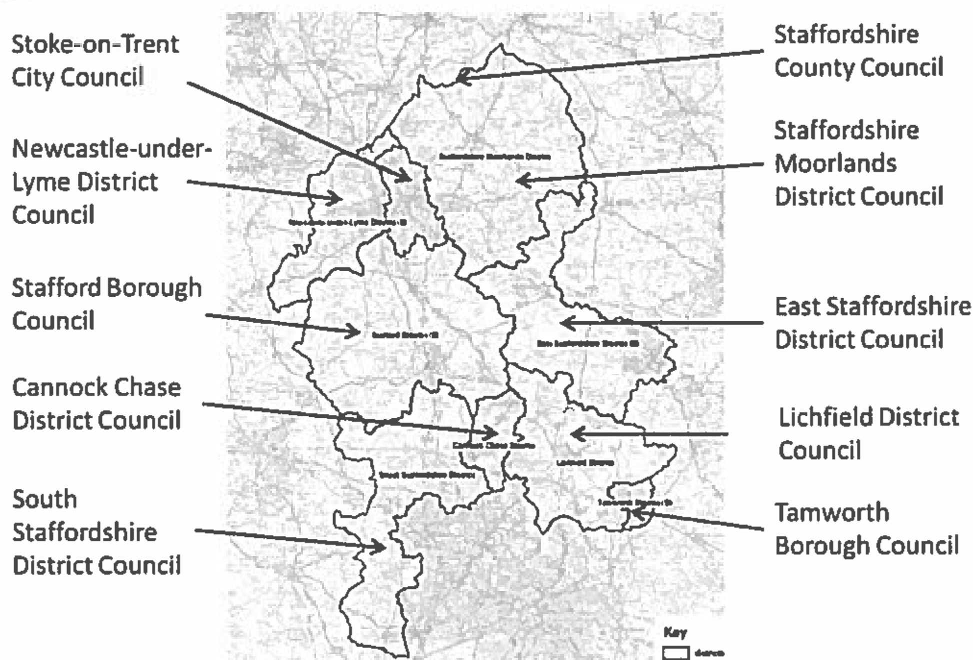


Social Care

Since 2012, Staffordshire has been at the forefront of moves to integrate community health and social care services, through its innovative S75 agreement with Staffs and Stoke on Trent Partnership NHS Trust (SSOTP). Under this agreement, the Trust (whose boundaries are co-terminous with the whole of Staffordshire, including Stoke on Trent) has taken on responsibility for delivering the bulk of operational social care functions for older people, and people with physical disabilities/sensory impairment. It has very recently been agreed that this arrangement will continue for a further three years, from April 2015.

Local Government Structures

Politically, the picture is just as complex, with eight District and Borough Councils and Staffordshire County Council. Stoke-on-Trent City Council lies within the geographical boundaries of Staffordshire but is a separate, unitary authority.



Levels of Need - Over 65s

The challenge for Staffordshire is immense, and there is therefore a need to understand the population in more granular detail. In this BCF plan we are focusing initially on the Frail Elderly but in implementing the schemes we will undoubtedly start to affect the pattern of care for all older people. As part of this process we have started to segment the population aged over 65 based on the level of need identified in 2013, and have then set out predictions of what the population growth in these need areas will be by 2021. This allows the partners to target interventions based on the volumes of service users.

	2013	%	2021	%
Level 4 - Complex co-morbidity	2,900	1.74%	3,700	1.87%
Level 3 - Long-term condition with co-morbidity and social needs	5,100	3.06%	6,500	3.29%
Level 2 - Long-term condition and additional needs	15,100	9.05%	19,000	9.63%
Level 1 - Self management	95,700	57.37%	114,600	58.05%
Level 0 - Targeted high risk primary prevention	25,000	14.99%	28,000	14.18%
Population wide prevention	22,900	13.73%	25,600	12.97%
Total population aged 65 and over	**166,800**	100.00%	**197,400**	100.00%

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

Risk stratification:

Having used existing tools to segment the population at high level, and to map expenditure to levels of need, we intend to develop a more targeted approach to delivering interventions.

Risk stratification is an approach that has been tested predominantly in healthcare environments. The approach uses data to identify people who may change from one position of health status to a lower level of health status (e.g. living at home to requiring admission to hospital). Evidence suggests that risk stratification has the potential to have a positive predictive value for such things as hospital admission in the region of 30-50%. Risk stratification has been tested in social care environments but the evidence base for the approach is less well developed. Staffordshire will use risk stratification in its approaches to targeting interventions. Initially risk stratification will be undertaken on a simplistic level, but over time the approach will be developed by:

- Continuing to implement and test these agreed risk stratification and tools at practice level, in the context of the rolling-out of a case management approach;
- Creating patient-level linked data sets;
- Aligning and then fully integrating risk stratification tools across acute healthcare, primary healthcare and social care (i.e. to create a combined predictive model).

To date, all CCGs have been using models of risk stratification; the task from here is to define a single model of risk stratification that will be used across the county to ensure coherence and consistency. As part of the BCF implementation work we will have in place by the 31st March 2015 a single approach to Risk Stratification.

The pressures to achieve a coherent approach to stratification of the population is critical to our mutual success. The current and predicted costs relating to this population are shown in the table below:

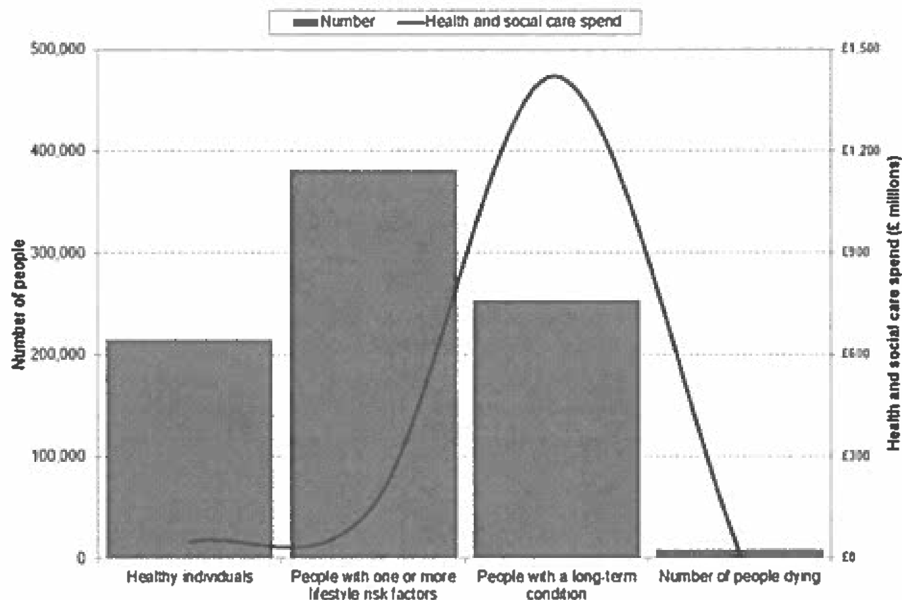
	2012/13 (000s)	2019/20 (000s)	Growth (000s)
Social Care - Adults Aged 65 and over [1]	£158,731	£188,138	£29,407 (19%)
NHS – adults aged 65 or over	£688,362	£833,874	£145,512 (21%)

[1] Please note:

- The figures for 2012/13 and 2013/14 are actuals from the PSS returns
- Figures for 2014/15 onwards are forecast figures
- Forecasted figures assume a 4% increase - 2% for inflation and a 2% demography each year
- The forecasted figures do not assume any transformation/efficiency savings

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.

Staffordshire's distribution of expenditure, 2012/13



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Across the county, there is a plethora of responsive and intensive community based services in place but they currently operate in isolation from 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 - enabling more investment in preventing future need for those currently at lower levels.

Activity and costs of Frail Elderly

- During 2012/13, there were around 35,100 non-elective (unplanned) admissions of people aged 65 and over. This represented 43% of all non-elective admissions, but 60% of non-elective admission costs. Around 24,200 of these admissions were of people aged 75 and over, and 10,600 of 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 from 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 of people aged 65 and over to residential and nursing care homes, a rate 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.

Conclusion

We are well placed in Staffordshire in that we have already 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*

The development of our BCF plan needs to be seen in the context of the particular challenges facing our local health economy.

During 2014, the local NHS has been subject to Intensive Support for Planning. This has given rise to extensive work relating to financial sustainability, and parallel work to improve urgent care pathways and reduce the pressures on our local hospitals.

We believe it was inevitable that our BCF process therefore got off to a slower start, and was not ready to be approved in September 2014.

Since September, the work on our BCF plan has accelerated and intensified. The progress is summarised in the following section.

We acknowledge that there is still a substantial amount of "work in progress", but can demonstrate that we are now on track to start delivering this plan in April 2015.

As a health and social care system, we are very conscious that the scale of the ambition we have set out in this Better Care Fund plan is very challenging. Yet we are equally conscious that it is only ambition at that scale that will enable us to address the challenges facing our local system.

The delivery of this level 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. It will be essential that robust programme management is employed to this end.

As a system, we have collectively agreed that the scale of the challenges facing us is so great that only a single, coherent approach, that brings together all partner organisations, can be sufficient to allow us to address them. We have therefore embarked on a process of establishing a comprehensive integrated commissioning infrastructure. This currently includes work across eight topic areas:

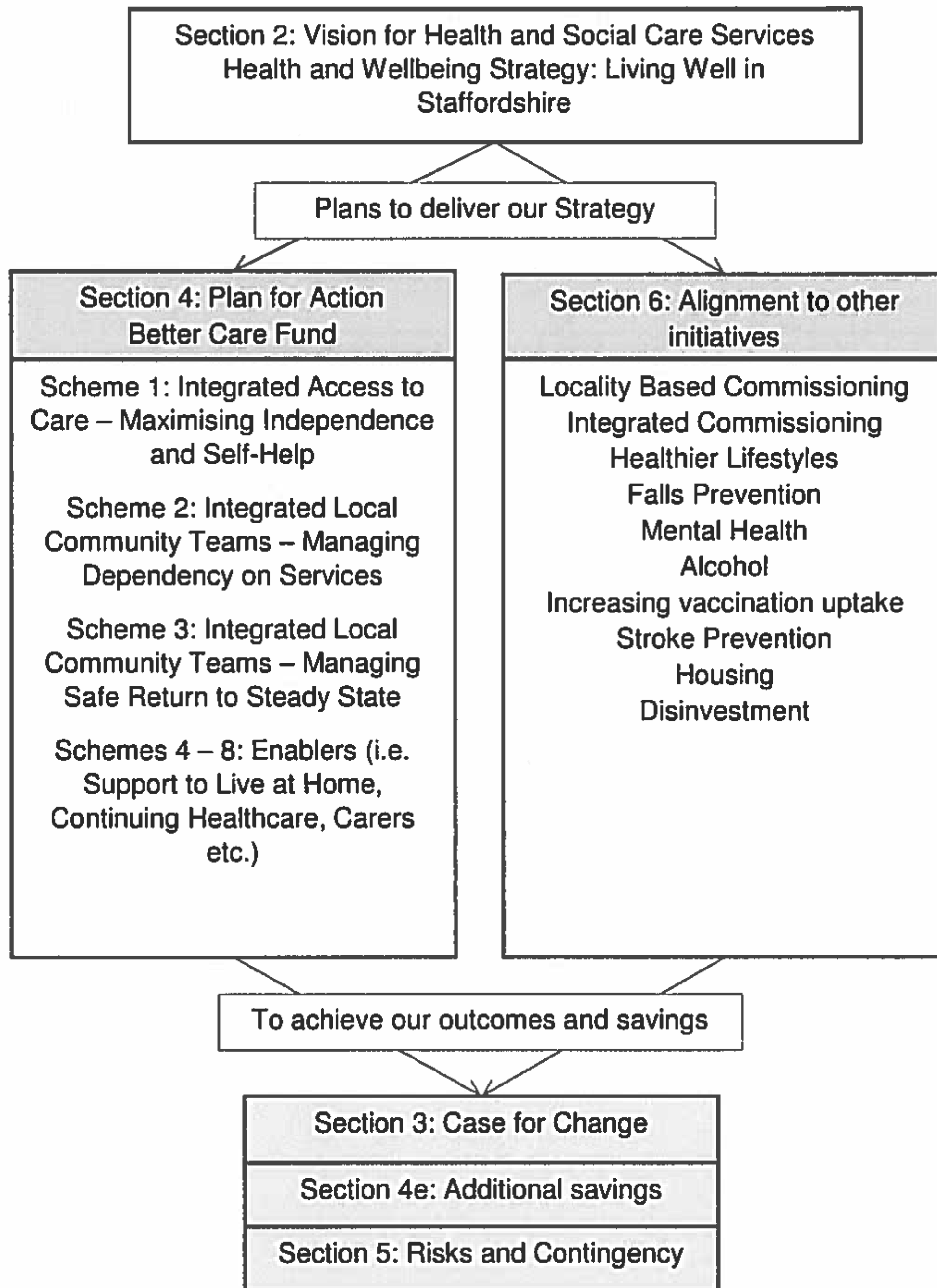
- Carers
- Support to Live at Home
- Frail Elderly
- Mental health
- Learning Disabilities
- Children's Services
- Drugs and Alcohol
- Sexual health

