Staffordshire Health and Wellbeing Board

3.00 pm Thursday, 9 June 2016
Trentham Room - No.1 Staffordshire Place

Our Vision for Staffordshire

"Staffordshire will be a place where improved health and wellbeing is experienced by all - it will be a good place. People will be healthy, safe and prosperous and will have the opportunity to grow up, raise a family and grow old, as part of a strong, safe and supportive community. "

We will achieve this vision through

"Strategic leadership, influence, leverage, pooling of our collective resources and joint working where it matters most, we will lead together to make a real difference in outcomes for the people of Staffordshire".

A G E N D A

1. **Welcome and Routine Items**

   Chair

   - Apologies
   - Declarations of Interest
   - Minutes of Previous Meeting held on the 10 March 2016 (Pages 1 - 8)

2. **Questions from the public**

3. **Personal Health Budgets - The Local Offer across Staffordshire and Stoke CCGs** (Pages 9 - 20)

   Tina Groom - Personal Health Budget Implementation Manager

4. **Healthy Housing** (Pages 21 - 26)

   Dr. Tony Goodwin – CEO Tamworth Borough Council

5. **Update on Health and Wellbeing Board Membership** (Pages 27 - 42)

   Chris Weiner - Commissioner for Public Health, Staffordshire County Council

6. **Staffordshire Sustainability and Transformation Plan** (Pages 43 - 58)

   Penny Harris – Staffordshire Transformation Director

7. **Better Care Fund (BCF)** (Pages 59 - 156)

Alan White – Cabinet Member for Health, Care and Wellbeing, Staffordshire County Council

Annex 3: Draft Financial Schedule – TO FOLLOW

8. **Assessment of CCG Commissioning Intentions and CCG Annual Reports** (Pages 157 - 164)

   Chris Weiner - Commissioner for Public Health, Staffordshire County Council

9. **Performance and Outcomes Report** (Pages 165 - 172)

   Richard Harling - Director for Health and Care, Staffordshire County Council

10. **Forward Plan - June 2016** (Pages 173 - 178)

11. **Date of next meeting : 8 September 2016**

Membership	
Dr Charles Pidsley (Co-Chair)	East Staffordshire CCG
Alan White (Co-Chair)	Staffordshire County Council (Cabinet Member for Health, Care and Wellbeing)
Ben Adams	Staffordshire County Council (Cabinet Member for Learning and Skills)
Dr. Ken Deacon	NHS England (Shropshire and Staffordshire Local Area Team)
Frank Finlay	District Borough Council Representative (North)
Dr. Tony Goodwin	District & Borough Council CEO Representative
Dr John James	South East Staffordshire and Seisdon Peninsula CCG
Roger Lees	District Borough Council Representative (South)
Helen Riley	Staffordshire County Council (Director for People and Deputy Chief Executive)
Chief Constable Jane Sawyers	Staffordshire Police
Jan Sensier	Healthwatch Staffordshire
Dr Mark Shapley	North Staffordshire CCG
Mark Sutton	Staffordshire County Council (Cabinet Member for Children and Young People)

Dr. Paddy Hannigan	Stafford and Surrounds CCG
Dr. Mo Huda	Cannock Chase CCG
Glynn Luznyj	Staffordshire Fire and Rescue Service
Richard Harling	Staffordshire County Council (Director of Health and Care)
Penny Harris	Staffordshire Transformation Directo

Contact Officer: Chris Weiner
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Note for Members of the Press and Public

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Minutes of the Health and Wellbeing Board Meeting held on 10 March 2016

Attendance:

Dr. Charles Pidsley	East Staffordshire CCG (Chair)
Alan White	Staffordshire County Council (Cabinet Member for Health, Care and Wellbeing)
Frank Finlay	District Borough Council Representative (North)
Bill Gowans	Together We're Better
Richard Harling	Staffordshire County Council (Director for Health and Care)
Dr. John James	South East Staffordshire and Seisdon Peninsula CCG
Mike Lawrence	Staffordshire County Council (Cabinet Member for Children and Community Safety)
Roger Lees	District Borough Council Representative (South)
Helen Riley	Staffordshire County Council (Deputy Chief Executive and Director for Families and Communities)
Chief Constable Jane Sawyers	Staffordshire Police
Jan Sensier	Healthwatch Staffordshire
Dr Mark Shapley	North Staffordshire CCG

Also in attendance: Paula Furnival (Programme Director), Mick Harrison (County Commissioner for Children and Community Safety), Amanda Stringer (Programme Manager) and Chris Weiner (Commissioner for Public Health).

Apologies: Ben Adams (Cabinet Member for Learning and Skills, Staffordshire County Council), Ken Deacon (NHS England, Shropshire and Staffordshire Local Area Team), Tony Goodwin (District & Borough Council CEO Representative), Andy Donald (Chief Accountable Officer, Stafford and Surrounds CCG), Fiona Hamill (NHS England), Paddy Hannigan (Chair, Stafford and Surrounds CCG), Mo Huda (Chair, Cannock Chase CCG), Glynn Luznyj (Staffordshire Fire and Rescue Service) and Rita Symons (Chief Accountable Officer, Together We're Better).

108. Declarations of Interest

There were none received.

a) Minutes of Previous Meeting held on 10 December 2015

It was agreed that the minutes of the previous meeting held on the 10 December 2015 were an accurate record and should be signed by the Co-Chair.

Referring to the actions from the previous meeting Chris Weiner, Commissioner for Public Health, Staffordshire County Council explained that following further work to identify gaps in information, a questionnaire would be circulated on diabetes.

Progress on the Pan Staffordshire Transformation Programme was queried and the following points were made;

- The Health and Wellbeing Board should be sighted on the Transformation Programme and there was a lack of transparency.
- The governance of the Transformation Programme was queried and it was explained that commissioners and providers now had a presence. A recruitment plan was being developed and would be made public shortly.
- Lessons could be learnt from the TSA process. It was important to ensure true engagement. This was a national issue.
- It was encouraged and confirmed that Staffordshire Healthwatch would be making representations to Healthwatch England regarding this matter as it was important for the public to have a voice.
- It was noted that the NHS England Board Member and Substitute Member had given apologies for the meeting but the Area Team Director for NHS England should be notified of the Boards concerns immediately.
- It was confirmed that the Cabinet Member for Health and Social Care had written to NHS England highlighting that taxpayers were paying for health and social care and therefore should be consulted on developments.
- It was suggested that the Regional Director for NHS England should be contacted.
- A special meeting of the Board was suggested.
- Changes to the local health economy such as the stepping down of two NHS Trust Chief Executives and changes at Burton Hospitals NHS Foundation Trust were referred to.
- Learning from the TSA process, those in the local system had to be included in the transformation progress.

It was **Resolved** that;

- The minutes of the meeting held on the 10 December 2015 be confirmed and signed by the Chair.
- The Co-Chairs of the Board contact the Area Team Director for NHS England immediately regarding the Board's concerns.
- A letter be drafted to NHS England expressing the Board's concerns.
- An Action Tracker be produced following every meeting.
- The Board be kept up to date with progress and outcomes.

109. Questions from the public

Garry Jones, Chief Executive, Support Staffordshire expressed frustration at the lack of voluntary sector representation on the Health and Wellbeing Board and asked when the Board would consider this request.

Dr Charles Pidsley, Co-Chair referred to a letter that had recently been sent to the Chair of Staffordshire Voice regarding the issue. It was suggested that a Local Government

Association (LGA) Peer Review of the Board would consider this request as part of the Review process and provide a view as to how the Board should proceed.

It was confirmed by Paula Furnival, Programme Director, that work would need to be undertaken to prepare for the Peer Review and to agree what the focus of this should be.

In the course of the discussion that followed;
- Support was expressed for an LGA Peer Review. It was suggested that the Review could be an opportunity to look at how the Board operated.
- It was commented that there were over nine hundred and sixty residential and domiciliary care providers in the county alone. It was important that that there were not too many representatives on the Board as this would stop business getting done.

It was **Resolved** that discussion on the proposal for an LGA Peer Review be included on the Health and Wellbeing Board's Forward Plan.

110. Health & Wellbeing Board Prevention Programme – Healthy Housing

A request to defer the item had been made as following a detailed review of the paper it had been concluded that it required some further work.

It was **Resolved** that this item be deferred for consideration at a future meeting.

111. Feedback on Staffordshire Families Strategic Partnership Board

Helen Riley, Deputy Chief Executive and Director for Families and Communities, Staffordshire County Council provided a presentation on Staffordshire Families Strategic Partnership (FSP) Board, supported by Mick Harrison, County Commissioner for Children and Community Safety, Staffordshire County Council. In the course of the presentation the establishment and membership of FSP Board was discussed along with the governance arrangements and interaction with Staffordshire Safeguarding Children Board and the Health and Wellbeing Board.

It was highlighted that;
- The FSP Board would set the direction of travel.
- A Families Executive Partnership Group had been established to take forward the strategy.
- An Integrated Commissioning Sub Group would bring partners together in commissioning which would improve the outcomes for children.
- Short life task and finish groups would be set up as and when required.
- The FSP Board included schools and community and voluntary sector representatives. The Board was considering how to include provider representation.
- Demand management encouraged interdependence. It was important to avoid duplication and address the route causes of issues and not the symptoms.
- The strategy inherited from the previous Children's Strategic Partnership Board was being refreshed by the FSB Board. It was important to have one strategy and include within this the Early Help Strategy and the Hidden Harm Strategy so that there could be one integrated plan.

- A Children and Families Transformation programme was building on approaches that were known to work. It was recognised that it was important to build resilience in families and communities. Early help was fundamental.
- There were a number of Pilot proposals. These would be initiated by partners to explore the delivery of different aspects of the model outlined within the report which included a whole system partnership approach that considered the whole family.
- It was important to consider how to prevent children, young people and their families coming into the system.
- All contracts across the system would be considered and opportunities to avoid duplication and to commission in partnership around route causes explored. The drugs and alcohol Intensive Prevention Service was referred to as an example of commissioning that had effectively brought services together to collectively work with families.

In the conversation that followed it was confirmed that;
- One thousand three hundred families had been turned around in the first two years of the Building Resilient Families and Communities (BRFC) programme. Only six percent of these families had come back into the system. The programme operated on a payment by results basis. The second phase of the programme had been broadened to included health and domestic abuse. It was anticipated that over the next five years, five thousand families would be supported.
- It was important for partners to work together to address the route causes of problems, what interventions could help and to measure the outcomes. It was a challenge to ensure health improved also.
- It was requested that a system wide matrix be developed to demonstrate independencies.
- The development of a young people's Healthwatch was being considered.
- It was suggested that progress of the FSP Board be reported back to the Health and Wellbeing Board in six months time.
- BRFC work should include health outcomes as well as wellbeing outcomes in the performance matrix.
- The Healthy Staffordshire Select Committee had recently completed a review of Emotional Wellbeing and Mental Health Services.

It was **Resolved** that:
- The Health and Wellbeing Board approve the working protocol for the Health and Wellbeing Board, Staffordshire Safeguarding Children Board and the Families Strategic Partnership Board.
- The Health and Wellbeing Board request a further update from the Families Strategic Partnership Board on its strategic intent, integrated commissioning protocols, delivery plans, outcomes framework and progress on the Children and Families Transformation Programme in six months time.

112. Performance and Outcomes report

Chris Weiner, Commissioner for Public Health, Staffordshire County Council presented the Health and Wellbeing Outcomes and Performance Summary report. A number of points were made including that;
- The provisional Office of National Statistics data for winter deaths 2014/15 were now available. There had been a substantial peak in national mortality which had had an

impact on the acute system and coincided with twelve hour waiting breaches in Accident and Emergency. It was suggested that more could be done to increase flu immunisation rates and that targets were not ambitious enough.

- People were not dying where they wanted to. Performance on end of life care was going in the wrong direction.
- Work around delayed transfers of care had been progressing since September 2015. University Hospitals of North Midlands NHS Trust had reclassified the recording of delayed transfers of care but this had not been successfully completed in Burton area where there was a strong belief there was a misclassification.

In the discussion that followed comments were made that;

- There was a huge amount of work being undertaken to address resilience. The social care teams were actively engaged in Burton. It was suggested that the Public Health team engage with the System Resilience Group on this issue.
- It was important to communicate effectively with the public. The Board's messages could be, for example, sent out with Council Tax bills and in the Your Staffordshire magazine.
- There was no mechanism for the Board to collectively share its message and a communication strategy would be helpful.
- It would be useful to share with the public the Board's priorities and gather the public's views on these.
- NHS England's Public Health team were driving immunisation nationally.
- Board Members could report back individually on how the organisations that they represented were addressing individual issues.
- Interesting conversations could be held with the public regarding end of life care.
- There was over medicalisation of end of life care. Thirty percent of the NHS budget was spent on the last year of life.
- There had been work to engage with the public regarding end of life care in Staffordshire.
- The treatment of someone at the end of their life was the patient's choice and the GP would take this into account.
- Nationally there was not enough planning around death and it was important to have these conversations. A joint Health and Wellbeing Board message around this would be helpful.
- People had been reluctant to engage in advance care planning in North Staffordshire but it was positive to start conversations with people early. There was an opportunity for GPs to be de-prescribers of medication.
- Sixty seven percent of people wanted to die at home.
- Four Staffordshire CCGs looked to procure an end of life service. This had been prompted by poor outcomes. There had been a lot of work undertaken with patients as part of this procurement process, but the process had now been paused. There was more work to do to consider the views of people County wide and not just current patients. Healthwatch Staffordshire would be happy to support this.
- Many people did not have an advanced plan in place. People may have a lasting power of attorney but health and wellbeing considerations were not included.
- Many people approaching the end of their life did not have immediate family living nearby.
- There was an opportunity to debate public attitudes towards death.
- There had been excellent patient engagement work undertaken by Macmillan.

- Caution was expressed about the impact of communication plans in changing behaviour. It was emphasised that the Board should not do something if there was not the evidence that it could have an impact.

It was **Resolved** that;
- Jan Sensier, Chief Executive, Healthwatch Staffordshire and Richard Harling, Director of Health and Care, Staffordshire County Council present a proposal regarding an end of life focussed workshop session.
- The Health and Wellbeing Board note the information contained within the Health and Wellbeing Outcomes and Performance Summary Report for Staffordshire – February 2016.

a) The Story of Health and Care in Staffordshire

Chris Weiner introduced the Story of Health and Care in Staffordshire document to the Board. This would form the building blocks of the Joint Strategic Needs Assessment (JSNA) and provide demographic information about Staffordshire. The ageing population was highlighted and that there may be difficulties in caring for older people in the future as there would be a lower proportion of young people to provide paid care.

In the conversation that followed a number of points were raised including that;
- Older people were often carers themselves.
- GPs were likely to see increased demand.
- Medical technology and increased medication meant that more could be done for people.
- Practice nurses as well as GPs provided services to older people.
- A Primary Care Strategy was in development.
- The Board should have sight of the Primary Care Strategy. It was important to understand why there were pressures in the system and whether this was due to population changes or because of improved medical technology and people utilising services more. The Board needed to have an understanding of what was planned.
- The Primary Care Strategy should make reference to the JSNA.

It was **Resolved** that;
- The Health and Wellbeing Board note the information contained within The Story of Health and Care document.
- The Story of Health and Care in Staffordshire should be disseminated by Board Members to their own organisations.