The first three of these are included within this Better Care Fund plan. We have here also expanded the Frail Elderly area to include End of Life, as this represents a key element of that topic.

Between them, these areas cover the full range of the health and social care priorities set out in the Joint Health and Wellbeing Strategy and will provide the necessary infrastructure required to enable delivery of the service redesign and improved outcomes that reflect the level of our ambition.

Each of these areas is challenging, but that around Frail Elderly is the most challenging, due to its size, complexity, and position as core business for both health and social care. We have therefore selected this area to be the focus of the Better Care Fund, using this document and the associated planning process, to provide impetus and discipline, while also making parallel progress in the remaining areas.

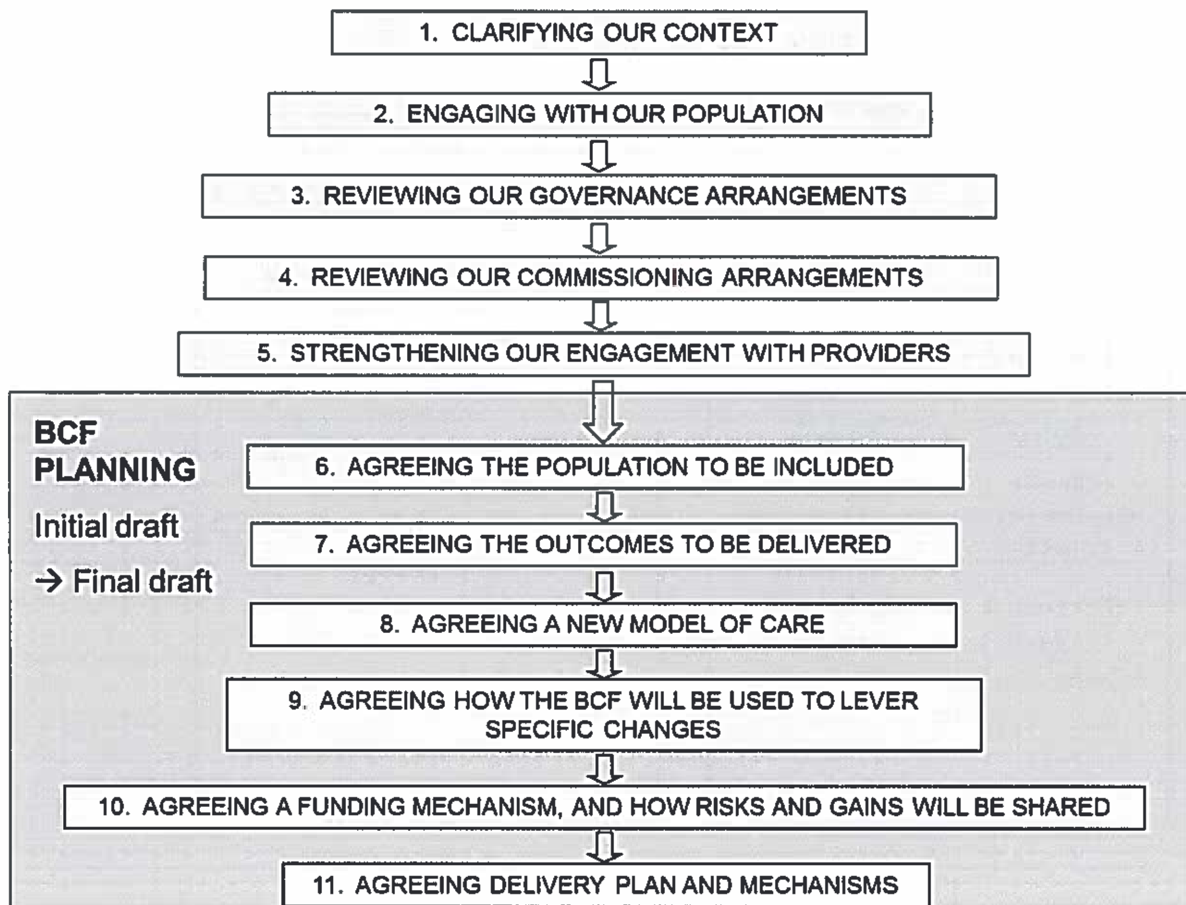
Within the focus on Frail Elderly, the illustration overleaf shows how the various sections of the plan link together, in order to give a comprehensive view of our intentions and the governance that we are building around them.



We fully recognise the challenge and scale of these intentions. We have therefore established a Programme Management Office (PMO) for delivery of the Joint Health and Wellbeing Strategy. Within this, the Better Care Fund will be led by a Director-level implementation group and supported by a dedicated team comprising 4-5 full time officers. The first task for this team will be the development of a comprehensive delivery plan. The progress to date is detailed below alongside the plan for 2015 onwards.

Our Transformation Journey-Summary of Work Plan

In setting out our plan for action we have identified eleven high-level workstreams which will underpin the delivery of the BCF. Below is an outline plan of actions for the early part of 2015 to ensure that the delivery related to those schemes commences on the 1st April 2015.



1. CLARIFYING OUR CONTEXT

What we have already achieved	What we are committed to achieving in 2015/16 and beyond
✓Responded to a KPMG review of our local health economy	Implementation of key recommendations to support BCF delivery
✓Laid the foundations of a major transformation programme	Agree single transformation team for health and social care system
✓Agreed 2 year Financial Recovery Plans and 5 year strategy	Implementation of key schemes across FRPs and BCF
✓Aligned these plans across agencies.	Implementation of BCF schemes system wide from 1st April 2015
✓Agreed and shared our financial and performance baselines/targets. (See the appended "fact pack").	Delivery of the protection of Social Care, including risk share efficiencies

2. ENGAGING WITH OUR POPULATION (See also section 8.a))

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Individual engagement exercises held by CCG's (Long Term Conditions etc)	Further enhance engagement with populations supported by Engaging Communities Staffordshire and Healthwatch
✓CCG engagement exercises for Cancer/EOLC over 7000 people engaged	Build on large scale exercises undertaken over last two years whilst applying learning from those exercises
✓Embedded engagement as part of commissioning and decommissioning services	Commence enhanced discussion with communities on prevention building on the "Choose Well" campaign

3. REVIEWING OUR GOVERNANCE ARRANGEMENTS (see also section 4.b))

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Developed the Health and Wellbeing Board	Continue to develop the role of the HWBB in overseeing delivery of the BCF
✓*Maintained the Integrated Commissioning Executive Group*	Reform Integrated Commissioning Executive as part of revised Governance
✓Agreed to the establishment of a pan-Staffordshire Joint Transformation Board (Chief Officer Level) to oversee transformation	Ensure that that JTB works to enable transformation across the system
✓Reviewed governance and programme management arrangements at high level.	Implement all new governance arrangements (including extended BCF Implementation Group) from January 2015
✓Committed to using the BCF as the vehicle for delivering key priority changes.	Deliver key elements of underpinning work for BCF (systems, processes, structures) to enable delivery from 1st April 2015

4. REVIEWING OUR COMMISSIONING ARRANGEMENTS

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Agreed a Health and Wellbeing Strategy 2013	Review of progress in delivering the strategy
✓Agreed a Frail Elderly Strategy (all CCGs) December 2014	Implementation of Frail Elderly strategy to support BCF - first actions complete by 31st March
✓The 5 CCGs have agreed a single lead commissioner for each major provider	Development of single lead CCG across further areas of work in BCF
✓Agreed areas for Joint Commissioning with the County Council	Implementation of full joint commissioning on Learning Disabilities from 1st April 2015
✓Agreed principles on locality-based commissioning/District Councils	First proposals for prevention signed off and implemented through locality based commissioning from 1st April 2015

5. STRENGTHENING OUR ENGAGEMENT WITH PROVIDERS

(see also section 8.b and c)

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Committed to leading change in tandem with the major Acute, Community and Mental Health providers, through the Joint Transformation Board.	JTB meeting and facilitating transformation across the health and Social Care system plan by 31st January 2015
✓Prioritised work to ease immediate pressures on the acute Trusts through strategic resilience plans	Continued support to Providers from CCGs and Social Care to manage demand and DTOCs
✓Agreed joint pathways for community hospitals	Work between Provider and Commissioner to implement revised pathways for Frail Elderly by 31st March 2015
✓Revised Section 75 contract with SSOTP	Revised contract aligned with CCG contract with SSOTP by 31st March 2015

6. AGREEING THE POPULATION TO BE INCLUDED

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Agreed that our BCF plan will focus on improving the experience of (a) frail older people with long-term conditions, and (b) carers.	Implementation of agreed schemes through agreed delivery infrastructure within BCF linked to CCGs / Providers / Districts and Borough Councils
✓Piloted risk stratification tools within all 5 CCGs.	Review risk stratification approaches and agree single approach to support delivery of BCF schemes. Single approach to be in place by 31st March 2015
✓Completed "high level" risk stratification to quantify the number of people in our target groups.	Using Public Health model, focus on key groups and target resources which limit acute interventions. First plans implemented from 1st April 2015

7. AGREEING THE OUTCOMES TO BE DELIVERED

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Defined and quantified the desired outcomes.	Set up systems to monitor key indicators related to BCF by 31st January 2015.
✓Designed a high-level performance framework, including jointly agreed metrics (see Appendix)	High-level BCF Performance framework in place by 31st January 2015. Scheme-level performance frameworks in place by 31st March 2015.

8. AGREEING A NEW MODEL OF CARE

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Agreed a high-level model of care to deliver the required outcomes.	Translating this model into delivery plans in each CCG area linked to Operational Plans
✓Reached agreement that this model, and the associated deliverables, will be owned and implemented by all CCGs (albeit with scope for local variation in the delivery arrangements).	Plans across and within CCGs/Districts/Boroughs to implement model, by March 2015

9. AGREEING HOW THE BETTER CARE FUND WILL BE USED TO LEVER CHANGE

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Agreed the priorities that will be delivered from 2015 onwards. (The BCF schemes – see Annexe 1)	All schemes will be ready to be implemented on 1st April 2015
✓Established a timetable and high-level milestones for the BCF schemes.	A detailed work plan for Jan-March is included in this plan, to ensure readiness for implementation by April 2015.