113. Better Care Fund

Paula Furnival, Health and Wellbeing Board Programme Director referred to the Better Care Fund (BCF) guidance which had been made available approximately two weeks prior to the meeting. There was a steering Board which oversaw the BCF and could give assurance that they were content with the plan.

The second submission of BCF plans for 2016-17 would be made on the 21 March 2016. This would include narrative on what the plan would contain in accordance with the guidance. The requirements included for example, detail of the care and wellbeing offer, access to information, advice and guidance across the system, what was

happening currently for example around enablement and how the BCF plans would support progress on preventing unnecessary admissions and supporting discharge.

The final decision on the plan would be made in April 2016 and would come through the Board's steering group which oversaw the BCF.

The Disabled Facilities Grant had been granted and allocated to the District and Borough Councils. There had been an eleven percent increase in this but the Social Care and Care Act capital grant had been removed.

In the course of the discussion it was commented that;

- The County Council had increased Council Tax by three point nine five percent which included two percent ring fenced for social care.
- The BCF had to work, as spending power was determined by the success of this. £16.9 million needed to be transferred from health to social care.
- The Clinical Commissioning Groups (CCGs) were in difficulties financially also. All had to share the burden of the financial deficit.
- Reducing people requiring acute care was the solution.

It was **Resolved** that the Health and Wellbeing Board continue to have oversight of the BCF process.

114. Forward Plan

Paula Furnival, Programme Director, verbally updated the Board on upcoming items. These included the;

- Deferred Healthy Housing item.
- An item on the future commissioning of Healthwatch Staffordshire.
- Consideration on what had been achieved by the Board over the past twelve months.
- CCG commissioning intentions and annual reports.
- LGA Peer Review scoping and endorsement.
- Personal Health Budgets
- Sustainability, transition planning and the Case for Change.
- The Better Care Fund
- End of life care.

It was commented that Engaging Communities Staffordshire had built up a central repository of user feedback. It was difficult to incorporate information from all sources. Work was underway to explore how to consider patient experience and the shift to spend on prevention. Initial ideas could be shared with the Board.

The meeting was the last that Paula Furnival would attend as she was stepping down from her role as the Board's Programme Director. The Co-Chairs thanked Paula Furnival for her hard work and contribution to the Board.

It was queried if there would continue to be a Programme Office for the Board and it was confirmed that arrangements going forward were still in discussion and would be shared with the Board shortly.

It was **Resolved** that the verbal update on the Forward Plan items be noted by the Health and Wellbeing Board.

Chairman

Topic:	**Personal Health Budgets- The Local Offer**
Meeting	**Health and Well Being Board**
Meeting Date:	**09/06/2016**
Authors:	**Tina Groom - Personal Health Budget Implementation Manager**

1. Introduction

National Policy expects Personal Health Budgets (PHBs) to increase significantly in the future against the current baseline, with a number of key priorities.

By April 2016, in addition to the current cohort of the "right to have" a PHB being all patients in receipt of fully funded Continuing Health Care (CHC) and Children's Continuing Care (CCC), planning guidance states that PHBs or integrated budgets should be an option for people with Learning Difficulties and/or Autism and behaviour that challenges and Children with Special Educational Needs.

This has to be communicated and approved by the local Health and Wellbeing Boards and a Local Offer agreed ready for April 2016

2. Recommendation

2.1.

1) Approval of a Pan Staffordshire and Stoke local offer
2) A Phased Approach
   All CCGs agree from April 2016-2017 that the offer is extended to include:-
   A) All patients in receipt of fully funded CHC
   B) Children's Continuing Care
   C) Children in receipt of Health funding via CHC who have not met the fully funded criteria and jointly agreed with the Local Authority and Education. Children with Education, Health Care Plans (EHCP)
   D) Patients in receipt of joint health and social care that have gone through CHC but have not met the fully funded criteria.
   E) Section 117mental health packages jointly agreed between health and the local authority in the community.

This is the suggested first stage of further roll out of PHBs beyond CHC. These are all individually funded care packages and do not include contracted services.

Phase 2 would be to consider contracted services from April 2017 but this will need to be communicated via the Health and Wellbeing Boards as services become available.

This was approved by the pan Staffordshire commissioning congress in March 2016.

3. Background and Context

3.1.

PHBs were piloted across England between 2009 and 2012. In response to the evaluation findings, the Government announced a phased approach to introducing PHBs, starting with those people with higher levels of need. Since the pilot, PHBs have been included in numerous documents including legislation, regulation and guidance.

The publication of "Forward View into Action: Planning for 2015/16 set out-

"To give patients more direct control, we expect CCGs to lead a major expansion in the offer and delivery of personal health budgets, to people where the evidence indicates they could benefit. As part of this by April 2016, we expect that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning difficulties in line with the Sir Stephen Bubb review. To improve the lives of children with special educational needs, CCGs will continue to work with alongside local authorities and schools on the implementation of integrated education, health and care plans and the offer of personal health budgets. CCGs should engage widely with their local communities and patients including their local Health Watch and include clear goals on expanding personal health budgets within their local Health and Well-being strategy."

Primary Legislation

Health Act 2009
Part 1- Quality and delivery of NHs Services in England
Chapter 3 – Direct Payments

Secondary Regulations

The National Health Service (Direct Payments) Regulations 2013 as amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013 (DH 2013)

Guidance on Direct Payments for Health Care: Understanding the Regulations (NHS 2014)

Standing Rules

The national Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013 (DH 2013)

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No3) Regulations 2014 (DH 2014)

The NHS Mandate

The Mandate: A mandate from the Government to NHs England: April 2014 to March 2015 (DH 2014)

Five Year Forward View
The Forward View into Action: Planning for 2015/16

Personal Health Budgets for different groups of people

NHS Continuing Health Care

Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Care and Children and Young Peoples Continuing Care (NHS England 2014)

Children and Young People

The Mandate: A mandate from the Government to NHS England: April 2014 to March 2015 (DH 2014)

0-25 SEND code of practice; a guide for health professionals (DH/DFE 2014)

Learning Disabilities

The Mandate: A mandate from the Government to NHS England: April 2014 to March 2015 (DH 2014)

The Forward View into Action: Planning for 2015/16

Transforming care: A national response to Winterbourne View Hospital, Department of Health Review: Final Report (DH 2012)

Winterbourne View- Time for Changes: Transforming the commissioning of services for people with learning disabilities and /or autism (Sir Stephen Bubb 2014)

Mental Health Conditions

The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016 (DH 2014)

The forward view into action: Planning for 2015/16

Personal Health Budgets – The Local Offer across Staffordshire and Stoke CCGs

Tina Groom

PHB Implementation Manager

January 2016

Introduction

A Personal Health Budget is an amount of money to support a persons identified health and wellbeing needs, the use of which is planned and agreed between the individual, their representative. Or, in the case of children, their families or carers and the local NHS team. It is not new money, but it is money that would normally have been spent by the NHS on the person's care being spent more flexibly to meet their identified needs.
Stoke-on-Trent has had an additional project in place which has supported some non-Continuing Health Care patients with long term conditions/mental health via a personal health budget or small grant. This project is currently under review

Personal Health Budgets (PHBs) have undergone an organic development journey over the last 3-4 years, since the policy was first introduced. Following a pattern similar to the rest of the country, uptake has been slow across the county and largely limited to patients in receipt of CHC.

National policy expects the use of PHBs to increase significantly in the future, against the current limited baseline, with a number of priority initiatives for 2015/16.

By April 2016, in addition to the current cohort of the "right to have" a personal health budget being all patients in receipt of Continuing Health Care funding and Children's Continuing Care, planning guidance states that personal health budgets or integrated budgets across health and social care should be an option for people with learning difficulties and children with special education needs. This has to be communicated and approved by the local Health and Wellbeing Boards and a Local Offer agreed ready for 1st April 2016. The offer requires submission at both Staffordshire and Stoke-on-Trent Health and Wellbeing Boards.

It is important to note that CCGs have the flexibility to plan and introduce personal health budgets at a pace and scale that meets their local circumstances. However the independent evaluation of the pilot programme and wider learning showed that people with higher levels of need benefit more from a personal health budget. This paper suggests that it is those with higher levels of need who are targeted as the Local Offer develops.

The Growth of PHBs

The use of PHBs has grown and will continue to grow as part of a move to increasing personalisation of care for individual patients and service users;

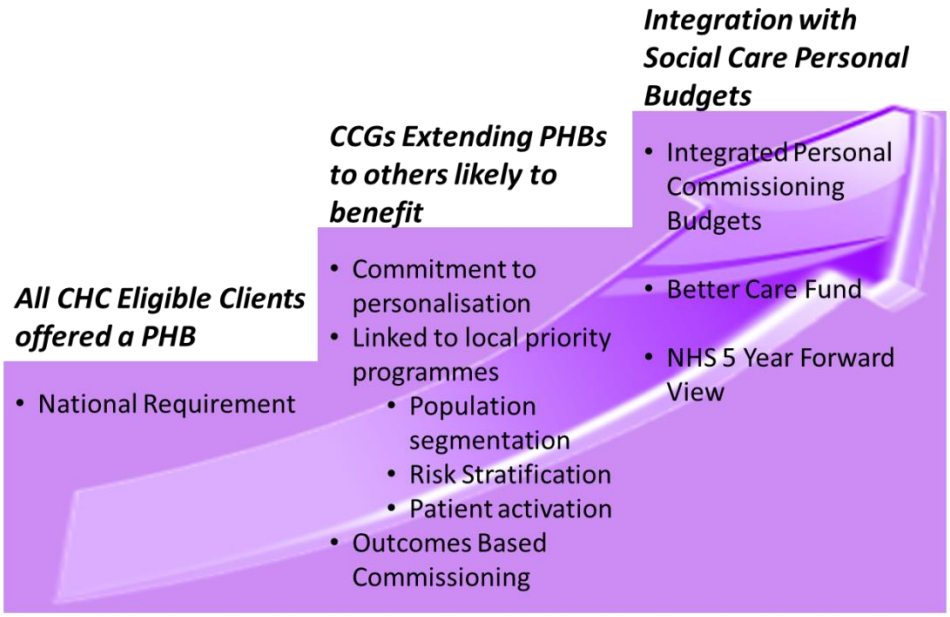


Fig 1 - The Growth of Personal Health Budgets

All Continuing Health Care (CHC) patients have had a right to have a PHB since October 2014 and it is reasonable to assume that uptake will continue to grow as people become aware of this right and as it is promoted nationally and locally.

It is unlikely that CHC patients in care homes or those on "fast tracks" will have the potential to benefit from a PHB. Therefore, focus should be given to the offer of a PHB to those in receipt of domiciliary care packages. Experience from elsewhere has also shown that only a relatively small number of service users (relative to the total CHC cohort) go on to manage a PHB.

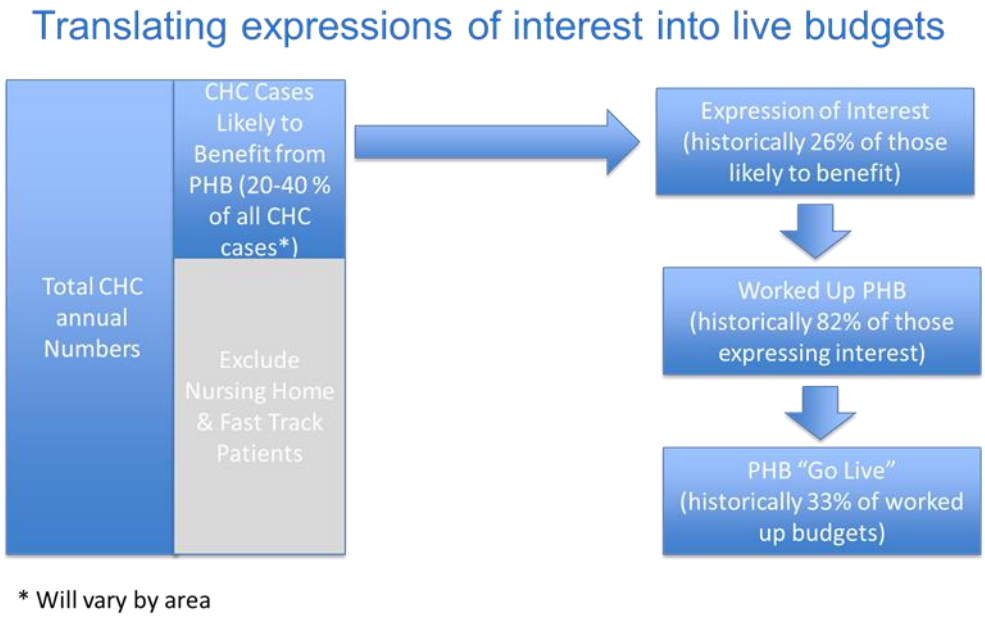


Fig 2 – Translating Service User expression of Interest in PHB into "Live" Budgets (Drawn from analysis of PHB uptake in Northamptonshire – a "Going Further, Faster" pilot site)

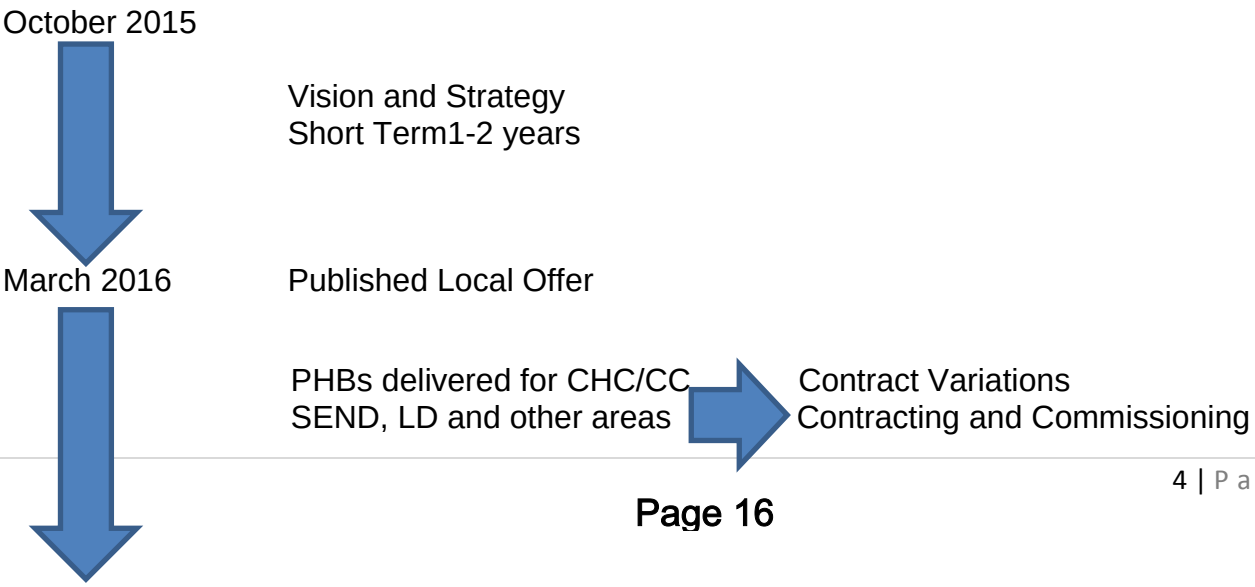
The NHS 5 Year Forward View (NHS England, 2014) places importance on patient empowerment and the personalisation of services around them. International and national

evidence shows that this can reduce utilisation and therefore spend. As a priority, NHS England's planning guidance for 2015/16 (The Forward View into action: Planning for 2015/16) requires CCGs to offer PHBs to people with learning disabilities and/or Autism and also encourages CCGs to adopt a more personalised approach to service delivery for mental health patients. The parity of esteem programme is about valuing mental health equally with physical health. The five year forward view has a commitment towards a more equal response across mental health and physical health, meaning improved access, more effective care and measured outcomes.

Sustainability

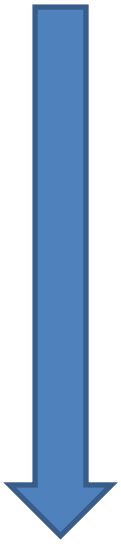
CCGs are currently not in a position to be able offer personal health budgets from services provided via "block contracts". However, consideration should be given as to how resources could be "freed up" to allow for greater flexibility and personalisation. This should be done at each contracting round to examine further expansion of personal health budgets. It does not mean that all services have to be offered via a personal health budget but just a portion of the services received. For example a person is assessed as requiring physiotherapy and this will be delivered over 6 sessions. The individual should be able to choose how and when these sessions are delivered. Instead of over 6 straight weeks could it be provided more effectively once every month for 6 months? Does the person need to come to a building between 9-5 or can the provision be provided at home on a Saturday? Or could the cost of the 6 sessions be given to the individual to use for private physiotherapy from a service recommended by the CCG?
As CCGs consider what services could be "cashable" to provide more choice and flexibility for individuals this should be communicated via the Health and Wellbeing board and the local offer updated.
It does not necessarily mean removing money from block contracts but asking providers to determine how they will offer these services offering personalisation, choice and flexibility. Are there services that are under performing and if so can the resources from this be used for personal health budgets?
Is there a service that has long waiting lists that resources could be freed up to allow service users to access private providers?
It is expected that the current PHB team will manage the cases identified in the phase 1 cohort identified at the end of this paper. The existing team is able to manage 80 cases as identified in the business plan that was presented and approved by the CCGs in January 2015. The business case also identified the need for an additional 2wte band 5 registered professionals to manage over 120 cases.

Timescales for Expansion of PHBs



Based on local plans Changes

March 2017



Vision and Strategy
Long Term 3-5 years

Increasing number of PHBs
In line with local plans

Published commissioning intentions
Include expanding local offer for PHBs

Large scale contracting and commissioning
Changes

March 2019 PHBs operating at scale for CHC/CC
LD, SEND and other significant groups

Learning Difficulties

Currently there are 142 fully and joint funded Learning disability patients in receipt of CHC across Staffordshire and Stoke.14,200 people living in Staffordshire have a diagnosis of Learning disability (Aged 18 and over); 6,600 people have a diagnosis of Autistic spectrum Disorder (Aged 18 and over). For adults over 18 it is estimated that between 3,100 and 5,100 are living with LD and ASD. Additionally there are 19 “Winterbourne” patients being managed via SSSFT. The transforming care programme encourages more innovative services to give people a range of care options, with personal budgets, so that care meets individual needs.

Long Term Conditions

CCGs may be looking at wider adoption of PHBs; as part of broader service redesign of Long Term Condition pathways, or to specifically address and tackle in different ways the needs of high utilisation patients, through case managed, personalised approaches to care delivery. To give patients more direct control, CCGs are expected to lead a major expansion of PHBs where evidence indicates they could benefit. This could equate to 0.1-0.2 percent of the population over the next 3-5 years. This scale of rollout would represent major progress. For Staffordshire and Stoke 0.1 percent of the population equates to approx. 1,200 people or 0.2 percent 2,400 people. Integrated commissioning across health and social care presents new opportunities (and challenges) to CCGs to deliver seamless care to patients and deliver the efficiencies demanded from the Better Care Fund. Integrated Personal Commissioning (IPC) budgets are being piloted in a number of areas of the country and their use is likely to increase in the coming years.

Integrated personal commissioning blends health and social care funding for individuals with complex needs. Its aim is to provide a "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or Voluntary sector.

Engagement

National Guidance states that "CCGs are expected to engage widely and fully with their local communities and patients, including with their local Healthwatch, and include clear goals on expanding personal health budgets within their published local Joint Health and Wellbeing Strategy" by April 2016. It is important that the CCGs engage with the PHB team and steering group who have representation from Healthwatch and other voluntary organisations.
GPs are a particularly key group to engage in the future development of PHBs as they will know the patients who could ultimately benefit from taking more control over their health via a PHB.

Children

There are currently 156 children and young people in receipt of CHC funding who are entitled to a PHB. CCGs are also required to continue to work alongside local authorities and schools on the implementation of integrated Education Health and Care Plans (EHCP), and the offer of personal budgets to those with an EHCP (replacing Statements of Special Educational Needs) who could benefit. This is a wider cohort with around 3,000 Children with Statements of Special Education needs in the four South Staffs CCGs and approximately 2361 across Stoke and North Staffordshire.

Value for Money

Experience across the country of delivering a PHB services over a number of years has shown that the costs of delivering an effective PHB service is likely to be offset by "cashable" efficiency savings coming from two identifiable sources;

Package Costs - It is too soon to draw meaningful conclusion from our work locally. However drawing on the experience from elsewhere and our current live PHBs we could reasonably expect CHC PHBs to be, on average, at least 10% lower than the traditional package costs that they replaced – evidence that service users pursue value with their budget and help reduce commissioner spend.

Budget Underspends - People with PHBs are very good at making sure they only pay for services actually received from care providers. As a result, about 30% of budgets are likely to underspend over the course of a full year, leading to reclaims by the CCG. These reclaims are usually less than £10,000, but prior to being in a PHB this was probably being billed by providers and paid without question by commissioners, without the means to fully check the invoiced amount. Currently PHB team have identified refund of £5,471.29 and another of £21,000.00 from pilot PHBs. The current PHBs are less than 12 months old.

In addition to these savings, and with an eye to the research evidence, there are also likely to be savings arising from reduced utilisation of services outside of the PHB (e.g. on GP

visits, hospital attendances) by giving patients greater control, although this has not been well measured yet.

For Discussion – Some Proposed Actions for CCGs

The following are proposed as actions for the CCGs to pursue in relation to PHB development and management;

1. **A Pan – Staffordshire Local Offer**
   There should be one "Local Offer" for Staffordshire and Stoke-on-Trent encompassing agreed principles, direction of travel and timescales for implementation of the offer.

   However, individual CCGs will retain the opportunity to include any additional elements they may want in their areas, allowing for flexibility to respond to local need and circumstances.

2. **A Phased Approach**
   CCGs to agree that the Local Offer 2016-2017 the following cohorts to be considered:

   a. All patients in receipt of domiciliary care packages under CHC
   b. Children in receipt of CHC / jointly agreed (with local authority) packages
   c. Patients in receipt of joint health and social care that have gone through CHC but have not met the fully funded criteria.
   d. Learning Disability and/or Autism and challenging behaviour patients in receipt of joint health and social care packages that have gone through CHC but have not met the fully funded CHC criteria.
   e. S.117 mental health packages jointly agreed (with the local authority) in the community
   f. Develop a Section75 agreement between Health and the LA around the process of funding joint packages of care.

   This is the suggested first stage of further rollout of PHBs beyond CHC. These are all individually funded care packages and do not include contracted services. To be agreed in line with suggested timescale from April 2016.

   The next stage would be: - To consider contracted services as an option from April 2017 but this will need to be published via the Health and Wellbeing Board and updated as services become available.

Learning disability and/or Autism and challenging behaviour patients in receipt of NHS funded care – a plan needs to be established for this cohort of patients quickly which clearly articulates;

i. The number of patients
ii. The type and cost of care currently being provided
iii. What needs to be done to free up resources to fund PHBs from April 2016.

Children with special educational needs and EHC plans in receipt of NHS funded care – again a plan needs to be established to articulate

i. The number of children
ii. The type and cost of care currently being provided

iii What needs to be done to free up resources to fund PHBs from April 2016

High utilisation patients – For example complex patients with multiple long term conditions. Proposed that the CSU identify the top 50 (in terms of historic cost in secondary care) high utility patients and the PHB team identify those within this cohort who may benefit from the offer of a PHB, and progress the offer, reporting back through the performance report on the success they have in improving outcomes and reducing cost utilisation.

Need to agree a reporting process for PHBs and evaluation of PHBs under Local Offer.

It is important to note that this paper has been passed by the NHS England Regional Personal Health Budget Lead for the Midlands region.

Topic:	**Health & Wellbeing Board Prevention Programme – Healthy Housing**
Meeting:	**Health and Well Being Board**
Date:	**9/06/2016**
Authors:	**Jon Topham**
Report Type:	**For discussion**

1. Introduction

1.1. District and Borough Councils deliver a wide range of housing related services that have a direct impact on health and wellbeing including;

- the provision of good quality neighbourhoods and housing accommodation through their planning functions;
- the prevention of homelessness;
- assisting vulnerable people to live safely and independently at home including the provision of Disabled Facilities Grants (DFGs);
- Ensuring homes are safe and warm including preventing falls and tackling cold homes and fuel poverty.

1.2. In 2015, the Board agreed a programme of prevention and early intervention work, which included developing an integrated approach to housing and health.

2. Recommendation

2.1. That the Housing and Wellbeing Group be mandated to share the learning and develop Healthy Housing as an approach across the county.

2.2. That the Health & Wellbeing Board receive periodic reports from the Housing for Wellbeing Group

2.3. That Housing is specifically considered as a key contributor to the integration of health and social care within the Better Care Fund and as an essential element for the delivery of service transformation.

2.4. To note that the Housing for Wellbeing Group will be discussing DFGs

Topic:	**Health & Wellbeing Board Prevention Programme – Healthy Housing**
Meeting Date:	**9th June 2016**
Board Member:	**Tony Goodwin, CEO Tamworth Borough Council**
Author:	**Jon Topham (SCC: Health & Care)**
Report Type:	**For Information**

1. Introduction and Background

- District and Borough Councils deliver a wide range of housing related services that have a direct impact on health and wellbeing including;
    - the provision of good quality neighbourhoods and housing accommodation through their planning functions;
    - the prevention of homelessness;
    - assisting vulnerable people to live safely and independently at home including the provision of Disabled Facilities Grants (DFGs);
    - Ensuring homes are safe and warm including preventing falls and tackling cold homes and fuel poverty.

- In 2015, the Board agreed a programme of prevention and early intervention work, which included developing an integrated approach to housing and health.

- The scope included:
    - Develop a Staffordshire approach for the role of housing in Health and Wellbeing
    - Learn from the Tamworth refresh of the Healthier Housing Strategy
    - Advice and input now arranged with Public Health England

- Housing has also been recognised as part of the Staffordshire County Council Business Plan and is part of the Health and Care Directorate plan

- Housing has previously been discussed at the Health and Wellbeing Board, with a presentation from Stafford Borough Council on 10 October 2013.

2. A new approach

- In December 2015 a Housing and Wellbeing Group was convened, to develop approaches on shared priorities and to share knowledge and learning.

- The group involves representation from every District in Staffordshire, including Stoke on Trent. The East Staffordshire membership is virtual, but all other Districts are represented physically at this group

- Work with Districts has emphasised the need for a twin track approach; firstly to recognise the need each District has to manage its own business; second to draw out the areas where greater sharing and cooperation is helpful and achievable

- Following scoping with Districts, three priority areas have emerged, which are:
    - Improving the delivery of aids and adaptations (including DFGs) to prevent falls, support carers and facilitate hospital discharge
    - A coordinated and consistent approach to tackling cold homes and reducing fuel poverty
    - Preventing and delaying hospital admission and supporting Hospital Discharge including effective mechanisms for joined partnership working between support agencies (Let's Work Together)

- Action Groups have been set up to develop the workstreams as follows
    - Aids and adaptations / DFGs – what are the barriers to effective delivery and what innovative models can be explored to overcome these? Scrutiny of existing delivery arrangements including performance and quality standards for delivery. Exploration of the opportunities to prevent or delay the need for a health or care intervention, and an assessment of the wider demand for adaptations and how we can facilitate and manage this.
    - Cold Homes – what is the scale and impact of cold homes and fuel poverty in terms of demand on health care services, how do we target activity to the right homes, what is the cold homes offer across the County and what opportunities exist to draw down external funding?
    - Prevention and Hospital Discharge– what is the scale of the issue, what do we need from the NHS, and what is the realistic Housing offer around the County

- The Group also shares learning from around the County, and has discussed initiatives being developed at a local level including:-
    - The Tamworth approach to their Healthier Housing Strategy refresh;
    - Use of data such as Health Impact Assessments, Stock Modelling and Thermal Imaging to influence effective targeting, for example in Stafford and East Stafford;
    - Innovative approaches to improving health and wellbeing amongst rough sleepers such as the Community Matron in Stoke, Stafford, Newcastle and Staffordshire Moorlands.

- Whilst still in its infancy, this work is helping to inform what the local housing offer to health and social care might look like and invaluable learning is emerging, about what will make the difference:-
    - Home based interventions have the potential to make a significant contribution to the current transformation agenda; shifting services from clinical settings to the community, preventing hospital admissions and facilitating effective discharge.
    - There are good opportunities to work with wider partners, e.g. Public Health England. To learn from others and share local good practice.
    - There are good opportunities to cooperate on data and intelligence, and the Tamworth Housing & Wellbeing profile created with The Insight Team is a model that we could seek replicate across the County. This approach can help Districts to consider their approach to Housing and Wellbeing in a more structured way.
    - If we can link Housing with wider commissioning we can maximise preventative options, although more work is needed to make this happen in a systematic way. We should produce a local “manual” that identifies the work that District Housing Departments can play and highlight the difference that can be made.
    - Housing has yet to feature significantly within the business of the Health and Wellbeing Board, the Housing for Wellbeing Group can act as a focus for this, providing a single point of contact for both the County and CCGs. This group can act as a vehicle for imnproving contact between current partnership structures like Together We Are Better and BCF and Districts.

3. Recommendations

- That the Housing and Wellbeing Group be mandated to share the learning and develop Healthy Housing as an approach across the county.

- That the Health & Wellbeing Board receive periodic reports from the Housing for Wellbeing Group

- That Housing is specifically considered as a key contributor to the integration of health and social care within the Better Care Fund and as an essential element for the delivery of service transformation.

- To note that the Housing for Wellbeing Group will be discussing DFGs

Topic:	**Update on Health and Well Being Board Membership**
Meeting	**Health and Well Being Board**
Date:	**09/06/2016**
Authors:	**Christopher Weiner**

1. Introduction

1.1. Recent personnel changes within the Health and Well Being Economy of Staffordshire necessitate a review of the membership of the board.

2. Recommendation

That the Staffordshire Health and Wellbeing Board:

2.1. Approves the appointment of Dr Richard Harling (Director of Health and Care, Staffordshire County Council) to the Board

2.2 Approves the appointment of Penny Harris (Staffordshire Transformation Director) to the Board

2.3 Approves the appointment of Mark Sutton, Cabinet Member for Children and Young People to the Board

2.4 Formally thank Mike Lawrence and Rita Symons for their historical work with the Staffordshire Health and Well Being Board.