10. AGREEING A FUNDING MECHANISM

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Agreed which budgets will be included in the BCF pool.	Ensure that agreed schemes are implemented alongside pool.
✓Agreed the content of a S75 agreement for the new pooled fund.	Develop and sign off section 75 by 31st March 2015
✓Agreed how risks and gains will be shared.	Implement approach to managing risk in line with agreement reached.
✓Agreed a risk log including mitigating actions	Monitor risks and mitigation to ensure delivery of BCF on track.

11. AGREEING DELIVERY PLAN AND MECHANISMS

What we have achieved in 2014/15	What we are committed to achieving in 2015/16
✓Established joint SROs for BCF	Maintain joint SRO approach
✓Established Task and Finish Group	Maintain and enhance role of Task and Finish Group (to become Implementation Group)
✓Resourced programme to ensure delivery of revised BCF	Maintain resource levels into the PMO / confirm further resource requirements by March 2015
✓Established reporting mechanisms to HWBB, council and CCGs	Enhance reporting mechanisms through Commissioning Congress /HWBB - in place by March 2015

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

In terms of governance, current arrangements are that the **Health and Wellbeing Board** has overarching accountability for the delivery of the integrated commissioning programme.

The **Integrated Commissioning Steering Group**, reporting to Health and Wellbeing Board, is taking forward the programme across the eight areas and also the supporting issues around governance and legal agreements between partners.

In advance of these formal arrangements, a number of shadow arrangements are already in place, providing valuable intelligence on the practicalities of integrated commissioning and also delivering early successes from the approach.

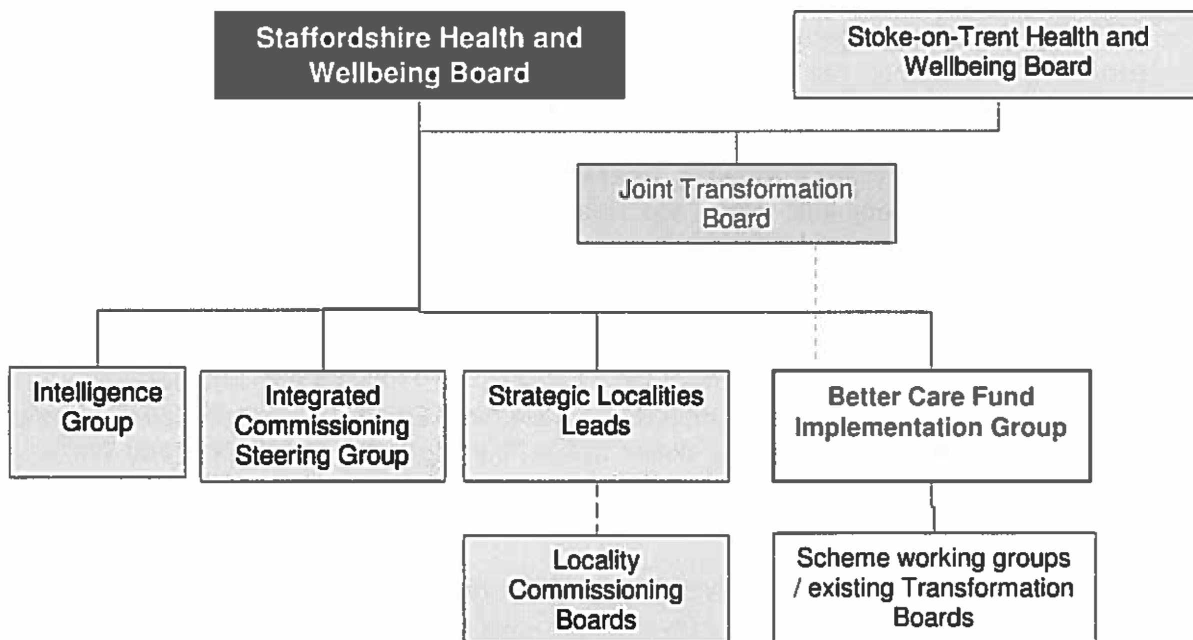
Complementing these actions, we have also been taking forward a programme of locality-based commissioning. **Local commissioning boards** have been established to ensure a strong connection to the powerful local knowledge and impact of District and Borough Councils, through their existing local structures. The **Strategic Locality Leads** group provides a vehicle for districts and Boroughs to design, and implement, the aspirations of Integrated commissioning. This group includes representatives from all eight district and boroughs in Staffordshire. This group already includes the Better Care Fund as a standing agenda item and hence provides an essential vehicle for district and Boroughs to design, implement and influence the Better Care Fund Schemes within localities.

Joint Transformation Board

Reflecting the cross-system nature of many of the changes that are required, and the interdependencies with Stoke on Trent and its providers, a **Joint Transformation Board** has been established. The Joint Transformation Board includes representatives from all six CCGs in Staffordshire and Stoke on Trent, Stoke-on-Trent City Council, Staffordshire County Council, Staffordshire and Stoke-on-Trent Partnership Trust, University Hospital of North Midlands NHS Trust, Burton Hospitals Trust, Royal Wolverhampton NHS Trust, North Staffordshire Combined Healthcare NHS Trust, South Staffordshire and Shropshire Healthcare NHS Foundation Trust). In future, the Joint Transformation Board will therefore act as an escalation point - enabling commissioners and providers to work together to find solutions and remove obstacles hindering progress to the Better Care Fund Schemes.

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

The diagram below describes the proposed governance arrangements for the management and oversight of the Better Care Fund Plan.



The responsibility for delivery of the Better Care Fund plan clearly lies with the **Staffordshire Health and Wellbeing Board**.

Co-ordination and management of operational delivery of the Better Care Fund will be exercised through the **Better Care Fund Implementation Group**. The Better Care Fund Implementation Group is co-chaired by Andrew Donald (Accountable officer for Stafford and Surrounds CCG and Cannock Chase CCG) and Andy Burns (Director of Finance and

Resources at Staffordshire County Council). It will include senior representatives from the County Council, all the Staffs CCGs and other key partners

The BCF Implementation Group will be supported by a small programme management office; it will maintain oversight of all the BCF schemes and will have two primary responsibilities:

- To implement the required infrastructure for the BCF (e.g. Pooled fund arrangements, governance arrangements etc.)
- To oversee the co-ordination and delivery of the schemes included in the Better Care Fund.

Recognising the importance of mainstreaming the Better Care Fund schemes within existing transformation and integrated commissioning work programmes, where applicable the schemes will utilise existing governance arrangements or working groups. Alternatively, new interim arrangements will be created.

These working groups will include provider and district/borough representation where applicable and will be managed by dedicated, professional project management resources. It is anticipated that each scheme will be supported by a project manager, with additional project management resource to manage the development of effective governance and performance of the BCF.

One of these new arrangements will be the creation of a **Performance and Modelling Sub-group.** This subgroup will monitor and report on the targets set in the BCF's nationally-determined and locally-agreed performance metrics.

The Health and Wellbeing Board's **Intelligence Group** identifies and reports on key performance indicators that inform the Health and Wellbeing Board on progress of the delivery of the Health and Wellbeing Strategy. This group will receive updates from the BCF Performance and Modelling subgroup and thereby report performance of the Better Care Fund to the Health and Wellbeing Board.

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

The Better Care Fund 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.

c) List of planned Better Care Fund Schemes

The original list of Planned BCF schemes detailed in the September submission focused on Carers, Support to Live at Home and the Frail Elderly. The Steering Group have reflected on the submission and the feedback from the assessment of the September submission, and noted the comment that many initiatives were seen as pass through / no change, when in

fact the system realises clearly that schemes to transform services are critical to deliver service and financial sustainability.

Therefore the three original schemes have been incorporated into three revised schemes (plus "enabling schemes") which fit strategically with our priorities (see table below). All the BCF schemes now have detailed implementation plans identified at Annex 1. It should be noted that they link back directly to CCG FRPs and the County Council MTFS as well the five year strategic plans. They also take account of the 23 "Support for Planning" recommendations.

Scheme no.	Scheme
1	Integrated Access to Care – Maximising Independence and Self-Help
2	Integrated Local Community Teams – Managing Dependency on Services
3	Integrated Local Community Teams – Managing Safe Return to Steady State
4 – 7	Enabling Schemes
8	Care Act Implementation

Ref no.	Scheme	Sub-Schemes	Investment from BCF
1	Integrated Access to Care – Maximising Independence and Self-Help		£0
2	Integrated Local Community Teams – Managing Dependency on Services		£16.960m
3	Integrated Local Community Teams – Managing Safe Return to Steady State		£19.168m
4 - 7	Enabling Schemes	4.1 – 4.4: Support to Live at Home (including DFG, Assistive Technology and ICES)	£9.556m
		5: Continuing Health Care	£56.007m
		6: End of Life Care	£1.516m
		7: Carers	£0.792m
8	Care Act Implementation		£0.738m

It should be noted that there are key elements of frail elderly commissioning and end of life commissioning that are not included in the annexes, as they are subject to separate large scale procurements. Although not included in this schedule, these broader initiatives will contribute to our overall strategic delivery.

The schemes proposed are aligned with initiatives planned by individual organisations. Delivery will be coordinated across organisations, although the level of delivery of each scheme may differ because of the present circumstances within the local area. (For example there may be a heavier focus on "step up" in North Staffordshire because of its relationship with Stoke-on-Trent. Each of the schemes is described at a strategic level below).

Scheme 1: Integrated Access to Care - Maximising Independence and Self-Help

The aim of this scheme will be to support people to maximise their independence by diverting even more individuals into self- and early help solutions than would be possible through separate health and social care systems - thereby avoiding a still greater proportion of inappropriate attendances at A&E and/or admission into ongoing social care services.

Health and social care will work together to support individuals to avoid becoming dependent on health and care services by:

- promoting low level prevention, and self- and early help through joint effective marketing and communication campaigns building on foundations developed through public health
- integrating and enhancing the currently separate web offers
- integrating the currently separate health and social care first contact services (i.e. 111, other community hubs and Staffordshire Cares)
- creating a joint health and care back office service.

An integrated health and social care first contact service will be resourced with skilled call handlers and experienced clinical and social care professionals. The first contact service will:

- draw on an asset-based philosophy to provide information, advice and guidance to self- and early help solutions, using locality based resources
- where required, prescribe, initiate and co-ordinate community health services and social care support such as rapid response, acute visiting service, community equipment
- put a professional decision maker at the front of the pathway thereby enabling a rapid and effective preliminary assessment to be made and provide more effective signposting to self-help and community services to promote independence and personal wellbeing

The benefits of this scheme will include:

- Reduction in A&E attendances
- Reduction in individuals having assessment
- Co-ordinated care in the community
- Increase in individuals' independence
- Increase in pro-active self-management
- Increase in the quality of care

Scheme 2: Integrated Local Community Teams - Managing Dependency on Services

The aim of this scheme will be to ensure that individuals within the community whose needs have increased receive integrated personalised care tailored to their needs and aspirations,

to return them to ongoing stability without the need for acute intervention, and thereby maximise their independence and wellbeing. This service will be focused on those individuals identified as being most likely to experience a decline in their ability to remain living independently in the community and hence become at risk of requiring non-elective admission to hospital.

Initially focussing on the frail elderly cohort of our population, this programme will develop and put in place integrated over-arching, generic principles and processes for stepping up support to avoid crises requiring acute interventions. These core processes will then be scalable when targeting further cohorts of our population in further phases of implementation.