Topic:	**Membership Changes to the Board**
Date:	**9th June 2016**
Board Member:	**Alan White & Charles Pidsley**
Authors:	**Christopher Weiner**
Report Type	**For decision**

Purpose of the Report

1. The report provides an update on the Board's terms of reference and responsibilities and asks the Board's approval for the revised membership following recent changes within the Staffordshire Health, Care and Well-Being economy.

2. The report also provides an update of the duties of the Board as a means of updating new and existing members of their duties and responsibilities.

Background

Health and Wellbeing Boards were established through Section 194 of the Health and Social Care Act 2012. In summary the Board's core functions that it must undertake are to:

- Prepare and publish a Joint Strategic Needs Assessment based on a local authority footprint. In doing so the Board must involve Healthwatch, undertake a wider stakeholder engagement exercise and in the case of 2 tier areas engage each District and Borough Council.
- Prepare a Joint Health and Wellbeing Strategy setting out how the needs identified in the JSNA have been prioritised and addressed. The Board must engage Healthwatch and undertake a wider engagement exercise as part of its development. The Board must be mindful of any direction given by the NHS Commissioning Board when preparing the JSNA and JHWS.
- Promote the integration of health and social care services.
- Provide advice, assistance and other support in encouraging arrangements under section 75 of the NHS Act 2006.
- Encourage providers to work closely with the Board and encourage those that provide health, health related or social care services in an area to work "closely together".
- Prepare and publish a Pharmaceutical Needs Assessment every 3 years (in addition, good practice is for the production of an Eye Health & Sight Loss Needs Assessment including children's eye health but this can be incorporated into the wider needs assessment).
- Provide an opinion as to whether CCG Commissioning Plans have taken proper account of the JHWS. The Board can in turn write to the NHS Commissioning Board outlining its opinion of the CCG Commissioning Plans, notifying the CCG at the same time.
- Review the extent to which CCG Commissioning Plans have contributed to the delivery of the JHWS

The Health and Wellbeing Board can also:

- Arrange for the functions of 2 or more Boards to be exercised jointly or by a joint committee of the Boards.
- Request information relevant to the achievement and performance management of its priorities from CCGs, the Local Authority, local Healthwatch or any body represented on the Board as required. These bodies have a duty to provide such information.
- Give its opinion as to whether the local authority is discharging its duty in giving due regard to the JSNA and JHWS through its commissioning intentions.
- Exercise the functions of a local authority, with the exception of its scrutiny functions, where these functions are formally delegated to it.

Membership

Legislation sets out a required list of people that must sit on the Health and Wellbeing Board. Those people required to be on the Board include at least one County Councillor (for Staffordshire there are 3 Cabinet Members), the Director of Adult and Children's Services, the Director of Public Health, a representative from Healthwatch and a representative from each of the Clinical Commissioning Groups (for Staffordshire they are the Chair of each CCG). The Board must also involve a representative of NHS England in the development of the JSNA and JHWS. The membership is outlined in appendix 1.

In addition the Staffordshire Health and Wellbeing Board has previously chosen to extend its membership to include 2 Elected Member representatives from the District and Borough Councils, a District and Borough Council Chief Executive and the Chief Constable of Staffordshire Police, the Staffordshire Transformation Director and a representative from the Staffordshire Fire and Rescue Service.

The Board has a co-Chair arrangement whereby the Board is jointly chaired by a Cabinet Member from Staffordshire County Council (the Cabinet Member for Health, Care and Wellbeing) and one of the Chair's of the Clinical Commissioning Groups.

The Board is now asked to approve the updated appointments of:

1. Dr Richard Harling (Director of Health and Care- Staffordshire County Council. Director of Public Health and Director of Adult Social Services).
2. Penny Harris- Staffordshire Transformation Director
3. Mark Sutton, Cabinet Member for Children and Young People

In terms of the legislation the Board can review its membership at any point in time. As an Executive Committee of Staffordshire County Council the council can appoint additional members to the Board but it must consult the Board when doing so.

Terms of Reference

- The Board has terms of reference which set out the practical arrangements for how the Board will operate. The key principles that underpin the terms of reference include: Sovereignty around decision making. Board members will be accountable through their own organisation's decision making processes. It is the expectation that Board members will come to the table with the authority to take decisions.
- Agendas for formal Board meetings will be issued 10 working days in advance of a meeting. Where this is the case then such decisions will not normally be subject to separate ratification processes by partner organisations except where such ratification is explicitly required. Where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies. Where possible all decisions should be reached through consensus.
- Decisions and agendas for Board meetings will be publically accessible, except where exemption criteria apply.
- The Board can agree a programme of training and development activity over and above the schedule of formal meetings.

(Full terms of reference are available in appendix 2)

Declarations of Interest

Health and Wellbeing Boards were established as a committee of the local authority which established it. As a consequence the Board is covered by the relevant legislation that governs local authority committee procedures (including Section 102 of the Local Government Act 1972 and Localism Act 2011). In practice this means that members of the Board and their substitutes are required to abide by a Code of Conduct based on the 7 Nolan Principles of Public Life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership). Board members must also complete a register of interests (Disclosable Pecuniary Interests - DPIs). DPIs cover matters such as sponsorship, contracts tenancies and securities. The purpose of declaring DPIs is to give confidence to the public that Board members are making decisions on the basis of the interests of the communities of Staffordshire rather than any personal interest. Where a Board member feels they have a DPI in relation to a decision being taken by the Board then they are required to declare this at the start of the meeting and will not be able to speak or vote on the matter. Guidance can be offered to Board Members at any point in time prior to, or during a meeting. Board members have been requested to update their DPIs from May 2015.

Recommendations

That the Staffordshire Health and Wellbeing Board:

a) Approves the appointment of Dr Richard Harling (Director of Health and Care, Staffordshire County Council) to the Board
b) Approves the appointment of Penny Harris (Staffordshire Transformation Director) to the Board
c) Approves the appointment of Mark Sutton, Cabinet Member for Children and Young People to the Board
d) Formally thank Mike Lawrence and Rita Symons for their historical work with the Staffordshire Health and Well Being Board.

Appendix 1: Membership of the Staffordshire Health and Wellbeing Board

Core Roles	**Representation**
At least one councillor from	*Alan White* *Ben Adams* *Mark Sutton*
The Director of Children's Services	*Helen Riley*
The Director of Public Health and Director of adult Social Care	*Richard Harling*
Representative from Health Watch	*Jan Sensier*
Representative from each relevant Clinical Commissioning Group	*Paddy Hannigan* *Mo Huda* *John James* *Charles Pidsley* *Mark Shapley*
NHS England	*Ken Deacon*
Additional Roles	
District and Borough Elected Member representatives	*Roger Lees* *Frank Finlay*
District and Borough Chief Executive	*Tony Goodwin*
Staffordshire Police	*Jane Sawyers*
Staffordshire Fire and Rescue Service	*Glyn Luznyj*
Staffordshire Transformation Director – Together We're Better	*Penny Harris*

Appendix 2: Terms of Reference (May 2016)

Introduction

The Board is a key strategic leadership body that will drive ongoing improvements in health and wellbeing across Staffordshire. The Board is established under the provisions set out in the Health and Social Care Act which received Royal Assent on the 27 March 2012. The Board assumed its statutory responsibilities from April 2013. The terms of reference will be reviewed as appropriate to ensure they support the strategic intentions of the Board and compliance with all relevant legislation.

Our Vision for Staffordshire

"Staffordshire will be a place where improved health and wellbeing is experienced by all – it will be a good place which will be healthy and prosperous in which to grow up, achieve, raise a family and grow old, in strong, safe and supportive communities".

We will achieve this vision through

"Strategic leadership, influence, pooling of our collective resources and joint working where it matters most, we will lead together to make a real difference in outcomes for the people of Staffordshire".

The Board will focus its efforts where combined partnership effort will lead to significant impact upon the health and wellbeing of the local people and communities of Staffordshire over and above what could be achieved by any one organisation on its own. The Board has reaffirmed its core purpose as providing leadership around "prevention which would be achieved through greater integration and the increased empowerment of people". The Board will continue to focus its efforts where it can make the biggest difference.

The Board will have oversight, where appropriate, of the use of resources across a wide spectrum of services and interventions, to achieve its strategy and priority outcomes and to drive a genuinely collaborative approach to commissioning, including the co-ordination of agreed joint strategies. The Board will provide leadership and have oversight of the totality of commissioning expenditure in Staffordshire which is relevant to achieving the Board's strategic priorities, working to minimise duplication, avoid cost shunting and maximise the cost effectiveness of resources and services.

The Board has a set of core duties as laid out in the 2012 Health and Social Care Act, these are:

1. To jointly prepare and publish a Staffordshire Joint Strategic Needs Assessment, ensuring that it engages with and captures the voice of the community, and is used to inform collective and individual strategic decisions of the Board and the individual bodies that make up the Board.
2. To jointly agree and publish a Staffordshire Joint Health and Wellbeing Strategy (JHWS), setting out ambitious outcomes for improved health and wellbeing across Staffordshire.
3. To encourage health and care commissioners to work together and to co-ordinate commissioning decisions to advance the health and wellbeing of the people of Staffordshire.
4. To consider the partnership arrangements under the Section 75 of the 2006 NHS Act (such as joint commissioning and pooled budgets where appropriate.
5. to involve third parties including HealthWatch and people living and working in the area in the preparation of the JSNA and JHWS (also District and Borough Council's in the preparation of the JSNA)
6. To encourage integrated working.
7. To ensure patient and public voice is heard as part of the Health and Wellbeing Boards decision making, receiving and considering patient and public feedback through the statutory board membership and regular reports of Staffordshire Health-watch.
8. To review the plans of the Clinical Commissioning Groups, NHS Commissioning Board LAT and Local Authority, reviewing whether these contribute to the delivery of the JHWS.
9. A duty to work in partnership.
10. Duty to review how far a CCG has contributed to the delivery of the JHWS and the performance assess how well their duty has been discharged in terms of having regard to JSNA and JHWS
11. Increase local democratic legitimacy in the commissioning of health and care services.

In addition to the duties of the Board as set out in the Health and Social Care Act, the Staffordshire Health and Wellbeing Board has also agreed additional functions relevant to achieving outcomes for Staffordshire and the wider Staffordshire partnership environment:

12. To oversee the effective delivery of the Staffordshire strategic priority outcomes
13. To ensure continuous improvements in quality; encompassing patient experience, safety and effectiveness.
14. To work with the Local Safeguarding Children and Adult Boards to ensure all partners promote the safety and welfare of children and young people and vulnerable adults.
15. To establish the basis of collaboration with Stoke City Health and Wellbeing Board
16. To represent the needs and issues for Staffordshire at local, regional, national and international level.
17. To monitor, review and evaluate progress and impact against the outcomes and actions agreed in the Staffordshire JHWS and ensure action is taken where appropriate to improve outcomes.
18. Evaluate performance against locally agreed priorities.
19. Evaluate performance against nationally set outcomes frameworks for the NHS, public health and social care.

The Board doesn't exist to become embroiled in the "operational detail" of any one issue or organisation around the table.

How we will Work to Achieve these Ambitions

Accountability

The key principles upon which the Board will function are as follows:

- The Board will link closely with the Staffordshire Strategic Partnership (SSP) and the Stoke on Trent and Staffordshire Local Enterprise Partnership to ensure communication and co-ordination around common priorities to the benefit of local communities.

- There will be sovereignty around decision making processes. Core members will be accountable through their own organisation's decision making processes for the decisions they take. It is expected that Members of the Board will have delegated authority from their organisations to take decisions within the terms of reference.
- Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations (provided that at least 10 working days' notice of forthcoming decisions had been given). However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies.
- It is expected that decisions will be reached by consensus.
- Decisions and agendas for the Board will be publically available, except where exemption criteria apply, via the website. The Board will actively provide information to the public through publications, local media, wider public activities and an annual report.
- Core members have a responsibility to feed back to their respective organisations the deliberations and decisions of the Board as appropriate.
- The terms of reference will be reviewed annually in light of learning from the experience of Board members.

The Board may establish themed sub-groups from time to time to advise the Board. These groups will be accountable to the Board for the delivery of their stated aims and outcomes within agreed timescales. The Board may arrange for the discharge of its functions by a sub group of the Board or an officer of the authority.

The Health and Wellbeing Board is an executive function of Staffordshire County Council. The Healthy Staffordshire Select Committee will be the key means of scrutiny of the Board's activity. This will generally involve an invitation to the Chair or Co Chair to attend relevant meetings of the Select Committee, linked to an agreed work programme

Membership

The core membership of the Board is as follows:

- Cabinet Member for Health, Care and Wellbeing, Staffordshire County Council

- Cabinet Member for Learning and Skills Staffordshire County Council
- Cabinet Member for Children and Young People
- An Elected District & Borough Council Representative
- An Elected District & Borough Council Representative
- A Chief Executive Officer District & Borough Council Representative
- Representative of North Staffordshire Clinical Commissioning Group
- Representative of South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
- Representative of East Staffordshire Clinical Commissioning Group
- Representative of Stafford and Surrounds Clinical Commissioning Group
- Representative of Cannock Chase Clinical Commissioning Group
- Representative of NHS England, Shropshire and Staffordshire Local Area Team
- Chief Constable of Staffordshire Police
- Director of Health and Care Staffordshire County Council
- Director for Families and Communities Staffordshire County Council
- A designated representative from HealthWatch
- Representative from Staffordshire Fire and Rescue Service

There isn't a requirement for the Board to be politically proportional.

Additional membership will be considered by the Health and Wellbeing Board as appropriate. The overall size of the Board will, however, be kept at a level which is manageable and able to support efficient and effective decision-making.

The Board intends to ensure effective engagement and dialogue with wider stakeholders through the development of a Health and Wellbeing Provider Forum. The views of the Provider Forum will be fed back into the Board to inform its decision making.

Board Leadership

In terms of providing leadership and driving forward with pace the agenda for health and wellbeing in Staffordshire Board Members will need to be committed to:

- Placing the patient and public at the heart of decision making
- Provide strategic leadership based on evidence with a focus on areas where the Board can make the biggest difference
- Act with courage and conviction when making decisions that will have long term benefits to local communities
- Working in partnership to deliver impact
- Communicate effectively and consistently across Board Members and across stakeholders.

Chairing of Meetings

The Health and Wellbeing Board has established the following arrangement for the Chairmanship of meetings:

- The Co-Chairs of the Health and Wellbeing Board will be the County Council's Cabinet Member for Health, Care and Wellbeing and a representative from a Clinical Commissioning Group.

These positions do not attract an additional special responsibility allowance.

Meeting Arrangements

The Board will meet publically 4 times a year on a quarterly basis. Additional meetings of the Board may be convened with agreement of the co-Chairs. Board Members will also be asked to attend development sessions as appropriate which will be specifically structured to provide time for reflection, development and training to ensure continued focus upon effective leadership and outcomes.

The Board will establish its own Forward Programme of activity which will be reviewed regularly to ensure it remains both strategic and timely. The Forward Plan will be considered at every meeting to facilitate discussion as to priority areas, new items and agenda timetabling. Any reports for a meeting of the Board should be submitted to the County Council's Member and Democratic Services team no later than eleven working days in advance of the meeting to ensure the ten day timescale

for notification of forthcoming decisions is adhered to. No business will be conducted that is not on the agenda.

Agendas and papers for Board meetings will be made publically available via the website unless covered by exempt information procedures. Agendas and reports will be circulated and published ten days prior to the meeting.

Quorum

The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the Clinical Commissioning Groups.

Substitution Arrangements

Each core member is required to nominate a single named substitute. Should a substitute member be required, advance notice of not less than 2 working days should be given to the Council, via the Member and Democratic Services Team. The substitute member shall have the same powers and responsibilities as the core members including the ability to vote of matters before the Board.

Voting

All core members, and their named substitute, will have the right to vote on matters before the Board. A decision will be passed on the basis of a simple majority vote. In the event of a majority vote not being possible the Chairman shall have the casting vote.

Expenses

The partnership organisations are responsible for meeting the expenses of their own representatives.

Conflicts of Interests

The Localism Act 2011 (section 27 (4)) sets out matters relating to the Code of Conduct and the Registration of Interests (and subsequent regulations). These will apply to Health and Wellbeing Board members.

These require Board Members to abide by Code of Conduct based on the 7 Nolan principles of Public Life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership). Under this code, Health and Wellbeing Board Members, and their substitutes are required to register defined 'Disclosable Pecuniary Interests' (DPIs) that they are aware of relating to both themselves and their partner. The Council is also required to publish the Register of Interests as well as having it available for public inspection.

Topic:	**Staffordshire Sustainability and Transformation Plan**
Meeting	**Health and Well Being Board**
Date:	**9/06/2016**
Authors:	**Penny Harris**

1. Introduction

1.1 Staffordshire and Stoke on Trent (SSoTs) Together We're Better programme commenced in November 2015.

1.2 This has been reinvigorated with new leadership and governance to deliver the Staffordshire Sustainability & Transformation Plan (STP).

1.3 Staffordshire faces a number of significant challenges in delivery of health and care, from performance across all the constitution standards to financial balance, quality (as measured by CQC assessments and increased demand for services).

1.4 This presentation document sets out framework for development and delivery of the Sustainability and transformations plan (STP) to ensure its successful completion.

2. Recommendation

The Health and Well Being Board:

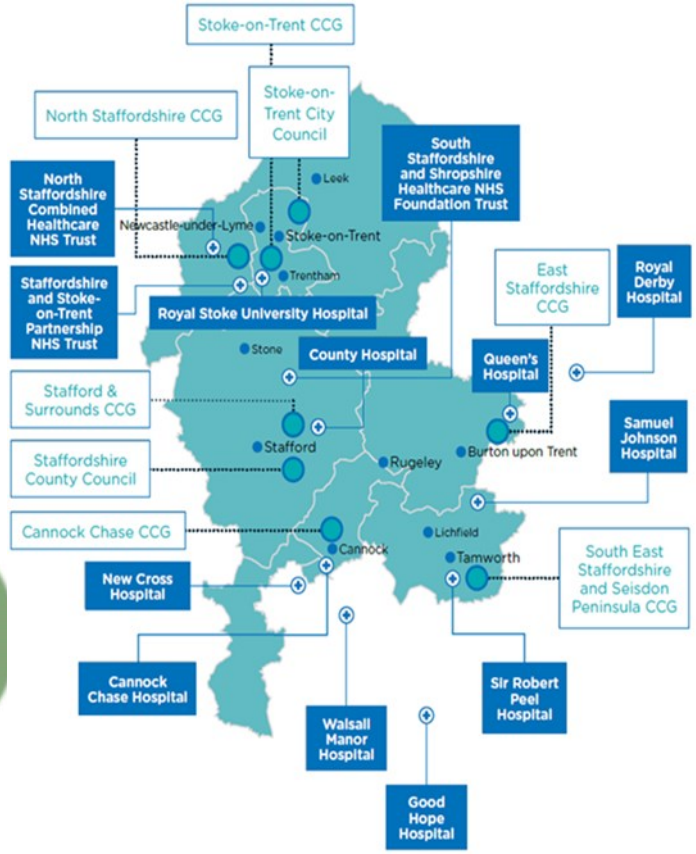
2.1 Considers the contents of this presentation

2.2 Notes the time line for development of the final submission of options at the end of June 2016

2.3 Supports the Sustainability and Transformation Planning process.

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Staffordshire Sustainability and Transformation Plan



Strategic Framework for the Programme

1. Introduction

1.1 Staffordshire and Stoke on Trent (SSoTs) Together We're Better programme commenced in November 2015.

1.2 This has been reinvigorated with new leadership and governance to deliver the Staffordshire Sustainability & Transformation Plan (STP).

1.3 Staffordshire faces a number of significant challenges in delivery of health and care, from performance across all the constitution standards to financial balance, quality (as measured by CQC assessments and increased demand for services.

1.4 This sets out framework for development and delivery of the Sustainability and transformations plan (STP) to ensure its successful completion.

2. Purpose of the STP

2.1 The NHS is required to produce a five year sustainability and transformation plan (STP), place-based and driving the Five Year Forward View.

2.2 It is recognised that the local NHS system will only become sustainable if they accelerate their work on prevention and care redesign. This is therefore not just a health issue.

2.3 Every health and care system has been asked to come together to create their own ambitious local blueprint, covering October 2016 to March 2021.

2.4 This requires:

- Place based planning for local populations.
- System leadership through team working, developing a shared system, planning and execution.
- The process needs to allow for learning and adapting. and requires an open, engaging and iterative process, harvesting the energies of clinicians, patients, carers, citizens and local community partners, including the independent and voluntary sectors and local government, through health and wellbeing boards.

2.5 The challenges facing the Health & Care System.

Reviewed at the workshop on 6th April 2016, the key challenges are:-

- **Increasing elderly population and explosion of chronic disease and comorbidities**
- **More than half of the population of Stoke live in the most deprived areas.**
- **Obesity levels exceed English averages and levels of diabetes are rising.**
- **Acute health service providers are failing to meet core consultation standards, especially in urgent care and cancer.**

2.6 Vision for the STP

Vision

Staffordshire and Stoke-on-Trent will be vibrant, healthy and caring places where people will be as independent as possible and able to live happy and healthy lives, getting high quality health and care support when required.

Aims

- Deliver better outcomes for the citizens of Staffordshire and Stoke-on-Trent
- Increase the proportion of people's lives that they spend healthy
- Develop a clinically and financially sustainable health and care system.

Priorities

- Urgent Care
- Primary Care & Community Services
- Clinical & Financial Sustainability
- Health Inequalities

Workstreams

Priority Workstreams

- Frail Elderly & LTC
- Urgent & Emergency Care
- Enhanced Primary & Community Care
- Planned Care (Inc. Specialised Commissioning)
- End of Life

Other Workstreams

- Cancer
- Mental Health
- Prevention & Well-Being

Enabling Workstreams

- Communications & Engagement
- Workforce
- OD & System Leadership
- IT & Technology
- Travel
- Contracting
- Cost Reduction

Risks

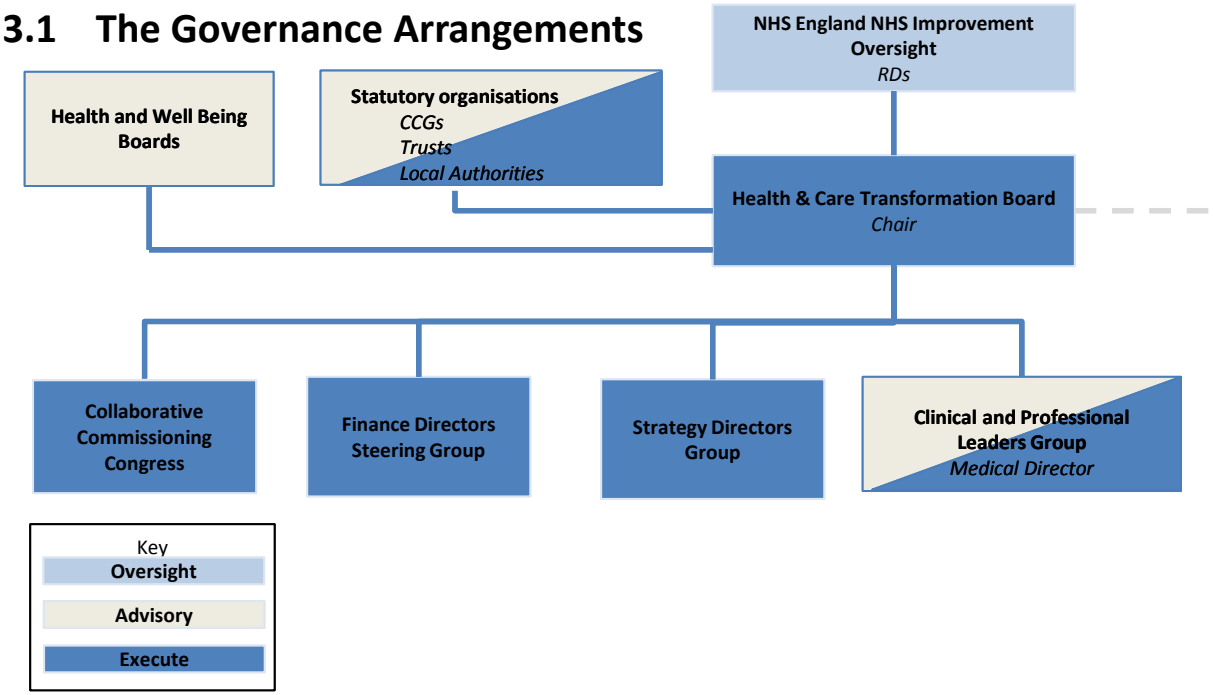
Risk Register

2.7 The key challenges and vision have focused the STP on four key challenges:-

- **To deliver sustainable improvements in the urgent care system through introducing a Staffordshire wide improvement in care of the frail elderly and other key pathways, addressing the Keogh requirements and exploring the potential for the introduction of community based clinical hub(s).**
- **To enhance the primary and community services, for example, through the development of Multi-Speciality Care providers across the county, providing consistently high standards of care that enable more people to be supported in the community, reducing the reliance on the acute sector. This will also provide opportunities for addressing the workforce challenges across the sector.**
- **To ensure the clinical and financial sustainability of the health and care system as a whole. The system is currently using more than its fair share of the national resource. Issues of duplication of services in all sectors, planned care capacity, levels of provision and workforce. It is also acknowledged as a core deliverable for each workstream.**
- **Addressing the key health inequality issues for the population of Stoke on Trent and the rising levels of obesity across the whole county, utilising examples of evidence based best practice shared by PHE.**

3. Structure of the Programme

3.1 The Governance Arrangements



Membership
Independent Chair
NHS England (Midlands and East) Operational leads
Programme director
Medical Director
Healthwatch
Chief Officers for:
6 CCGs:
- North Staffordshire CCG,
- Stoke-on-Trent CCG,
- East Staffordshire CCG,
- Cannock Chase CCG,
- South East Staffordshire and Seisdon Peninsula CCG, and
- Stafford and Surrounds CCG

2 Local Authorities:
- Staffordshire County Council
- Stoke-on-Trent City Council

5 Provider Trusts:
- University Hospital North Midlands,
- Burton Hospitals NHS FT,
- Staffordshire and Stoke-on-Trent Partnership Trust
- North Staffordshire Combined Healthcare FT,
- South Staffordshire and Shropshire Healthcare FT

- **The Programme Board will meet on a monthly basis.**

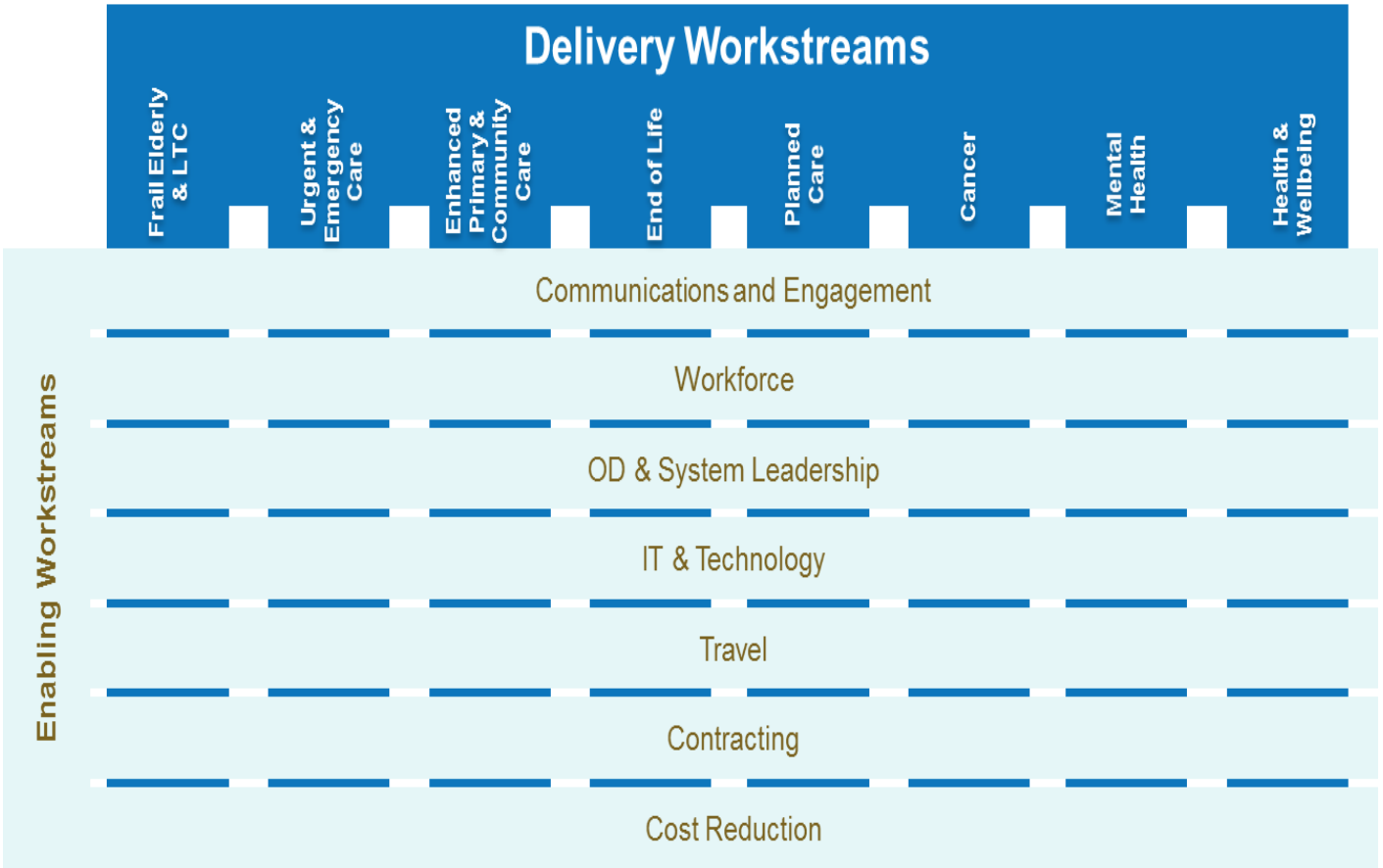
All working within a Strategic Framework sets out the parameters within which the workstream SROs discharge their responsibilities including:

1. **A common purpose; agreed system-wide challenges; system-wide objectives and priorities.**
2. **Clear Governance arrangements have already been discussed and agreed.**
3. **A work programme, key milestones, programme structure, and agreed scope for each work stream.**
4. **Principles and strategy for engaging patients and other key stakeholder groups and for communicating with staff and the public.**

3.2 The Core Workstreams

- **The programme will be delivered through a number of delivery and enabling workstreams.**
- **Each workstream is led by a Senior Responsible Officer (SRO), who is a chief officer/chief executive in the Staffordshire system.**
- **The roles of the SRO was agreed at Programme Board of 18th April 2016**
- **The scope of each of the workstreams will be approved at the Programme Board and formally form part of this framework.**
- **Each workstream will have:**
  - **Clear objectives**
  - **Agreed milestones, KPIs and outputs**
  - **Detailed delivery plan**
  - **Fomal PID(s), to be approved at Board**
- **The Enabling workstreams will also accord with these requirements and will support the core workstreams, but equally identify issues/opportunities to be addressed by the system.**

3.3 Key Steps for Success



3.4 The Role of the Workstreams

- Each of the workstreams is designed to support the development of the thinking to drive the STP for Staffordshire
- The initial focus is to identify the key issues to be addressed in the relevant area and the options for addressing these challenges to improve the sustainability of the Staffordshire system
- Sustainability is determined by both quality and financial affordability for the system. This will support cost reduction through improved quality, reduced waste, improved system efficiency and reduction of overheads.
- The workstreams will develop into the working groups for the delivery of the agreed STP once plans are agreed and the lifespan of any group will be determined by the defined deliverables at each stage

4. Management Arrangements

4.1 The Formal Assurance of the Programme

- The Programme Board is accountable to the Regional Leads for NHSE and NHSI through the Independent Chair.
- NHSE and NHS Improvement are responsible for the formal assurance of the Programme.
- Monthly assurance meetings will be held with the Independent Chair and Programme Director.
- Any issues from the assurance process will be reported to the Programme Board.