Health and social care will work together to support individuals experiencing an increase in their care needs to avoid non-elective admission into the acute care system by:

- Developing integrated local community teams, based on GP practice populations of 30,000-50,000 (or 80,000 to 120,000 dependant on the locality services provided)
- Upskilling front-line staff through training and professional development to take an appropriate and proportionate approach to assessing individuals' changing needs
- Enabling staff to help individuals to understand their strengths and capabilities, and the support available to them in the community and through other networks and services
- Enabling staff to take a positive approach to risk management, encouraging individuals to take informed choices about how their care is delivered and thereby supporting ongoing independence and control
- Supporting staff through peer support and having a clear escalation process and access to senior professionals to seek advice to aid their decision making and provide quality assurance
- Changing the protection culture from one of potential over–prescribing, which drives long term dependency on services, to one of a reablement culture, which seeks to maximise ongoing independence and wellbeing
- Enabling professionals to access a range of health, social care and community support via the integrated first contact service (Scheme 1), thereby providing alternatives to admitting the individual into higher levels of support within the acute sector

The benefits of this scheme will include:

- Reduction in NELs
- Reduction in individuals having high care packages
- Increase in individuals in lower care packages
- Reduction in admissions to community hospitals
- Reduction in admissions to care homes
- Co-ordinated care in the community
- Increase in individuals' independence
- Increase in the quality of care

Scheme 3: Integrated Local Community Teams - Managing Safe Return to Steady State

The aim of this scheme will be to maximise the timely step-down of individuals' needs to their lowest level of dependency / maximum level of independence, be it from an ongoing or escalated service. This will encompass the deeper integration of existing intermediate care and reablement services.

Initially focussing on the frail elderly cohort of our population, this programme will develop and put in place integrated over-arching, generic principles and processes for step down support for individuals who have experienced crises requiring acute interventions. These core processes, which are consistent with the newly-agreed pan-Staffordshire Frail Elderly Pathway, will then be scalable when targeting further cohorts of our population in further phases of implementation

Health and social care will work together to support individuals who have been admitted to the acute system in order to return them to the greatest level of independence within the community by:

- Ensuring that individuals are appropriately discharged following an escalated hospital need back to their place of residency, wherever possible, in order to maximise independence.
- Ensuring that individuals with care plans and receiving ongoing in-community support are regularly reviewed, such that risks are managed and over-delivery and unnecessary activity is avoided.

The benefits of this scheme will include:
- Reduction in average LOS for acute and community hospitals
- Reduction in non-elective re-admissions within 30 days
- Reduction in DTOC
- Increase in intermediate care services following NEA
- Reduction in individuals being admitted to a residential home
- Increase in individuals accessing reablement services after NEA
- Increase in the quality of care

Schemes 4 – 8: Enabling Schemes

In addition, there are a number of enabling schemes which support and are integral to the delivery of the three other schemes, as follows:

Scheme 4: Support to Live at Home

- 4.1: Disabled Facilities Grant - Providing home adaptations so that people with disabilities can remain living safely at home within their communities.
- 4.2: Adult Social Care Capital Grant - Providing capital funding to support development of personalisation, reform and efficiency.
- 4.3: Technology Enabled Care Services (TECS) and Assistive Technology - Providing Technology Enabled Care Services and Assistive Technologies so that people living in Staffordshire are supported to manage and improve their health and well-being.

- 4.4: Integrated Community Equipment Service (ICES) - Providing aids and equipment so that people with disabilities or recovering from healthcare interventions can remain safely at home within their communities.

Scheme 5: Continuing Healthcare (CHC)

Providing support to those patients requiring long term high cost care in their home (own, residential or nursing).

Scheme 6: End of Life

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

Scheme 7: Carers (Inc. Carers Breaks, Mental Health Carers Support and Information for Carers) (Includes Dementia Carer Cafes)

Jointly commissioning improved outcomes for carers through a Whole Carers System Redesign, which includes the re-commissioning of Carers Breaks and wider universal carers support.

Scheme 8: Care Act Implementation Funding

A formal change programme to ensure robust and effective implementation of the Care Act. Work is under way to support all partners to understand their responsibilities within the Care Act and the changes which will need to be implemented.

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.

Our ambition is that our integrated approach should in due course extend its scope to cover almost the totality of our collective actions around community services for the Frail Elderly. Other aspects, such as Ageing Well, which will be particularly centred on the contribution of Districts and Boroughs, will be contained within separate, but parallel, plans (see section 2, p. 19). Together, this suite of plans will comprise a comprehensive and coordinated approach to addressing the challenges facing Staffordshire, securing excellent outcomes for local people within the resources available.

This is a stretching vision and will take some time to realise. In order to avoid the risk of delay and stagnation, we have resolved to press ahead with the current range of schemes and seek to build on these as quickly as possible, rather than wait until all is in place.

As a health and social care system, we recognise both that we face a significant gap between our current liabilities and our existing funding, and that success and failure of each individual partner represents success or failure for the whole system.

We have followed the recommendations of the Intensive Support for Planning work, which has identified a range of suggested areas of savings. These savings are not sufficient to bring the health and social care system as a whole back into financial balance on a sustainable footing. Based on our analysis of the financial forecasts, we have calculated that an additional saving of £16.9m is required to have been secured across the system as a whole in 2015/16 to ensure that the costs of the Care Act are covered and the protection of Social Care is demonstrated.

In modelling the benefits of the BCF, we have deliberately been prudent in our assumptions – on the basis that considerable savings from health and social care services for older people are already factored into the CCGs' FRP/QIPP targets, and the council's Medium Term Financial Strategy.

Recognising the interdependence between us, we have therefore agreed the need to identify further savings, over and above those already built into current plans. During 2014, we established a small task group to undertake a further review of the evidence, in order to identify additional initiatives we could implement to create financial headroom. This work focussed on initiatives that can improve the system by shaping demand, improving flow, reducing waste, optimising use of resources, identifying economies of organisation, optimising procurement and changing policy. A number of initiatives have been identified that could provide additional savings, over and above the existing plans.

The initiatives included in the BCF Plan submitted in September 2014 were:

Initiative	Estimated savings
Shape Demand	
Prevent the impact of falls	£4 million
Prevent strokes	£3 million
Increase uptake of flu vaccinations	£0.5 million
Introduce shared decision making for surgery	£1 million
Reduce Waste	
Redesign service offers based on service users levels of activation	£1 million
Optimise use of resources	
Integration of Continuing Health Care	£2 million
Redistribute IAPT capacity to prioritise older adults	£1 million
Optimise procurement	
Shape the extra care housing market to support older adults to be more independent	£1 million
Capitated budgets for frail elderly and MSK	£2 million
Change Policy	
Stricter application of adult social care eligibility criteria	£1.5million
Reducing expenditure on interventions of no or little benefit	£1.5million
	£18.5 million

Work is underway to analyse a number of the above initiatives and to check for double counting in FRP's and MTFS and the progress to date is available on request.

Top-level descriptions of many of these initiatives are set out below in Section 6, which describes how the Better Care Fund fits within the wider redesign work being taken forward across the health and social care system as a whole. A key element of this broader work is that it is not restricted simply to a narrow understanding of health and social care services, but also takes in wider considerations, such as those affecting lifestyles and housing. This allows the significance of District and Borough Councils to be more properly recognised.

The areas focused on are based on an initial analysis of evidence. Whilst delivery is challenging, we know as a system we need to deliver more transformational change to create a sustainable system. There is an absolute commitment to work together to deliver this.

Further work on these areas is underway. However, a minimum value of £16.9m of savings must be guaranteed in 2015/16 to protect social care, including Care Act Implementation (see section 7). Our agreed proposal for managing the financial gap is shown below, but in essence it proposes that as partners we consider the BCF over a three year period (2015/16, 2016/17 and 2017/18) on the understanding that all partners have signed up to the following:-

- That CCGs commit a resource of £6.9m in real cash in 2015/16 (comprising £1.9m for Care Act implementation and £5m to protect social care)
- That both parties commit to identify and deliver £20m savings in 2016/17, to be shared on a 50/50 basis (with £10m to protect social care and £10m to support CCGs financial recovery). (The initiatives identified in the table above, totalling £18.5m of savings, would contribute towards this £20m)
- That the County Council will provide cash to bridge the funding gap in 2015/16 (expected to be £4m) arising from the time taken to deliver £20m full year savings in 2015/16
- This settlement does not form part of the Part 2 Template, but will be incorporated in the discussions regarding the Section 75 Pooled Fund Agreement.

What the above agreement achieves is a real commitment from CCGs to work jointly to support the Social Care system, with recognition from the County Council of the pressures on CCGs. It gives all parties the opportunity to jointly deliver the transformation required.

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. 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.

Pending this, the BCF Implementation Group has produced a risk log which identifies the risk, scores the risk and outlines the appropriate mitigation. A summary of this Risk Log is shown in the table below and the full Risk Log is included as a supporting document.

Between January and March 2015, the PMO will develop a more comprehensive delivery plan, with the full suite of project initiation documents, risk registers, project owners, baseline data, detailed metrics for progress and delivery, along with clear mitigation plans.

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.

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor (likelihood *potential impact)	Mitigating Actions
Programme Risks						
Varying views of commissioners and providers may result in fragmentation and inconsistency in the application of the BCF Schemes, and will compromise delivery of the BCF outcomes.	Paula Furnival, Director, HWB	Andy Donald/Andy Burns	High (4)	High (4) Up to £2.3m financial benefits (full year effect) of BCF not delivered. Risk falls on BCF Pool.	16	A Pan Staffordshire Joint Transformation Board has been established, plus a CCG "Commissioning Congress" with one CCG leading on each major contract. The Health and Wellbeing Board has signed off the BCF plan and will continue to have overarching responsibility: from January 2015, this will include the Provider Trusts. The existing BCF Task and Finish Group will become a longer-term Implementation Group, and will be expanded to include representation from all the CCGs. Issues will be escalated to the Joint Transformation Board. The BCF plan is aligned with provider plans, and they have been engaged in the development of this plan.

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
Because of competing pressures, including continuing strain on the acute sector, delivery of the BCF plan will not be prioritised	Paula Furnival, Director, HWB	Andy Donald/Andy Burns	High (4)	High (4) Up to £2.3m financial benefits (full year effect) of BCF not delivered. Risk falls on BCF Pool.	16	The BCF schemes are aligned with partners' plans and will be prioritised. Between Jan and March 2015, a mapping exercise will be completed with partners to identify issues and opportunities to realise BCF benefits. Implementation will be driven through the system-wide programme delivery approach as described above. Implementation of the BCF will be regularly monitored (e.g. using the high-level performance framework already developed, and scheme implementation plans). This will ensure visibility and transparency.
MTFS and FRP transformation plans are not delivered or suffer slippage, therefore BCF schemes (which are the incremental benefit of integration on top of the these plans) cannot be delivered or will also slip.	Paula Furnival, Director, HWB	Andy Donald/Andy Burns	High (4)	High (4) Up to £2.3m financial benefits (full year effect) of BCF not delivered. Risk falls on BCF Pool.	16	The joint governance arrangements described above will monitor implementation of the FRP, MTFS and BCF transformation plans.

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
Organisational change in the health and social care system will disrupt delivery of the BCF plan	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) Up to £2.3m financial benefits (full year effect) of BCF not delivered. Risk falls on BCF Pool.	16	The BCF Transformation Board and Joint Transformation Board will ensure that appropriate contingency plans are put in place.
There will be unanticipated increased demand for A&E services, resulting in non-achievement of performance metric in relation to A&E attendances and hospital admissions.	Marcus Warne, COO N Staffs CCG	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) Risk falls on BCF Pool. Up to £5.276m P4P money would be paid directly to acute providers by the BCF Pool.	16	Effective programme management and forecasting of demand. Appropriate contingency plans in place.
Lack of commitment to integration and/or resistance to change by providers results in reduced BCF benefit as co-ordination will not be achieved.	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) Risk falls on BCF Pool. Up to £2.3m financial benefits (full year effect) of BCF not delivered.	16	This will be addressed through strong contract management and programme management. An organisational development programme will be put in place with all partners to reinforce and embed the shared objectives of the BCF (see action plan).
Workforce issues including recruitment and skills development delays speed at which change can take place.	Martin Samuels, Commissioner for Care, SCC	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4)	16	SCC Market Development Team working with care providers and educational institutions to make a career in social care more attractive, thereby improving both recruitment and retention. Programme has

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor (likelihood *potential impact)	Mitigating Actions
						received significant praise and support nationally, such as from Skills for Care. Refreshed model of an excellent social care pathway, drawing on nationally-recognised examples of best practice, has set out expected levels of activity at each stage of the pathway and is being used to determine the required workforce. SSoTP has committed to ensure that the resulting staffing structure is fully recruited.
Improvements in prevention, joint working and diversion of demand will fail to deliver: (a) reduction in delayed transfers (b) reduction in A&E attendances and N.E.Ls. (c) reductions in residential and nursing placements - Impacting on overall funding available to support core services and future developments.	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) Up to £2.3m financial benefits (full year effect) of BCF not delivered. Risk falls on BCF Pool.	16	Prudent financial estimates have deliberately been used for the BCF, taking account of the scale of savings to be achieved elsewhere in the system (i.e. through the FRPs). Delivery of financial objectives will be monitored by the BCF Transformation Board, as above. Risk share principles have been agreed, to cover the eventuality that the specific financial objectives of the BCF are not achieved.

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor (*likelihood *potential impact*)	Mitigating Actions
Risk sharing arrangements can not be agreed between partners and that a Risk Share Agreement can not be developed. This would mean that the BCF schemes could not be implemented and benefits could not be delivered.	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) Risk falls on BCF Pool. Up to £2.3m financial benefits (full year effect) of BCF not delivered.	16	A "Risk Share Principles" document is in place and has been signed off by the HWB. This will be finalised (through the S75 legal agreement) by March 2015. Gain Share principles have also been agreed for additional savings towards meeting FRP and MTFS requirements.
In-year planned savings earmarked for the protection of social care are not realised	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) £15m for protection of adult social care. Risk falls on SCC	16	Agreement in principle has been reached about how risks will be shared, as described in the BCF plan and separate document.
Funding from CCGs for revenue element of Care Act implementation is not sufficient to cover the costs.	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	Medium (3)	High (4) £1.977m revenue element of Care Act implementation funding through the BCF Risk falls on SCC	12	0
There are barriers to implementing risk stratification (e.g. because of difficulties obtaining patient identifiable data)	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4)	16	An agreed risk stratification methodology will be adopted by March 2015. Further work will be undertaken at operational level (and through GP practices) to implement a consistent operational approach. See section 3 of the BCF Plan.

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor (likelihood *potential impact)	Mitigating Actions
LAs and CCGs are unable to share data using NHS identifier (e.g. because of information governance problems).	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	Very High (5)	High (4)	20	Work with CCG/CSU colleagues to complete an implementation plan.
Failure to implement the new model of health and social care results in patients not having a "lead accountable professional" or joined-up assessments.	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	High (4) Risk falls on BCF Pool. Up to £2.3m financial benefits (full year effect) of BCF not delivered.	16	This will be addressed through Scheme 2. The detailed PID will cover such as areas as planning and identification of roles, responsibilities, and the development of joint protocols and tools. Detailed preparatory work will be completed by March 2015.
Failure to communicate effectively with key stakeholders integral to the delivery of the BCF Schemes will result in failure to realise the benefits of the BCF.	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	Medium (3)	High (4) Risk falls on BCF Pool. Up to £2.3m financial benefits (full year effect) of BCF not delivered.	12	Stakeholder Mapping will be completed by March 2015. A robust and comprehensive communications strategy and plan will be developed by February 2015. This will be "owned" by the HWB and JTB. A Community Impact Assessment will be completed during 2015 and there will be public consultation at key points in BCF delivery, in line with legal requirements.

There is a risk that:	Risk Owner	Accountable Officer	How likely is the risk to materialise?	Potential impact	Overall risk factor (likelihood *potential impact)	Mitigating Actions
There is failure to embed a culture of integration and focus on reablement and enablement throughout, resulting in inability to deliver financial and quality benefits	Paula Furnival, Director, HWB	Andy Donald, Andy Burns, Senior Responsible Officers BCF Staffordshire	High (4)	Very High (5) Risk falls on BCF Pool. Up to £2.3m financial benefits (full year effect) of BCF not delivered.	20	The HWB appreciates the importance of clear communication and demonstration of the benefits to working practices of integration and reablement, so that staff can appreciate the beneficial impact on their work. Early and effective staff engagement and training will be a key part of the implementation plans, using two way communication such as workshops to bring members of relevant teams from health and social care together.

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.

This plan is built on reducing unplanned interventions predominantly in the NHS Acute Sector. The system of Payment by Results means that failure to reduce unplanned admissions by 3.5% could entail a cost to the CCGs and they recognise that they will need to pay for this under the tariff regime. Further work will need to be undertaken across all partners to ensure that risks of unsuccessful transformation are shared between Commissioners and Providers and this will be a key matter that needs to be discussed through the Joint Transformation Board to develop a true system of risk sharing across all partners.

For any performance pay received recognition will need to be made that these funds were generated by top slicing partner funds that make up the initial £56m Better Care Fund. Given that all partners are aware that for all Staffordshire CCG's these funds are already committed within current contractual agreements with providers, therefore any cash released as "performance pay" that has resulted from efficiencies relating to non-elective targets, first call on these funds usage is to ensure that no party is exposed to being unable to fund their original contractual commitment made within the BCF.

A Risk Share Agreement will be developed. The principles regarding the risk in relation to the 3.5% reduction in NELs (performance pay) is shown in the table below.

The development of this plan also requires clear risk-share agreements between health and social care commissioners. Risk share principles have been agreed, and captured in a paper which we have developed in collaboration to provide a firm basis for moving forward (see also section 7). This paper is included as a supporting document.

Clearly there is some further work to do to develop detailed Risk Share Agreements; however, the position regarding each scheme is detailed in the table below:

<table>
<tr><th>Scheme</th><th>Risk Share Arrangement</th></tr>
<tr><td>1: Integrated Access to Care – Maximising Independence and Self-Help</td><td rowspan="3">Risk Share Principles document is in place and signed off by the HWB - September 2014

Gain Share agreed for additional savings towards meeting FRP and MTFS requirements - September 2014

Agreed milestones and governance to develop and implement Risk Share Agreement - January 2015</td></tr>
<tr><td>2: Integrated Local Community Teams – Managing Dependency on Services</td></tr>
<tr><td>3: Integrated Local Community Teams – Managing Safe Return to Steady State</td></tr>
<tr><td>4.1: Disabled Facilities Grant (DFG)</td><td>Grant and risk associated with this funding continues to passport to District and Borough Councils in 2015/16</td></tr>
<tr><td>4.2: Adult Social Care Capital Grant</td><td>Risk will continue to be managed by Staffordshire County Council</td></tr>
<tr><td>4.3: Assistive Technology</td><td>Risk will continue to be managed by Staffordshire County Council</td></tr>
<tr><td>4.4: Integrated Community Equipment Service (ICES)</td><td>Existing S75 in operation including risk share arrangements</td></tr>
<tr><td>5: Continuing Health Funding</td><td>Contractual arrangements currently exist and CCGs will continue to operate existing arrangements in order to manage and share risk</td></tr>
<tr><td>6: End of Life</td><td>Contractual arrangements currently exist and CCGs will continue to operate existing arrangements in order to manage and share risk</td></tr>
<tr><td>7: Carers</td><td>Block contract currently exists for a finite block of hours and existing arrangements will continue to operate in order to manage and share risk</td></tr>
</table>

8: Care Act Implementation	Expectation that County Council will own all risks relating to the Care Act once funding from BCF is identified and delivered
3.5% reduced non elective admissions	Risk Share Principles document is in place and signed off by the HWB - September 2014 Gain Share agreed for additional savings towards meeting FRP and MTFS requirements - September 2014 Agreed milestones and governance to develop and implement Risk Share Agreement - January 2015

Section 6: Alignment

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

In considering the alignment of the BCF Plan with other initiatives it is worth noting that Staffordshire has been subject to a number of reviews over the last two years both at a Staffordshire-wide level and at a locality level. Many of these reviews have identified similar problems that need resolution - i.e. significant resources being spent on the most expensive part of the health and social care system and little evidence of strategies to prevent this pattern from continuing.

Our Systems Resilience Plans are a key enabler of system-wide transformation. These set out collaborative approaches to understanding the system-wide pressures and solutions. They will ensure 'systems resilience' within Staffordshire - not only focussing on unplanned acute admissions but the planned care system, including Referral to Treatment Times.

CCG two year operational plans and the five year strategy set out clearly the analysis of the challenge in each of their localities. The five year strategy sets out the vision for longer term change. The two and five year plans are supplemented by various other reports including the recommendations in the Support for Planning report and the recommendations of the Trust Special Administrator which recommend significant transformation for future sustainability of the Mid Staffordshire part of the system. All these plans have now been considered in producing this revised BCF submission, and any benefits derived from the BCF are over and above current plans.

Refreshed S75 agreement for social care

Since 2012, Staffordshire has been at the forefront of moves to integrate community health and social care services, through its innovative s75 agreement with SSoTP. Under this agreement, the Partnership Trust has undertaken, on behalf of the County Council, delivery of the bulk of the operational social care functions for Older People and People with Physical Disabilities / Sensory Impairment. It has very recently been agreed that this arrangement will continue for a further three years from April 2015 onwards.

At the heart of the s75 agreement (representing its key innovation), is a risk share arrangement, under which the County Council provides a fixed budget to SSoTP, within which services must be delivered. This provides maximum scope for the Partnership Trust to

develop innovative approaches to service delivery, leveraging the potential from integration with community healthcare services, in order to achieve improved outcomes in the most efficient manner possible.

An essential element of the refreshed s75 agreement between the County Council and SSoTP has been the development of a model of excellent social care performance, based on best practice evidence from across the country. This sets out default outcomes and levels of expected activity at each stage in the service user journey, with indicative associated funding, and has been used to map out a course to a 'best in class' delivery of Adult Social Care, in terms of both service user experience and budget. This agreement feeds into the County Council's MTFS.

The refreshed s75 agreement provides the vital context within which a number of the specific BCF schemes will be delivered. The expectation is that the BCF schemes will deliver further improvements, over and above those already identified within the MTFS, through their focus on greater integration of health and social care services. To a great extent, it is anticipated that these additional benefits will accrue primarily in the healthcare system, as a consequence of further steps towards integrated commissioning and operational delivery, through reductions in both NEL admissions and DToCs.

In order to increase further the scope for securing additional benefits through synergies between health and social care, the County Council is working with the CCGs to develop integrated arrangements for the commissioning and contract management of the Partnership Trust. The aim of this work is to ensure consistency of purpose and vision in the conversations between commissioners across health and social care and the Partnership Trust, recognising the extensive common ground expressed in the schemes set out in this BCF Plan, while respecting the specific contexts of the County Council and the CCGs.

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 in this plan) and 3) Locality based commissioning.