4.2 The Programme Board Decision Making

- The members of the Programme Board will all be jointly responsible for ensuring decisions are made to move the system to a financially and ethnically sustainable service model.
- The board will recognise the individual statutory responsibilities for each organisation, but will expect the leadership to work together to ensure a Staffordshire-wide plan can be delivered.
- A formal decision making process will be agreed to enable joint decision making within the NHS.
- An advisory panel will be set up with each Local Authority to ensure the appropriate executive leads can be fully appraised of key issues to enable decision making within their governance systems.

4.3 Communications and Engagement

- **Best practice advice on communications and engagement will be provided through the enabling workstream to each SRO.**

- **The core principle in taking forward the STP after June submission of the draft options will be based on co-production, with full engagement with key stakeholders, including patients and public.**

- **Mapping of the communications and engagement plans and key stakeholders for the relevant area will be the responsibility of the SRO, but this will be assured by the communications and engagement workstream.**

5. Emerging Hypotheses

- A transformation of primary and community care at pace across SSoT is required in order to reduce demand and ensure a future sustainable workforce allowing citizens to be treated in a more suitable setting.

- If we can solve our demand issues by changing clinical behaviours earlier in the pathway, we move from an expensive and workforce heavy 'urgent' healthcare system to a much more planned and orderly one, giving citizens more control.

- We need to change the way patients interact with the healthcare system, there is currently too high an expectation and reliance on what the system can deliver rather than self caring, this will empower patients to be in charge of their own healthcare.

- Adopting new models of care at scale, including urgent and emergency care and integrated health and social care will allow citizens to access their health and care support at the right place and the right time.

- We need to reduce the reliance on bed based care to allow people to stay at home for longer.

- Managing variation across the system will close the quality and reduce the financial gaps, giving a consistent service to patients.

6. The Practical Steps

• Demand and capacity model complete	3 June
• Programme Workshop (2)	7/8 June
• Capability and Capacity Review	20 June
• Draft STP	w/c 20 June
• Final Submission of Options	End June

Then full engagement in exploring options before moving to decisions and implementation

Topic:	**The Better Care Fund**
Meeting	**Health and Well Being Board**
Date:	**09/06/2016**
Authors:	**Alex Jones**

1. Introduction

1.1 The Better Care Fund (BCF) was set up by Government in 2013. It aligns a proportion of health and social care budgets to incentivise the NHS and local government to work more closely together while shifting resources into community health and social care services for the benefit of the people, communities, and the health and care system.

1.2 Each local authority area is required to submit a BCF plan for approval by NHS England describing how the BCF will support integration of services and with agreement about how the BCF will be allocated. The requirement includes that the plans are signed off by the Health and Well-being Board (HWB).

2. Recommendation

That the Health and Well-being Board:

2.1 Agree the vision and schemes of the Better Care Fund – as set out in the attached plan.

2.2 Note that SCC and the CCGs have not yet agreed the funding and that this is with the national escalation process.

2.3 Note that SCC and the District Councils are developing proposals for use of the Disabled Facilities Grant.

Health and Wellbeing Board – 20/05/2016
Better Care Fund plan update

Report of Dr Richard Harling

Recommendations

That the Health and Well-being Board

1. Agree the vision and schemes of the Better Care Fund – as set out in the attached plan.

2. Note that SCC and the CCGs have not yet agreed the funding and that this is with the national escalation process.

3. Note that SCC and the District Councils are developing proposals for use of the Disabled Facilities Grant.

1.0 **Report**

1.1 **Background**

1.2 The Better Care Fund (BCF) was set up by Government in 2013. It aligns a proportion of health and social care budgets to incentivise the NHS and local government to work more closely together while shifting resources into community health and social care services for the benefit of the people, communities, and the health and care system.

1.3 Each local authority area is required to submit a BCF plan for approval by NHS England describing how the BCF will support integration of services and with agreement about how the BCF will be allocated. The requirement includes that the plans are signed off by the Health and Well-being Board (HWB). Alongside the BCF, the NHS has established Sustainable Transformation Plans, locally on a Staffordshire and Stoke footprint.

2.0 **Vision and schemes**

2.1 The BCF will support our vision that *"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"*

2.2 Delivery of the BCF vision will be through our natural communities and localities. This we believe will bring greater ownership and co-production allowing delivery to reflect local needs and assets. The approach will be person centred and integrated at a primary care level. The focus will be on population health, reducing demand and enabling patients and service users to be active participants.

2.3 Summary of schemes within the BCF plan,

16/17 schemes	Aim
Front door	We will develop an integrated single point of access (Front Door), expanding the remit of the current service, that will triage and route people appropriately following assessment.
Enhanced community care model	Increase independent living & self-management and reduce and shorten hospital admissions by strengthening community based prevention, support, health and care networks. This is complementary in nature to a person-centred model for integrated care and support, based around registered populations and natural communities, which promotes the health, well-being and resilience of local people.
Reablement/intermediate care	Effective alignment of intermediate care and reablement across health and social care. Health and Social Care will work together to ensure that individuals receive a co-ordinated personalised care tailored to their needs and aspirations to maximise their independence and wellbeing.
Discharge/ Delayed transfer of care	A new scheme Discharge/delayed transfer of care will build upon existing work in place overseen by System Resilience Groups' across Staffordshire mainly North Staffordshire/ Stafford and East Staffordshire. Scheme aims includes; •Develop Discharge to Assess (D2A) pathways for •Improve the Fast Track pathway (patients requiring palliative care) •Improve discharge process across organisational boundaries with a designated lead for discharge
Enabling schemes	The above is complemented by a myriad of health and social care services, all interlinked and promoting continued independence, whether support to cares, integrated community equipment services, Disabled Facilities Grant to adjust living environments, technology enabled care services aiding wellbeing and independence and contracted services that afford domiciliary care and support.

2.4 SCC and CCGs agree the vision and schemes – as set out previously and explored in greater detail in (Annex 1 & 2).

3.0 **Funding**

3.1 The BCF takes the form of a local, single pooled £5.3bn budget that aims to fund ways that the NHS and local government throughout England can work more closely together.

3.2 In 2015/16 the Staffordshire BCF plan included aligned budgets totalling £98 million pounds as well as a separate three year financial agreement between CCG's and SCC. The agreement outlined that CCG's would provide £1.9m for implementation of the Care Act and an additional £5m for protection of adult social care and that both parties would deliver savings totalling £20m with £10m of this available to protect adult social care.

3.3 In the second year of the deal 2016/17 the CCGs have been instructed to prioritise funding of increased acute hospital activity in order to provide additional income for the acute trusts and then to address their own deficits. As a result they are unable to commit the agreed funding aside from the Care Act to protect adult social care in 2016/17 and beyond. This leaves SCC with a financial gap of £15m against planning assumptions for 2016/17.

3.4 Staffordshire County Council and CCG's have not yet agreed the funding, as part of this the plan has now entered a national escalation process.

4.0 **Disabled Facilities Grant**

4.1 In line with the national approach taken in 2015-16, the Disabled Facilities Grant (DFG) will again be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing.

4.2 SCC and DCs are discussing: eligibility criteria and core standards for DFG funded services as well as the amount of the DFG uplift that needs to be set against SCC liabilities that were formerly set against the social care capital grant.

5.0 **Link to Strategic Plan**
The Better Care Fund is recognised as a priority within our business plan.

5.1 **Link to other Overview and Scrutiny Activity** N/A

5.2 **Community Impact** N/A

5.3 **Contact Officer**
Name and job title: Alex Jones, Project manager
Telephone No: 01785 277915
Address/email: Alex.Jones@staffordshire.gov.uk

Appendices / Background papers
Annex 1 - Staffordshire BCF plan
Annex 2 - BCF schemes
Annex 3 – Draft Financial Schedule – to follow

Staffordshire Better Care Fund

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

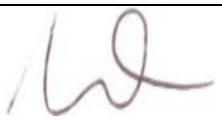
The CCGs together are coterminous with the County Council, subject to the usual differences between resident and registered populations

Total proposed value of pooled budget	2016/17	A minimum of £50,953,000 with the total pooled budget of £99,528,236.

Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	Stafford and Surrounds CCG
By	Andrew Donald
Position	Accountable Officer
Date	

Signed on behalf of the Clinical Commissioning Group	Cannock Chase CCG
By	Andrew Donald
Position	Accountable Officer
Date	

Signed on behalf of the Clinical Commissioning Group	East Staffordshire CCG
By	 Wendy Kerr
Position	Chief Finance Officer
Date	4 May 2016

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

Signed on behalf of the Clinical Commissioning Group	North Staffordshire CCG
By	 Marcus Warnes
Position:	Accountable Officer
Date 03.05.2016	

Signed on behalf of the Clinical Commissioning Group	Stoke on Trent CCG
By	Andrew Bartlam
Position	Accountable officer
Date	

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

Signed on behalf of the Health and Wellbeing board	Staffordshire Health and Wellbeing Board
By	Dr Charles Pidsley (Co-Chair)
Position	Co-Chair of Health and Wellbeing Board
Date	To follow

Contents

1. Progress in 2015/16

The Better Care Fund (BCF) Plan for Staffordshire consisted of a range of schemes designed to deliver the six priorities set out below:

- Focussing on **frail elderly pathways**, as the core element of our quality and Sustainability challenge.
- 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.
- **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**.**

The agreed approach to the BCF recognised that the majority of the funding was already committed to core services, therefore a virtual pool was formed recognising current contractual commitments. The consequence of this approach was that no additional "new money" was committed to the BCF and change has been complex and slow to achieve.

Some incremental changes have been delivered and a more integrated approach to service development and commissioning has begun to develop. Concern about the one year nature of the plan also has had an impact on partner's ability to take more risks.

The partnership recognises that the BCF plan is a key priority of our system transformation and has reconfirmed its shared commitment to integrated working. Since submitting our initial plan we continue to revise and review to improve our plan and this approach has been used to inform the 2016/17 submission. In particular, lessons have been learnt from the development and implementation of the existing plan. The operating and governance environment have been strengthened and a shared understanding of the financial challenges are clear. This work has been further enhanced and links directly with the development of the Staffordshire-wide Sustainability and Transformation Plan (STP). The Staffordshire wide STP includes Stoke on Trent Clinical Commissioning Group and City Council.

2. Local vision

Local vision for health and social care services (B.1.i)

> **"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)**

As part of the BCF review the local vision for health and social care remains highly relevant and appropriate for the area.

As a whole system, Staffordshire and Stoke-on-Trent are committed to building upon current delivery arrangements reviewing what is effective, complementing this work with a strong evidence base and enhancing this approach with the use of the positive contributions our community can make to service development and the delivery of care. This approach will seek to maximise people's assets, those of the community and to galvanise the voluntary sector. This will recognise the importance of a primary prevention approach that provides and enhances community resilience, providing readily available information and advice, building upon natural communities affording a local response that maintains and promotes self-management through local supports and services.

Delivery of the BCF vision will be through our natural communities and localities. This we believe will bring greater ownership and co-production allowing delivery to reflect local needs and assets. The approach will be person centred and integrated at a primary care level. The focus will be on population health, reducing demand and enabling patients and service users to be active participants.

People will be empowered to assume greater control, to understand alternative choices, to support self-management before the need to access formal services of a secondary health and social care nature.

For those whose needs require health and social care interventions, we will develop an integrated single point of access (Front Door), expanding the remit of the current service, that will triage and route people appropriately following assessment to support planning that again reinforces assets, choice and control and support that promotes enablement and reablement.

Effective alignment of intermediate care and reablement across health and social care will need to challenge all existing models and consider new delivery vehicles and options. This will maximise independence, support the recovery from illness and actively enable people to return to optimal levels of functioning. This includes, but is not limited to the treatment and support of people in times of health or social care crisis to avoid hospital admission and to support hospital discharge.

The underlying causes of delayed discharge are consistent throughout Staffordshire and in acute trusts over the Staffordshire borders, these include delays as a result of patient choice, long waits for assessments, limited capacity to provide care packages, nursing/residential home placement, housing issues and capacity/availability of community teams. A new scheme Discharge/delayed transfer of care will build upon existing work in place overseen by System Resilience Groups' across Staffordshire mainly North Staffordshire/ Stafford and East Staffordshire.

We are seeking a coordinated approach to ensure that people receive appropriate care and support that is seamless, appropriate, timely and targeted in nature. The size and scale of Staffordshire equally means we are utilising as indicated natural communities but established administrative boundaries to co-ordinate a personalised approach, importantly district councils are playing a part – recognising the importance of housing to deliver effective community care.

Within context of longer term strategic health and care planning (B.1.ii)

The BCF Plan remains a key catalyst for Health and Social Care working with other partners, to establish a complementary approach to whole systems working that builds upon approaches and infrastructures that are already part of the Staffordshire and Stoke-on-Trent landscape. The BCF has provided the opportunity to develop shared understanding, to adopt agreed objectives and to drive changes that are systems wide. The above vision is embraced by the whole system and the challenge is to deliver this in a way that is consistent but affords sensitivity to the geographical make-up of the footprint that is Staffordshire. We will learn through collaborative practice and continuous re-evaluation and this will drive the changes that we are seeking to capture.

We do recognise that pace of change needs to increase however; this pace of change needs to align with the timescales set out within the STP. The BCF remains a key driver to galvanise the whole system to understand the challenges to be addressed. The vision remains firm, it is both locally and nationally evidenced based, and we will seek to ensure a coordinated and consistent approach that seeks to maximise available resources and delivers the outcomes that people require.