A key development in terms of the role of districts/boroughs was the **review of 'locality working'**, commissioned by the Health and Wellbeing Board and led by 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, for local commissioning approaches to be established at borough/district level and for all agencies from all sectors to be seen as potential providers.

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. The Locality Commissioning Boards are aligning outcomes and resources in the form of locality commissioning prospectuses for 2015/16. This alignment includes public health commissioners, the police and crime commissioner, other county council commissioners,

CCG commissioners and district council commissioners. The key partners 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.

Healthier lifestyles

The Healthier lifestyle system has been redesigned in Staffordshire and three key elements are currently being implemented.

1. Services are being procured to a deliver a holistic approach to people whose needs cannot be met through self-help tools or locality based activities.
2. A hub is being developed building on existing infrastructure, to manage referrals and identify the most appropriate response, whether it be services, self-help tools or locality based activities.
3. A proportion of commissioning for healthier lifestyles has been delegated to the LCBs (described above) to commission locality based activities initially focussing on physical activity and nutrition.

The system will be in place by April 2015 and improvements will occur over the next few years. Older adults will be able to more easily identify support to improve their lifestyles in a way that is appropriate to their level of need and activation.

Falls Prevention

Falls are the largest cause of accidental injury, particularly in older people. In Staffordshire it is 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 per annum.

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. 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, 3) improving uptake of NHS England funded Medicines Use Reviews and 4) addressing home and outdoor environmental hazards.

Significant work goes on in Localities through the third sector - for example where falls assessment has been commissioned as part of managing through winter.

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 and 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 problems for people with 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 through a single responsible integrated commissioner. Services have been redesigned and implementation of the new model commenced in July 2014. Older people have been identified as a priority group and relevant pathways will be reviewed in the coming year.

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.

The focus on older adults also has the potential to contribute to a reduction in demand for residential support for older adults with complex needs including alcohol and drug use.

Children's Services

We know in parts of Staffordshire there is above average emergency hospital activity for children and young people. We have well developed integrated commissioning arrangements for children and as part of this we are undertaking a specific piece of work to understand and reduce the use of acute care by families.

Increasing vaccination uptake

70% of adults aged 65 years and over in Staffordshire received an influenza vaccination in 2012/13. This is below the national target of 75%. If uptake was increased to achieve the national target and PPV vaccination uptake was also increased this has the potential to reduce demand for health and social care services through reducing the number of influenza and pneumonia cases. Savings are estimated at £500k.

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 plans 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 approved 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 Flexi-care 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 per year.

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.

Prioritisation of Investment

Staffordshire CCGs with support from Staffordshire County Council Public Health have developed a clinical prioritisation process. This enables the relative priority of different interventions to be compared. A large number of interventions have now been scored through this process. However, the majority of mainstream interventions have not been considered. A similar process has been undertaken by an insurance company in Oregon, USA. A project is currently underway to translate the outcome from the 'Oregon' process into something that is compatible with the Staffordshire process. A parallel project is describing the CCG spend using the same definitions. This project is intended to advise the CCGs on areas that require increased investment and areas that have the potential for disinvestment. It is estimated that this process could identify sufficient activity for disinvestment to identify £1.5 million savings.

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

Health and Wellbeing Strategy:

The key priorities within the Staffordshire Health and Wellbeing Strategy include a focus on prevention, managing dependency on services and managing safe return to steady state as well as reflecting work needed on carers, frail elderly, support to live at home, as three of its nine areas.

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

Council MTFS

The schemes identified within the BCF submission align with Staffordshire County Council's Medium Term Financial Strategy (MTFS), priority outcomes and business plan proposals. Funding previously obtained via S256 funding continues through enabling schemes in 2015/16. Any subsequent change to this funding is deemed to be managed via transformational activities and is therefore not expected to adversely impact the MTFS. In addition to this Staffordshire County Council's MTFS requirement in 2015/16 is £16.9m (including £1.9m revenue requirement for the implementation of the Care Act) and an ongoing £15m requirement thereafter. Financial benefits derived specifically from Schemes 1 to 3 will not bridge this gap and therefore funding proposals are included in this submission (see section 7 a. Protecting Social Care Services). Staffordshire County Council has seen reductions in general funding of 4% (between 2014/15 and 2015/16). The Council is planning to make savings of 17m in 2015/16 and taking into account spending pressures, this leaves a funding gap of £7m. Over the past 6 years the Council has had a General Government Grant reduction of £75m (42%) and has had to make savings of £164m. Whilst this has been successfully managed in the past through innovation and efficiency savings the impact of continuing funding reductions has reduced general reserves to £15m as at 1st April 2014. These are expected to be further eroded as a result of overspending on Adult Social Care forecasted to outturn at c£10m (approximately 6% of the ASC budget). For this reason the Council has flagged the non-achievement of funding / savings delivered via the BCF as a key risk to its MTFS.

CCGs' 2 operational plans and 5 year strategic plan

CCG's have recently refreshed their two-year operational plans, including the development of commissioning intentions for 2015/16. These intentions include the integrated intentions laid out within this BCF Plan.

The five-year strategy 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.

There is, therefore, complete consistency between the CCG plans and the content of this Better Care Fund plan.

District and Borough Councils

The CCGs and the County Council are linking to the plans of the Districts and Boroughs, to ensure full alignment at county and local level.

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.

The Support for Planning report recommends moving to larger populations of GPs to co-ordinate community services better. This recommendation is reflected in Scheme 2 of the

BCF, which outlines the building of community teams based on GP populations of 30k to 50k. A key part of the design work will be to ensure that other initiatives in Primary Care – including existing "case management" arrangements - are aligned with BCF developments so that resources available can be targeted most appropriately.

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 Directly Enhanced Service for long term conditions management), CCGs are working closely with NHS England to achieve alignment.

Co-commissioning of services by the Local Area Team and the five 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 an effort to stimulate improved quality, reduced variation and achieve financial sustainability

There will be 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 will take some time to implement as often training programmes take a year or more.

Primary Care Strategy – the Shropshire & Staffordshire 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 and with the BCF. Particularly relevant aspects are as follows:

- 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 than 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.
- Increase vaccination uptake in adults aged 65 years and over: This is discussed in section 6a).
- 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).

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 Joint Health and Wellbeing Strategy, 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 more than £30m in 2014/15.

Funding currently allocated under the s256 transfers from NHS England to the County Council has been used in the main 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 deployed to ensure effective information and signposting is available to those who are not Fair Access to Care Services eligible. In Staffordshire, these existing £16m of

transfers from the NHS to social care will be continued under the Better Care Fund. In so doing, they will continue to facilitate an extensive range of pathway redesign activity and efficiency programmes in the delivery of the existing Adult Social Care services funded through this route. The scale of these is demonstrated by the fact that Staffordshire & Stoke on Trent Partnership NHS Trust has been tasked with delivering a significant efficiency improvement in each of the past three years. The s256 transfers, and the continuation of this funding through the Better Care Fund, will enable these services to be maintained in a redesigned form rather than having to be eliminated.

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 additional savings from core social services delivered through Staffordshire & Stoke on Trent Partnership NHS Trust. 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. When added to the CCG and Provider deficits, this leaves a significant shortfall across the system. (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 eleven 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. An initial list of further savings has been identified above in Section 4. This builds upon the recommendations recently received through the challenged health and social care system work.

Over and above this the CCGs and the County have agreed a proposal which is based on three year deal which allows for the protection of Social Care. This has been achieved because both Health and County Council Partners have agreed to put in additional resources in year one with an element of risk share across both to ensure Social Care is protected.

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.)

Our agreed proposal for managing the financial gap is shown below, but in essence it proposes that as partners we consider the BCF over a three year period (2015/16, 2016/17 and 2017/18) on the understanding that all partners have signed up to the following:-

- That CCGs commit a resource of £6.9m in real cash in 2015/16 (comprising £1.9m for Care Act Revenue implementation and £5m to protect social care)
- That both parties commit to identify and deliver £20m savings in 2016/17, to be shared on a 50/50 basis (with £10m to protect social care and £10m to support

CCGs financial recovery). (Initiatives, totalling £18.5m of savings, would contribute towards this £20m)

- That the County Council will provide cash to bridge the funding gap in 2015/16 (expected to be £4m) arising from the time taken to deliver £20m full year savings in 2015/16
- This settlement does not form part of the Part 2 Template, but will be incorporated in the discussions regarding the Section 75 Pooled Fund Agreement.

Protecting Social Care	2015/16	2016/17	2017/18
	£m's	£m's	£m's
Care Act Implementation	1.9	1.9	1.9
Protect Social Care	15.0	15.0	15.0
Savings from CCG Total Budget	16.9	16.9	16.9
Cash Contribution from CCG's	1.9	1.9	1.9
	5.0	5.0	5.0
	6.9	6.9	6.9
Savings in Health Economy*4	6.0*1	10.0*2	14.0
Bridging Finance from SCC	4.0*3	0	-4.0
	16.9	16.9	16.9

*1 Part Year savings in 2015/16 (50% of £12m)
*2 Full Year savings in 2016/17 (50% of £20m)
*3 [*1 +*2] shortfalls of savings in 2015/16
*4 Calculated as follows:

- 6 = 12*50%
- 10 = 20*50%
- 14 = 28*50%

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 a formal change programme in place to ensure robust and effective implementation of the Care Act. The approach focuses on giving partners responsibility for becoming Care Act compliant by addressing all of the strands of service and policy change. This is being supported by a programme office employing full programme management methodologies. The programme reports into the County Council's governance structures, as well as a Programme Senior Officer Group and Operational Lead steering group and the governance arrangements have been designed to secure full engagement from all relevant partners. At present, work is underway to support partners and lead officers within the Council to understand their responsibilities and tasks to implement the Care Act and the changes which are required, with full legal compliance expected by the end of April 2015. Further work will be required to ensure legal compliance with the financial expectations of the Act in 2016, as well as ensuring that the whole work force, internal and external, is appropriately trained with access to the technology required to do their job effectively.

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

Whilst several of the BCF schemes will benefit carers, scheme 7 will specifically protect investment (value £0.792m) in services for carers.

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.

Services are currently commissioned via two main contracts with the Carers Association Southern Staffordshire and North Staffs Carers Association.

A large scale tender across Staffordshire and Stoke on Trent is currently underway to deliver a co-ordinated and coherent universal service; a Carers Hub providing one point of contact across Staffordshire and Stoke on Trent.

Services commissioned under the Carers Hub will include:

- Universal Carers Assessment and Support Planning (with a focus on personalisation, prevention, empowerment, assets based approach, whole family approach)
- Targeted, personalised support following their assessment depending on their level and type of caring role e.g. low level information advice and guidance to high level support for those caring for individuals with complex mental health needs, learning disabilities, end of life carers.
- Information advice and guidance (using numerous methods and options: face to face, web based, drop in facilities, outreach, telephone, peer support)
- Carers Breaks (including social networks and activities, peer support, befriending, direct payments)
- Emotional, Health and Wellbeing support
- Carers Training
- Advocacy
- Emergency, Contingency, Future Planning
- Awareness raising, training and support for professionals (GPs, Hospitals, Schools, Employers, Social Care, Police, Fire and Rescue, Voluntary and Community Networks)
- Support to maintain employment, training and education

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's MTFS has assumed that the existing s256 funding of £16m would continue into 2015/16, along with an additional £15m from the NHS. Further, it has assumed that £1.9m of additional funding would be received, whether through the Better Care Fund or directly, to cover the revenue costs of Care Act implementation.

As noted on page 52 above, agreement has been reached on the resources each organisation will allocate to remove many of the risks for Social Care.

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.

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

South Staffordshire: There is an acknowledgement that there needs to be a move to consistent seven day working in the South of the County. Commissioners have established a joint working group with the Partnership Trust to pursue this. Many elements of seven day working are already in place and it is worth noting that at certain times in the year, seven day working around bank holidays etc. has already demonstrated benefits in the following week's performance in the Acute Sector. Contractual conditions now appear in all NHS contracts with regards to seven day working. Within the Acute Trusts a range of seven day working expectations have been incorporated into the CQUIN schemes, focusing on availability of services, flow and discharge.

The BCF implementation group have agreed that a single unified approach to seven day working is required across Staffordshire and have requested that the group in the North of the County is extended to all areas of Staffordshire. This is particularly relevant as UHNM are now responsible for providing Acute Services across significant parts of the Staffordshire patch.

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.

We are now actively using the NHS number as the primary identifier in both health and social care data systems. All local health and social care organisations have agreed and are committed to using the patient's NHS Number as the prime reference. The current Staffordshire and Shropshire Integrated Care Record (ICR) programme will reinforce this by using the NHS number as reference for all health and social care activities (see below).

Staffordshire County Council (SCC) has been using the NHS Demographic Batch Services (DBS) to match, collect and store NHS numbers for adult services clients. This was started prior to 'go live' of CareDirector, the new social care IT system, and by November 2014 c80% of clients had a valid NHS number stored in the social care system.

The NHS number is then available for staff and partner organisations to use on relevant correspondence, and this auto populates from the IT system (to minimise errors) on to key assessment documentation, plans etc. Moving forward the remaining numbers will be entered by the person updating Care Director when a client is referred. This could be a social worker, Occupational Therapist or administrator, who will source it from medical referral paperwork or a look up on their NHS clinical systems.

In our health organisations, the NHS number has traditionally been the primary identifier, but records need to be cleansed and validated.

For example, in the Partnership Trust, 97.1% of records currently have a valid NHS number. They are now 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 this the 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. This, together with monthly batch tracing of core systems, is expected to bring the proportion of records with valid NHS numbers to over 99% by April 2015.

We do NHS Number reconciliations as part of the Data Quality programme of work on a 6 monthly basis.GP Clinical systems are linked to the Spine and changes to patient demographics are highlighted to the user upon login to the clinical system via use of the Smartcard. Smartcard usage is mandated to both clinical and non-clinical staff in practices via position based access and provides a secure clinical environment.

Integrated Care Record programme

Use of the NHS number is a core principle of the Staffordshire and Shropshire ICR. This will be managed through the programme using a combination of governance and supported by technical solutions where this is relevant.

- The NHS number is displayed on all patient display screens including banners
- The NHS number is offered as the primary method of retrieving patients
- The NHS number is used for patient matching when moving or linking records between systems
- Where no NHS number is present, patients are added to work lists so that they can be traced

We wish to use this programme to support improvements in NHS number coverage in social care. The current plan is to extract MPI data from social care systems, to trace the MPI numbers and then to re-populate the social care systems.

All other data types planning to be exchanged in the ICR will use the NHS number as the primary identifier and match key.

Staffordshire health and social care partners are committed to using systems based upon Open APIs and Open Standards, and this is implicit in the current development of the Integrated Care Record. We are also keen to explore the opportunities for greater systems integration and information sharing, and so the ability to support this is part of the selection criteria for new systems and applications.

For any systems or applications where open API's or Open Standards are used, these are all controlled through the system vendors e.g. EMIS, TPP, PCTI, Vision etc. who are responsible for the accredited standards and adherence to the API standard.

A key part of our interoperability approach is the implementation of the Staffordshire and Shropshire Integrated Care Record (ICR). At present CareCentric assembles clinical data and contact data from 250 GP practices and three acute Trusts. The programme has also already procured a Carecentric shared record, presenting this data to two A&E departments, one out of hours' service and clinical users across three acute Trusts. The next phase adds data feeds, user licences and further integration with local IT solutions, expanding the data available through the system and rolling the shared care record portal out across Staffordshire and Shropshire. The timing of this work is currently being reviewed following the recent unsuccessful bid for NHS Technical Fund support, but the target dates are to deploy the core system by April 2015, adding the additional feeds, End of Life and Dementia modules by April 2016.

The commitment to open sharing of information and systems is shown by the level of support for this programme. All CCGs have included the ICR as a key enabler in their 5 year plans. The Joint Chief Executives and Accountable Officers meeting for Staffordshire and Shropshire approved the programme. Letters of commitment have been provided from health and wellbeing boards and partner organisations across Staffordshire and Shropshire. Three Trusts are currently mid procurement for electronic patient record systems and have asked to be part of phase 2 deployments. Whilst they would not provide data into the record initially, they have expressed a wish to access a viewer to make use of the record where it is available.

At present there are 2 potential options which are being discussed around NHS Mail provision. One option is to adopt NHS Mail 2 as the preferred method across the CSU and CCG's. The second option is to accredit the existing Email exchange solution to adhere to NHSE specification and accredited standards.

The need for appropriate Information Governance has been agreed by all the local health and social care providers, i.e.

- NHS North Staffordshire CCG
- NHS East Staffordshire CCG
- NHS Stafford and Surrounds CCG
- NHS Cannock Chase CCG
- NHS South East Stafford and Seisdon Peninsula CCG
- NHS Stoke on Trent CCG
- Staffordshire County Council
- Stoke on Trent City Council
- University Hospitals of North Midlands NHS Trust
- Burton Hospitals NHS Foundation Trust
- Staffordshire and Stoke on Trent Partnership
- North Staffordshire Combined Healthcare NHS Trust
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust

In order to build rapidly from existing good practice, exemplar data sharing agreements (DSAs) have been obtained from two other areas that have already implemented integrated care records (ICRs). These DSAs have been reviewed by our IG teams and used to draft a comprehensive DSA for the ICR programme. This draft will be sent to the CCG Caldicott guardians and CSU solicitors in early January 2015 for comment and revision, and will then be presented to the Staffordshire and Shropshire ICR project board at the end of January. Following board approval the DSA will be agreed and signed up with each partner organisation.

Staffordshire County Council already has comprehensive IG policies and procedures in place and SCC Public Health is compliant to level 2 of the NHS Information Governance Toolkit (needs renewal March 2015). This allows public health to access NHS data.

For future security, and because they are expecting to move to a public service network requiring a higher level of information governance, SCC are committed to achieving compliance for the whole local authority to IG Toolkit level 3 and the associated Caldicott 2 requirements. This will be appropriate for the future levels of information sharing proposed.

d) Joint assessment and accountable lead professional

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

To date, all CCGs have been using models of risk stratification; the task from here is to define a single model that will be used across the county to ensure coherence and consistency (see p. 31 above).

In the north of the county, the LHE has been developing an integrated risk stratification tool that will support the work of its integrated local care teams and the delivery of the LTC Year of Care project. Equivalent progress has been made in the south of the county. (As an example, in Cannock there is a focus on the top 1% of respective practice populations plus the identification of suitable individuals using other methods).

In most CCG areas engagement has 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.

As identified in the Case for Change we know that there are circa 24,000 people (i.e. around 2-3% of the population) defined as Frail Elderly. Our start point therefore will be to ensure that these people are identified and appropriately risk stratified using a consistent tool that will be agreed by the end of March 2015 (see p. 29). The way we will do this is to quickly assimilate the work already undertaken and then stratify those individuals into the five levels of need identified in the Case for Change.

To monitor implementation, all CCGs have agreed to collate a standard set of information including:

- 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 NHS Trust (i.e. measuring the split between health and social care);
- Number of individuals with a completed care plan following assessment;
- Number of individuals with an open episode of care
- Frequency of multi-disciplinary team meetings 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

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

Integrated assessment and case management already occurs across a number of settings and CCGs within the County.

- A previous CQUIN existed in relation to Case Management in 2012/13 (but was implemented in differing ways across CCG areas);
- Individuals with dementia have a key lead professional supported by a key worker across a population of 276,000 people in Stafford and Cannock through the award winning Memory First service.
- Within SSOTP, a model for integrated health and social care case management has been developed (but not yet fully implemented) that includes a definition of case management, principles and a competencies framework.

In general, however, there have been differing solutions for different areas and there is a need - recognised by all the partners - to agree on a model and then implement that model systematically across the County.

Our adoption of a pan-Staffordshire Frail Elderly Strategy, and the BCF, provide an opportunity for us to achieve this. All organisations are committed to ensuring that all "at risk" older patients / clients when accessing services have access to a Lead Professional (Care Coordinator) – either a named GP or another professional within the MDT. This Lead Professional will through that co-ordination ensure a joint assessment of these individuals. Integrated Care Records (ICRs) will be deployed, the target date being April 2015 for implementation of these (see p. 67). BCF scheme 2 – integrated local community teams that will manage dependency on services – will be the main vehicle for achieving this.

We acknowledge that there is further work to be undertaken across the County to ensure a detailed service specification; this will be achieved across all CCGs by June 2015 (see milestone plan). Other required actions, from June 2015 onwards, will include:

- Clarifying criteria for who is best placed to case manage different groups of people;
- Developing systems and networks that ensure case managers can easily access the external services they need to be effective;
- Involving stakeholders including independent and voluntary sector resources;
- Ensure the competency framework for case management is in place and understood;
- Implementing a training and development programme for professionals who will take on the case management role;
- Rolling out the performance framework described above, and regular monitoring by the BCF Implementation Group.

There are already a set of generally accepted assumptions across CCGs about what the model of care is intended to achieve: -

- Coordination of resources around individuals with multiple chronic conditions 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 backdrop of rising demand from an ageing population and increase in multiple chronic disease prevalence.

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

- The accuracy of the risk stratification and 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.
- The degree to which GPs influence the implementation of the model of care within their individual practice.

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

The CCGs and the County Council take significant action to involve Patients, Service Users and the Public. The County Council, the District and Borough Councils, and the CCGs all look to involve patients, service users and the public in every stage of service design, implementation and evaluation. The development of the BCF and its work programme will be built into the processes already available to all the partners. All elements of the BCF plan have been the subject of discussion with the public for some time through established routes, although these discussions have generally not been presented as being explicitly related to the Better Care Fund, in order to maintain existing connections and histories.

As the Francis Inquiry made clear, all of our organisations must consciously focus on ensuring that the voice of the local population is at the heart of our debates, 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 collectively established a new third sector organisation called Engaging Communities Staffordshire (ECS).

Building on the experience and expertise of the Local Involvement Network (LINk) and other local engagement approaches, ECS fulfils, but goes well beyond, the remit for HealthWatch, such that it provides a centre of expertise and knowledge about the people of Staffordshire and acts as the prime route for connecting with them. 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. Much of this has been undertaken under the generic banner of 'Conversation Staffordshire', a multi-faceted engagement programme between the CCGs and the County Council on the one hand and the people of Staffordshire on the other. As an extension of the Conversation Staffordshire agenda, more than 500 responses were secured as part of the major consultation on the Joint Health & Wellbeing Strategy in 2013, in which the District and Borough Councils played a central role. This process focused on seeking ideas and approaches for implementing the new Strategy, and revealed strong support for efforts focused on education in healthy lifestyles, improved access to primary care to reduce the number of attendances at A&E, a greater focus on mental health, and support for more effective prevention through a programme of health checks. An important expression of the strong recognition of the links between sectors was demonstrated by the support shown through the consultation process for a greater emphasis on housing as a key means of prevention of more serious needs, both around health and more widely.

Through its full membership of the Health and Wellbeing Board by virtue of 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. For example, 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.

More broadly, there is a raft of communication mechanisms in place locally that complement the countywide work of HealthWatch, in particular scrutiny through the County Council and the District and Borough Councils.