Changes to be delivered through the BCF (B.1.iii)

Implicit within the above is to provide a holistic local integrated service which is capable of fully meeting the typical health and social needs of a local population. Key elements to this approach are:

- Building multi-disciplinary core teams of health and social care professionals co-located where possible.
- Specialist services available to support the core team to meet individuals need in the community including mental health.
- Direct partnership work with primary care.
- Close partnership working with voluntary sector and local community.
- Accurate and up to date information and advice available in a timely manner to aid self-management. This will in turn reduce, prevent and delay the need for high intensity services.
- Effective coordination and seamless pathways for people reduce the number of duplicate visit and service efficiencies.

We envisage that this model can be developed further in order to improve the interface with primary and acute care services. In addition this will seek to further localise services so that the approach is comprehensive, complementary and integrated in nature embracing primary prevention, community and secondary services and acute, tertiary service provisions. We will build upon the current connections to community and voluntary services as well as the third sector to promote and enable self-management, choice and control at a local level maintaining independence. Services will be redesigned and re-specified to ensure enablement and reablement are fully integrated across health and social care. This re-specification will build upon our current position and further reinforce outcomes rather than outputs, ensure people are at the centre and in control and that we can evidence that

services are proactive rather than reactive or maintenance in nature. We will embed within governance underpinning formal partnership agreements and schedules that define and specify services.

Workforce transformation is critical to this process, we will further seek to ensure workforce capability and capacity is deployed to support culture and behaviour changes. Additionally, we will seek the views of patients in order to gain feedback on their individual experiences and this will further be used to inform the longer term changes required to deliver the enhanced community offer.

The change envisaged is a new "Staffordshire offer" that will develop and align with primary care as the focal point.

BCF changes / schemes set out (B.1.iv)

Summary of schemes within previous and new BCF plan

15/16 schemes	16/17 schemes	Rationale
Front door	Front door	No change, this scheme will encompass both health and social care.
Integrated Locality Community Teams - Managing Dependency on Services	Enhanced community care model	Building upon current work area achievement with ILCT's taking into account MCP model and other models across Staffordshire.
Integrated Locality Community Teams - Managing Safe return to steady state	Reablement/intermediate care	Recognition of a key element of the SSOTP transformation was reablement in 15/16. Intermediate care and reablement have been brought together under a single scheme.
	Discharge/ Delayed transfer of care	Some work has been delivered as part of managing patients back to Integrated Locality Community Teams - Managing Safe return to steady state. The 16/17 plan has been undertaken in line with local systems resilience groups.
Enabling schemes	Enabling schemes	No change.

The BCF remains a key driver to progressing the Enhanced Community Offer described above and we would seek to develop and implement a re-engineered front door. This would resolve more people's needs at the point of contact and a significant reduction in the number of people who move from contact into community health, social care and secondary services. This will require the release of resources currently being utilised within secondary care services.

Supporting individuals to maximise their independence by diverting individuals through self-help and early solutions; avoiding inappropriate attendance at A&E service and/or referrals into social care services.

Reablement and intermediate care that is coherent, coordinated and integrated to ensure we maximise people's abilities, by promoting targeted, intensive and appropriate care and support interventions that realise the potential for independent living. In essence services that are joined up delivered to the right people, at the right time and in the right place, afford rapid access to prevent avoidable admissions and support appropriate and timely discharges.

Effective discharge planning which supports the urgent care system including reducing delayed transfers of care. Plans are already in place managed by the relevant SRG's and work is on-going to ensure alignment between SRG plans and the BCF programme schemes.

The above is complemented by a myriad of health and social care services, all interlinked and promoting continued independence, whether support to cares, integrated community equipment services, Disabled Facilities Grant to adjust living environments, technology enabled care services aiding wellbeing and independence and contracted services that afford domiciliary care and support.

3. Case for change

Data driven explanation of issues the BCF plan is addressing (B.2.i)

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)
- 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).

Older people, >65, account for the majority of general hospital users (65%); frail older people in the acute care setting represent a low volume, high impact group; they have the longest length of stay, the highest rate of inpatient complications and subsequent re-admissions. At any one time, patients in this group account for 70% of bed days. Many older people with multiple medical problems are also frail. Too often, for many older people, a stay in hospital is disempowering: the environment itself, the noise, and the routines on the wards overwhelm and undermine them in ways that affect their ability to recover to how they were living before they were admitted.

In terms of growth, 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-

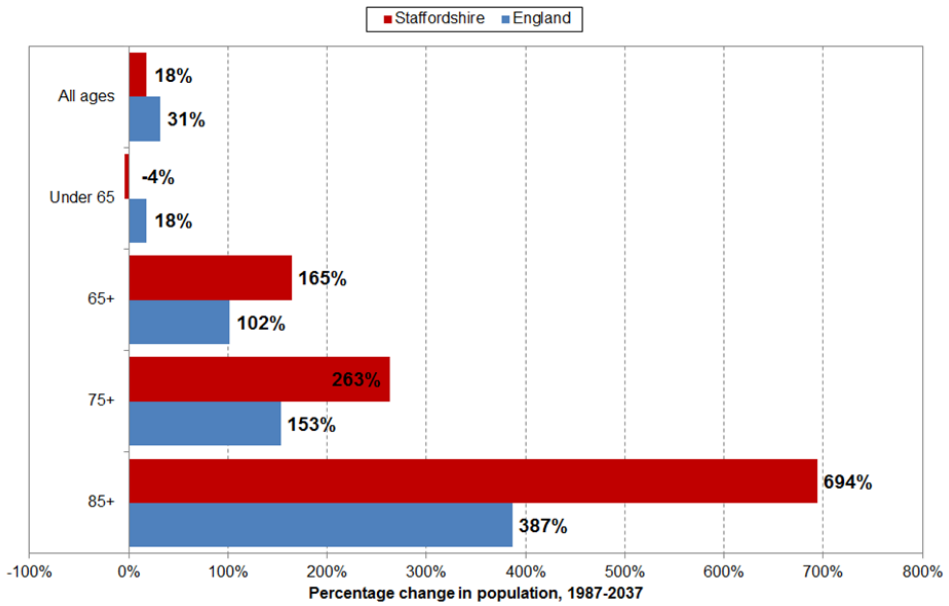
fold between 1987 and 2037. Over the same period, the number of working adults (who may be expected to care for their elderly relatives) will reduce.

The table below, drawn from ONS population data, provides a 5 year projection for the population aged 75 and over across Staffordshire:

Year	75-79 Forecast	80-84 Forecast	85-89 Forecast	90+ Forecast	Total
2014/15	68,000	47,200	28,400	16,200	159,800
2015/16	69,100	48,400	29,500	17,200	164,200
2016/17	71,000	50,200	30,600	17,900	169,700
2017/18	74,000	52,200	31,500	18,900	176,600
2018/19	77,900	54,400	32,800	19,600	184,700
2019/20	81,700	56,100	33,600	20,700	192,100

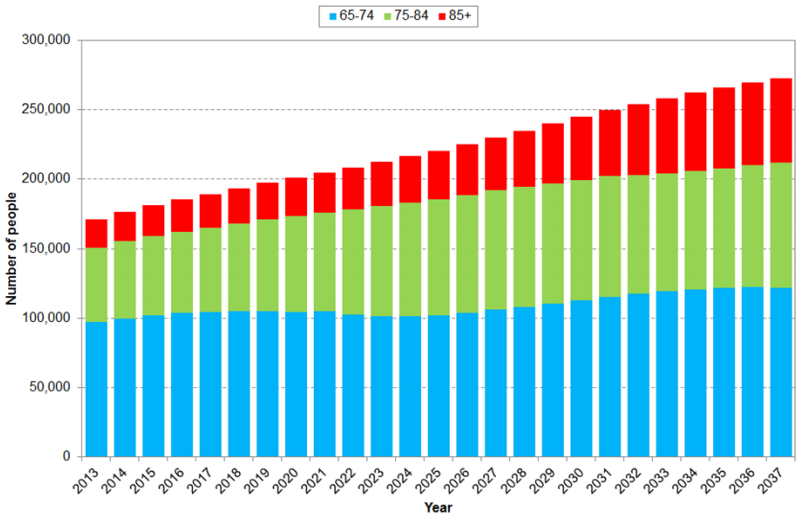
Future Change in Population

Percentage change by age group, 1987-2037

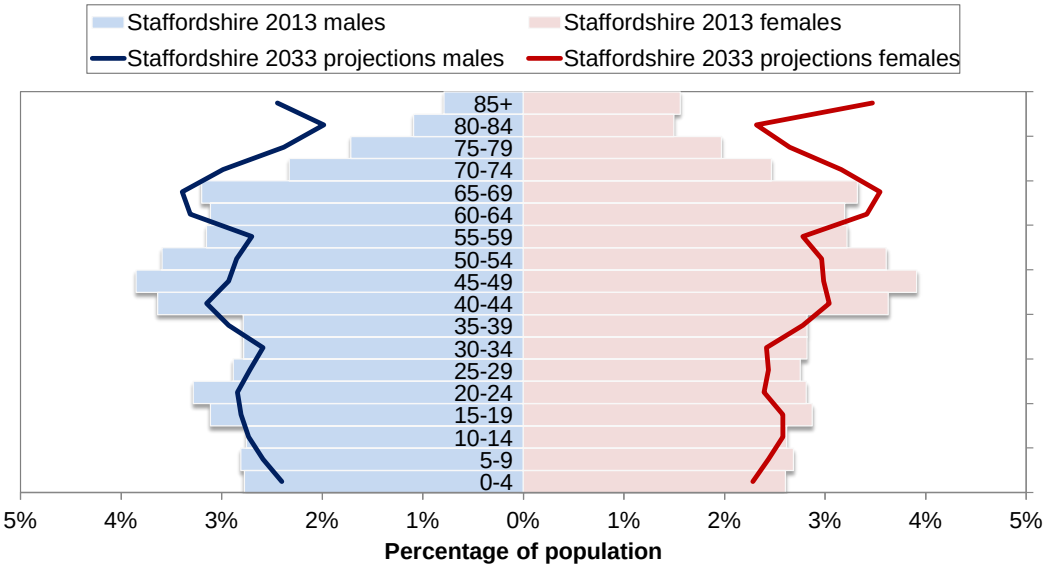


The impact on the care system of this decrease in the working age population will be exacerbated by the improving economic climate, such that people may have less time available in which to provide care to their own relatives and there will be greater employment competition for people who might otherwise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

Staffordshire population projections by age group, 2013-2037



The changing Staffordshire population pyramid



There is wide spread recognition that we have an ageing population; overall the population is predicted to increase by 6% from 2008–2037 with the over 65's cohort increasing by 58%.

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). There are 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.

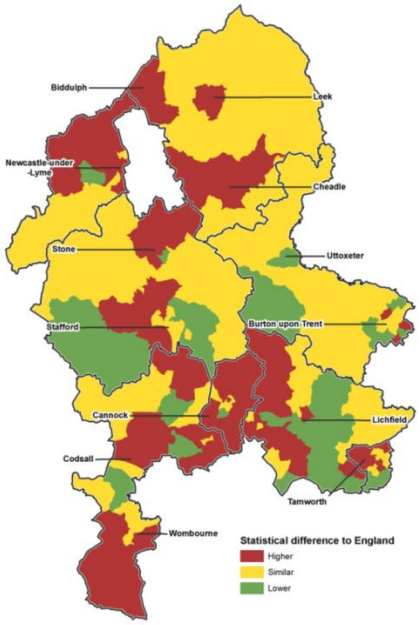
Current and projected numbers of selected health conditions and supported care arrangements for people aged 65 and over in Staffordshire

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



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.

An analysis of data has confirmed that during 2013/14 over 65's made up 23% of all A&E attendances, in addition, the over 65's accounted for 46% of all attendances by ambulance, 47% of admissions to wards and 75% of deaths in the A&E Department.

In comparison the overs 75's made up 14% of all A&E attendances, accounting for 32% of attendances by ambulance, 33% of admissions to wards and 52% of deaths within the A&E Department.

Non-elective admission costs for this cohort of over 65's equated to £51m during 2012/13; this is projected to increase to £53m in 2017/18 and if no changes are implemented £71.5m by 2037.

In addition to this we know that the evidence suggests that there is a significant relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. Gill et al (2008) observed that 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over the age of 80.

If the health economy does not react between now and 2019 we will face a 14% increase in the number of non-elective beds required, an additional 4500 non-elective admissions and 71% of all activity for over 65's will be for patients over 75yrs. These significant increases in care highlight the need to act now and implement changes to the way we care for this population moving forward.

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%

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 Staffordshire-wide health economy, as currently configured for long term condition care, is not sustainable in the face of these projected future increases in co-morbidity and the level of need predicted.

The answer to the problem cannot simply involve a shift in the geographical location of services - i.e. delivery within the community rather than in a hospital. Moving forward, 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.

Local opportunity identified (B.2.ii)

The overall financial challenges confronting health and the local authority is such that we are actively seeking to challenge established working practices, to learn through experience and from elsewhere, to listen to users, carers, partners and providers, to develop measures that will balance better outcomes and achieve cost reductions. This recognises the scale of the financial challenge and the conflicting priorities for each respective commissioning organisation. The enhanced working together through effective coordination will assure better outcomes and the best use of available resources. This will however not reduce costs but respond to the growing demands confronting services. An example of greater efficiency and effectiveness would be the re-specification of the existing reablement service which both supports maintaining individual's independence and thus avoiding hospital admissions and also supports individuals following on from an illness to reduce the need for long term domiciliary care packages/residential/nursing placements. In order to ensure that resources are targeted in the right way we will prioritise provision for reablement care for example for people who:

- Are at risk of admission to hospital which could be avoided through this provision.
- Are at risk of a delay in their discharge from hospital which could be facilitated through this provision.

- Are at risk of admission to a Residential Care Home which could be avoided through this provision.
- Have requested an assessment for a Social Care provision, the intensity of which could be reduced through the provision of this service, or no longer required because they are likely to recover during this intensive period of support.

Local narrative set out (**B.2.iii)**

The Enhanced Community Offer is the bedrock of the Staffordshire BCF and will afford a localised and personalised service that builds upon both natural communities and registered practice populations. This recognises the size, scale and complexities of the geography, demographics and organisational footprints operating within Staffordshire and Stoke-on-Trent. Our approach seeks to be bespoke but equally consistent so that we are equitable in our responses to people's needs. We are endeavouring to maximise what is part of the fabric of Staffordshire, to harness, to enhance and to complement with responsive services that bring together primary, social care and secondary health services. This is about understanding differences, recognising the value of such and creating an overall blueprint that will guide how services are provided within local footprints.

Case supported by use of data (**B.2.iv)**

Staffordshire has proactively sought to increase understanding and awareness of the operating environment to assure best use of available resources, to identify areas of unmet need, performance and qualitative issues. This has involved a number of external commissions, including KPMG, allied to residential and nursing care home and domiciliary care home provisions. These reports will complement intelligence held by commissioning organisations across health and social care to inform our schemes.

Staffordshire Priority schemes

Scheme 1 - Front Door

To create a hub of IAG that enables citizens to access the right support at the right time.

- Implementation of a new sustainable model that includes a professional support team.
- To reduce the number of citizens being referred to formal or statutory assessment.
- To create a first point resolution service with a timely response to customer queries.
- Encourage self-help & support utilising and developing the tools and services available to provide robust preventative interventions

Scheme 2 – Enhanced community care mode

Increase independent living & self-management and reduce and shorten hospital admissions

Improve identification of local populations and their associated profiles allied to health and wellbeing risks.