The County Council and the CCG's have all developed models of Patient, Service User and Public Engagement which support the local planning processes and strengthen the prioritisation of commissioning decisions. Local district patient groups and Patient Councils have been established with many reporting into governance arrangements within CCGs. Lay Members for Patient and Public Involvement act as a key conduit for local matters. The County Council has an extensive Customer Insight programme, which deploys a range of formal and informal techniques to access service user views and experience and feed them into the decision-making processes, complementing the direct engagement with the public that is the trademark of Elected Members.

Through these various routes, the County Council and all CCGs across the country have ramped up the levels of engagement. The level of patient, service user and public engagement can be evidenced through the following:-

- Local evidence through 'Call to Action' events have supported the vision for a new Health and Social Care vision and the transformation required.
- Conversation Staffordshire, undertaken through ECS to ensure its clear independence and transparency, has involved significant numbers of people about future service provision
- Over 7,000 people involved in discussions about Cancer and EOL changes
- Carers conversations, led by Healthwatch
- Proposed service changes for people with long term conditions have been debated widely in local areas
- The changes to Mid Staffordshire NHS Foundation Trust involved thousands of members of the public in the debate about future services
- Changes to services, for example Minor Injuries at Cannock, and reduction of surgical beds in Tamworth, have involved significant numbers of local people in the debate and discussions
- 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.

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*

Provider organisations were not involved in depth in the development of the Health and Wellbeing Strategy. However, they were engaged in the formal consultation process for that strategy and subsequently, and they have expressed agreement with the general principles upon which it is founded. Further work has continued with providers to ensure they understand and agree with the proposals outlined in this plan.

The work around the "Intensive Support for Planning" and the focus on frail elderly people has had the full involvement of health providers and they have signed up in principle to support the recommendations, which are entirely consistent with the focus of the Better Care Fund Plan.
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. A further event for the large NHS Providers took place on the 6th January to update them further on the to revise the BCF

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. Since the release of the recommendations work has been undertaken through local areas to develop further aligned plans between Providers and Commissioners. This has resulted in providers being part of the JTB also being key partners in developing those transformation plans for Staffordshire.

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 planning guidance for 2015/16 sets out a key requirement that plans are reviewed between organisations to ensure alignment.

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. The major providers are supportive of a reduction in non-elective admission, albeit sceptical about whether the reductions can be achieved. However there is local evidence that in 14/15 that increase in some areas are slowing. The need to understand the factors that are supporting achievement of this needs to be understood.

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. The modelling related to the reduction in unplanned Attendances, Admissions and Discharges has been completed as part of their Financial Recovery Plans (FRPs)

In northern Staffordshire, the Cross Economy Transformation Programme is proposing to 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. 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.

UHNM is the main acute provider in North Staffordshire, Stoke-on-Trent and Mid Staffordshire. 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 become part of UHNM activity, strategic planning between that CCG and those in the north will become increasingly integrated.

The CCG FRPs have been completed, £49.5m of potential NHS savings in 2015/16 have been identified but this does not include the BCF requirements. Through the BCF schemes circa £2m has been identified to support the BCF savings requirements. 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.

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.

Section 9: Conclusion

In conclusion:-

- Our plan (which has been substantially revised since September 2014) is one that reflects our determination to deliver change together.
- It is therefore a "grounded" one that captures learning from professional reviews of our local health economy (including the KPMG review in 2014).
- It fits into our wider transformation programme, in a way that is understood and owned across agencies.
- It recognises our system's most immediate and pressing problem – which is the need to improve the performance of local hospitals by reducing unplanned admissions, and minimising delayed transfers of care.
- It is the right plan, and includes the right priorities.
- It reflects what older people in our community want and deserve.
- It is aligned with our financial recovery plans (including both the CCG 2 and 5 year strategies, and the council's medium-term financial strategy).
- It is regarded as a key priority by the Health and Wellbeing Board and by all its constituent agencies.
- It is underpinned by an ongoing commitment to own and understand each other's challenges - sharing both risks and gains.
- It includes clear and ambitious targets.
- It is supported by robust governance and programme management arrangements – to ensure it will be delivered.

But

- It will be hard to deliver.
- It will require continuous focus, commitment and hard work.
- This will include further work from January 2015 to March 2015, to finesse our analysis and put robust delivery arrangements in place.
- We know we must be prepared to adapt and respond well to further challenges. (Contingency planning is even more important for our area than for others – ultimately, we will need to be flexible and creative)

Part 1 – Annex 1: Detailed Scheme Description

Please see separate document entitled:

"BCF Staffordshire Part 1 Annex 1 05.01.15"

Part 1 – Annex 2: Provider Commentary

The statements below have been made by relevant trusts in Staffordshire.

Statement on behalf of Staffordshire and Stoke-on-Trent Partnership NHS Trust:

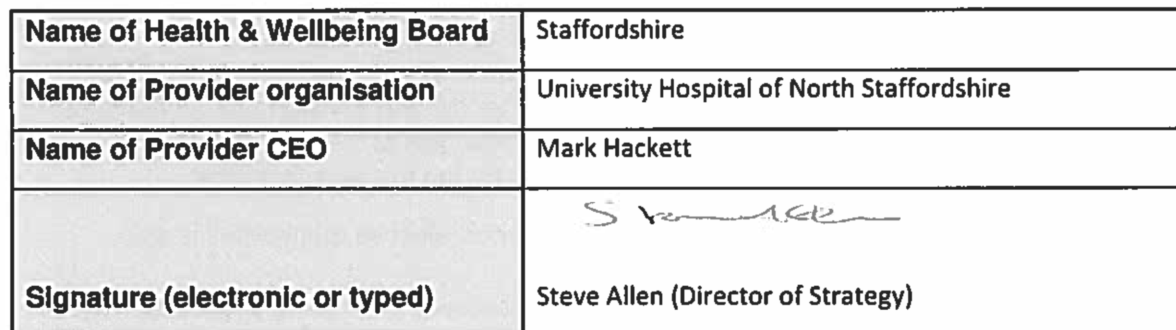
"SSOTP supports the Vision for Health and Wellbeing for Health and Social Care Services for Staffordshire and the schemes identified to deliver this vision. As an integrated provider of Health and Social Care services the Trust is already working closely with CCGs and the LA in a number of areas that support the delivery of this vision."

Jonathan Tringham
Director of Finance
Staffordshire and Stoke-on-Trent Partnership Trust

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	89,505
	2014/15 Plan	86,424
	2015/16 Plan	82,933
	14/15 Change compared to 13/14 outturn	-3%
	15/16 Change compared to planned 14/15 outturn	-4%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	701

Statement on behalf of University Hospital of North Staffordshire:

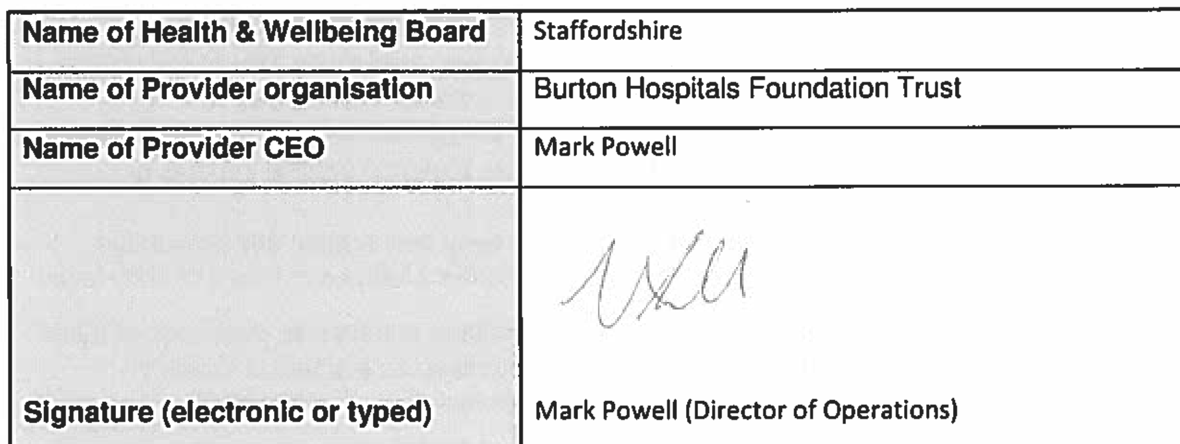


Name of Health & Wellbeing Board	Staffordshire
Name of Provider organisation	University Hospital of North Staffordshire
Name of Provider CEO	Mark Hackett
Signature (electronic or typed)	Steve Allen (Director of Strategy)

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We share the ambition in the BCF to reduce emergency admissions by 3.5% to the level of outturn in 14/15.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	It is important to stress that the Trust is wholly supportive of the ambition to reduce the level of non-elective activity. Furthermore, we support the revisions made to the plan since the earlier submission. The revised BCF plan which is more focused with an increased emphasis on delivery. These proposals are strongly aligned with the plans arising from work on Frail Elderly pathways undertaken in a review of Staffordshire as a challenged health economy. We particularly welcome: The further investment in 7-day working and the investment in stabilisation of the core social care service. We believe these schemes will have a positive impact in combination with other system transformation measures. Quantifying the precise level of the impact of these measures is difficult for the following reasons: • The trend in non-elective admissions is still upwards. • The population over 75 is going to grow by 13% in the next four years for the Staffordshire population served by this Trust. • Transformation schemes are by their nature innovations in practice and it is impossible to define precise impacts of innovative practice. • Schemes which focus on early intervention and prevention make take some time to deliver changes in levels of admission. In summary, our caution on committing to a precise projection of future non-elective activity should not be taken as a signal of a lack of commitment by this Trust to the ambition to reduce non-elective demand set out in this plan.

3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	Trust Capacity Plans cover a range of scenarios. If these plans result in reduced non-elective demand the Trust will respond by reducing occupancy levels to a manageable level and repatriate elective activity which is currently being undertaken elsewhere. Both of these changes will result in an overall reduction in system costs and will not increase costs to commissioners.

Statement on behalf of Burton Hospitals Foundation Trust:



Name of Health & Wellbeing Board	Staffordshire
Name of Provider organisation	Burton Hospitals Foundation Trust
Name of Provider CEO	Mark Powell
Signature (electronic or typed)	Mark Powell (Director of Operations)

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	We share the ambition in the BCF to reduce emergency admissions by 3.5% to the level of outturn in 14/15.

2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	It is important to stress that the Trust is wholly supportive of the ambition to reduce the level of non-elective activity. Furthermore, we support the revisions made to the plan since the earlier submission. The revised BCF plan which is more focused with an increased emphasis on delivery. These proposals are strongly aligned with the plans arising from work on Frail Elderly pathways undertaken in a review of Staffordshire as a challenged health economy. We particularly welcome: The further investment in 7-day working and the investment in stabilisation of the core social care service. We believe these schemes will have a positive impact in combination with other system transformation measures. Quantifying the precise level of the impact of these measures is difficult for the following reasons: • The trend in non-elective admissions is still upwards. • The population over 75 is going to grow by 13% in the next four years for the Staffordshire population served by this Trust. • Transformation schemes are by their nature innovations in practice and it is impossible to define precise impacts of innovative practice. • Schemes which focus on early intervention and prevention make take some time to deliver changes in levels of admission. In summary, our caution on committing to a precise projection of future non-elective activity should not be taken as a signal of a lack of commitment by this Trust to the ambition to reduce non-elective demand set out in this plan.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Trust Capacity Plans cover a range of scenarios. If these plans result in reduced non-elective demand the Trust will respond by reducing occupancy levels to a manageable level.