Creating efficient and effective interventions and pathways that reduce dependency.

Delivering interventions at the right time in the right place by the right skill set, maintaining people at their highest level of independence.

Improve the experience of local citizens and their carers.

Scheme 3 – Reablement/ Intermediate care

Effective alignment of intermediate care and reablement across health and social care. This needs to challenge all existing models and consider new delivery vehicles and options.

There will be a model of Intermediate care which will maximise independence, support the recovery from illness and actively enable people to return to optimal levels of functioning. This includes, but is not limited to the treatment and support of people in times of health or social care crisis to avoid hospital admission and to support people following an inpatient episode.

Scheme 4 – Discharge/ delayed transfer of care

The strategic objective of this scheme is to apply the Home First principle which includes:

- Develop Discharge to Assess (D2A) pathways.
- Improve the Fast Track pathway (patients requiring palliative care)
- Improve discharge process across organisational boundaries with a designate lead for discharge.

4. Overview of schemes

See Annex 1 for detailed scheme descriptors

5. Programme management, governance, milestone plan, risk log

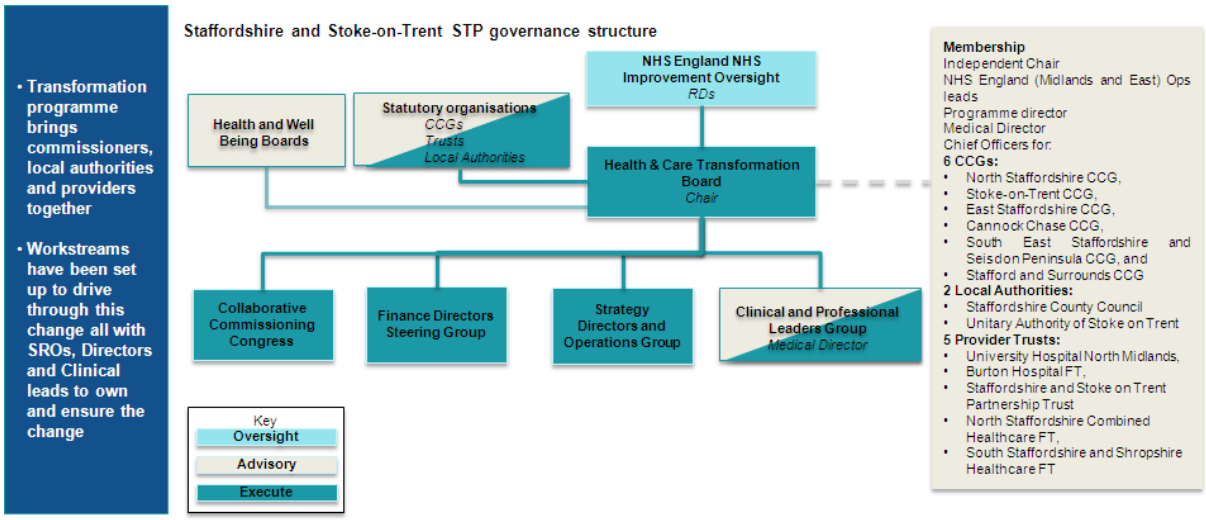
BCF governance and accountabilities set out (B.3.i)

It is anticipated that the current BCF Partnership Board will continue to meet on a monthly basis to ensure the delivery of the Staffordshire BCF plan and as a requirement of the Section 75 agreement. The BCF Board is accountable to the Health and Wellbeing Board who is accountable for the BCF plan.

The diagram below gives an overview of the current arrangements and the key responsibilities of the group can be found in B.3.iii.

It is recognised that the governance and accountability arrangements for the BCF will need to be reviewed and aligned to those that have been agreed to support the delivery of the Sustainability and Transformation Plan. It is anticipated that both the Staffordshire and Stoke-on-Trent BCF's will be integrated into the STP work programme. The precise detail and nature of this is to be finalised as partners would not wish to lose the commitment the BCF has established in particular health and social care integration and prevention.

The Sustainability and transformation Plan (STP) has a clear programme of activity that needs to be completed through 2016/17. It is anticipated that the BCF will be delivered through this programme of work. The current governance arrangements are as follows: -



BCF management and oversight set out (B.3.ii)

The BCF programme team has an established programme management approach for the schemes included in the plan, through this it records the source and application of funding for each scheme and the programme as a whole, specifies outcomes required and how they will be measured, allocates accountability for delivery of each outcome and scheme, reports on performance and supports a system leadership group.

Joint working arrangements set out (B.3.iii)

Joint working is promoted and supported on a number of levels in terms of formalised meeting structures, co-location of commissioning staff to aid communication and coordination of agendas, formal joint commissioning and contracted services.

Responsibilities	BCF Partnership Board	Implementation Group/ Task and Finish Group
Annual Review		
Sign-off the BCF Annual Review Report	X	
Commission the BCF Annual Review Annual Report		X
Deliver the BCF Annual Review Report		X
Risk		
Develop and maintain a Partnership Risk Register		X
Manage strategic risk, holding the Partnership to account.	X	
Manage the collective BCF risks within delivery of the BCF Plan (escalation and reporting to PB as appropriate)		X
Manage risk at an individual Scheme/ National Condition level (escalation and reporting to Implementation Group as appropriate)		X
Schemes and National Conditions		
Maintain a strategic overview of the implementation and performance of the individual BCF Schemes and National Conditions, holding the BCF Partnership to account	X	
Ensure the effective delivery of the BCF Plan escalating issues to the Partnership Board as required		X
Securing all necessary resources, drive the delivery of the BCF Plan and planned outcomes and benefits		X
Performance		
Monitor and manage high-level financial and operational performance	X	
Develop, manage and report key performance indicators		X
Review and challenge key performance indicator results	X	
Develop and approve BCF KPI reports to be submitted to the Partnership Board		X
Make strategic decisions based on the BCF KPI reports	X	
Commission Scheme audits where there are performance or contractual compliance concerns	X	
Review any Scheme audits undertaken		X
New Schemes		

Approve the implementation of new BCF Schemes, considering recommendations from Implementation Group	X	
Consider Business Case proposals for suitable new BCF Schemes	X	
Sanction Variations to the original BCF Section 75 that may be required by virtue of any new BCF Schemes approved	X	
Develop Business Cases for new BCF Schemes		X
Contract Change		
Sanction variations to the Partnership	X	
Sanction any formal Contract Change requirements	X	
Consider and subsequently recommend Changes to the PB regarding the Agreement and consider any implications (financial or otherwise) which flow from such proposed Change		X

BCF plan milestones set out (B.3.iv)

See milestone plan set out below

Scheme 1 - Front Door		
Pilot underway and impact analysis undertaken	Jun-15	Mar-16
Options paper	Mar-16	May-16
Implementation	Apr-16	Jun-16
Alignment between social care programme of work and NHS programme of work	Apr -16	May -16
Primary and Secondary Care Self-help and Independence Pilots		
GP pilot	Nov -15	Sept –16
Secondary care pilots	Feb -16	Feb-17
Evaluation of pilots	Oct-16	Nov-17
Roll out	Ongoing	ongoing
Primary and Community Care Information and Advice Line		
Baseline data/ Scheme KPI's and Outcome measurements agreed	Mar 2016	June 2016
Targeted promotion/ GP adoption strategy rolled out across all CCG areas	June 2016	March 2017
Business Design/ service capacity work	Oct 2016	Feb 2017
Final evaluation and Recommendations	Feb 2017	March 2017
Scheme 2 – Enhanced community care model		
Milestone	**Start Date**	**End Date**
Task and finish groups identified to enable practitioners to improve integrated working.	Jan-16	Jun-16
Operational delivery groups formed to develop relationships across sectors and start shaping local delivery.	Jan-16	Apr-16
Governance across Staffordshire under the together we're better transformation programme to be confirmed.	Jan-16	Mar-16
Data sharing agreement and memorandum of agreement developed and agreed by partners.	Feb-16	Sep -16
Mapping exercises undertaken to identify baseline information for the locality teams.	Feb-16	Jun-16
Evaluation of Community Wellbeing model and Vanguard sites visited to understand key learning points and consider for the Staffordshire model and its implementation.	Jan-16	Apr-16
Interdependencies and other key work streams across the local health economy to be understood to enable the models implementation.	Feb-16	May-16
Integrated systems, processes and pathways to be developed by practitioners with localities.	Feb-16	Sep-16
Communication and engagement plan considered to ensure key stakeholders are aware of the early implementer sites and the intended outcomes.	Feb-16	Apr-16
Implement new ways of working across the locality.	Apr-16	May-16
Evaluate the learning from the locality prior to considering future commissioning intentions and potential roll out.	Apr-16	Sep-16

Scheme 3 - Reablement/Intermediate care		
Milestone	**Start Date**	**End Date**
Financial modelling	Mar-16	May-16
Productivity benchmarking & comparison (KPMG)	Mar-16	May-16
Approval (Programme Board)	Apr-16	Jun-16
Implementation Plan	Apr-16	Jun-16
Mapping As Is - LIS/CIS/Intermediate care	Apr-16	Jun-16
Confirm funding streams	Apr-16	Jun-16
SCC advice re period of reablement (6 weeks or 12 weeks)	Mar-16	May-16
Review best practice	Mar-16	May-16
Remodel reflecting approach to maintenance care	Mar-16	May-16
Option appraisal	May-16	Jul-16
Approval SSOTP Programme Board and Integrated Commissioning Board	May-16	Jul-16
Implementation Plan	Jun-16	Aug-16
Procurement Process	Jun-16	Aug-16
Scheme 4 - Discharge/ Delayed transfer of care		
Milestone	**Start Date**	**End Date**
Roll out exemplar ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in acute hospitals	Nov - 15	Jan-16
Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in community hospitals	Nov - 15	Jan-16
Roll out Exemplar Ward (safer bundle) principles, where appropriate, in the mental health trust	Dec - 15	Feb-16
Align and improve discharge processes for South Staffordshire patients treated at Royal Stoke	Jan - 16	May-16
Plan for discharge within 48 hours for emergency admissions	Jan - 16	Mar-16
To have accurate and timely information related to discharge of patients with complex needs and use it to forward plan	Dec - 15	Feb-16
Establish a multi-agency accelerated discharge team	Dec - 5	Feb-16
Medical ownership of speciality outlier	Sep - 15	Nov-15
Develop 'without prejudice' agreements between health and social care to enable patients to move into a care home placement for assessment	Jan - 16	May-16
Work with Care Homes to assess previous residents within 24 hours	Feb - 16	June-16
Roll out of trusted assessor model across the health and social care economy	Feb - 16	June-16
Develop a single health and social care direction of choice policy	Jan - 16	May-16
UHNM will operate 3 community hospitals for step down and the management of patients from admission to final destination	Jan - 16	May-16
Reduce the number of care packages held open when people are admitted to hospital	Feb - 16	June-16
Increased supply of domiciliary care within North staffs	Dec - 15	May-16
Reduce the amount of time taken for residential and nursing care	Dec - 15	May-16
Increase capacity in Domiciliary care	Nov - 15	Mar-16

Risk log in place (B.3.v)

Annex 2 shows the risk log which is in place.

6. Governance around s75

Discussions are still on-going around the financial aspects of the BCF including the protection of social care. Once agreement has been reached a s75 will be developed in line with national timeframes. It is envisaged that elements of the existing s75 risk sharing agreement will continue due to existing contracts being in place. Existing arrangements anticipated to remain are detailed below.

Risk share / contingency identified (B.5.i)

As per the BCF Section 75 Risk Share Agreement, individual parties retain the responsibility and risk associated with their own contracts until such time as they are decommissioned and then re-commissioned as appropriate jointly through the BCF. At this time risk sharing agreements will be developed.

In terms of the pooled funding arrangements there are no additional risks as a result of the pooled arrangement.

Evidence of how risk share / contingency has been calculated (B.5.ii)

Unless otherwise agreed by the Partners and during the Review Period, the Partners will retain the responsibility and risk and benefits associated with Service Contracts (including Underspends and Overspends) where they are party to that Service Contract as a Commissioner until such time as the Partners agree that the Review Period has been concluded. For the avoidance of doubt this shall include the original commissioning Partners bearing risks associated with inflation, uplifts, Tariff deflation and efficiency targets as set out in the original arrangements for these services.

Where the Partners jointly enter into a Service Contract with a provider in respect of Services to be delivered in connection with the Individual Schemes, gains shall be shared on a 50% (Council) and 50% (CCG) basis (to be apportioned between participating CCGs as agreed by them). Risk share in respect of any such Service Contracts shall be agreed by the Partnership Board.

In terms of the Payment for Performance element this was not transacted for the 15/16 BCF and as a result of national changes will not be included in the 16/17 plan.

Non-financial risk sharing set out (B.5.iii)

Risk log set out in Annex 2 which includes service risk to clients.

Overall risk sharing approach and mechanisms set out (B.5.iv)

Where variations are made to Individual Schemes or new Individual Schemes are approved, risk share and performance arrangements for those Individual Schemes will be agreed by the Partnership Board and Schedules 3 and 5 shall be reviewed and updated accordingly.

7. Engagement

Engagement of health and social care providers set out (C.1.ii)

Notwithstanding the integrated approach set out within this document in order to deliver the BCF vision the financial arrangements that underpin the BCF are complex and challenging to resolve. This has created a series of interdependent risk. In order to understand and mitigate these an on-going dialogue has been established with acute and community NHS providers about the impact of the schemes and agreement about the model. The BCF risk register is being used to capture these to ensure appropriate mitigations are in place, of note is the potential reduction in community service funding.

Engagement of providers (C.1.iii)

Engagement events have been held with providers, these have included staff events, dialogue through the community transformation team and SRG. These have focused on establishing a service model for the "front door" scheme, defining the enhanced community offer and reablement/intermediate care.

Specifically for scheme 4 – discharge, this is part of the existing programme of work which is overseen by the System Resilience Group. System leaders from both providers and commissioners have contributed to the plan and continue to oversee delivery against the plan.

The table below gives an overview of the schemes, providers engaged with and the forum utilised to achieve this.

Scheme	Providers engaged with	Forum
Front door	Community service provider, primary care,	Existing transformation programmes of work
Enhanced community care model	Primary care, voluntary, acute providers, community services providers, mental health service providers	Engagement events as part of Together Were Better Programme (STP)
Reablement/Intermediate care	Community services provider	Existing transformation programmes of work
Discharge/Delayed transfer of care	Primary care, voluntary, acute providers, community services providers, mental health service providers	System Resilience Group's (SRGs) • Northern Staffordshire (including Stafford) • East Staffordshire

Assessment of future capacity and workforce requirements set out (C.1.iv)

As observed across England, Staffordshire has a series of workforce challenges that have the potential to affect different parts of the health and care workforce, and as such these will need to be addressed through transformation. It is important to recognise that this challenge is not necessarily work force numbers rather ensuring that the appropriate staffs (skills and ability) are available to support the delivery of the revised schemes and their impact on the wider health and social care system.

Key areas identified through our redesign work include:

- The capacity of wider primary care to deliver information, advice and guidance to support individual's decision making and access to appropriate urgent care advise.

- Alignment with the emerging new models of primary care required to address GP workforce capacity, sustainability and demand supported by the GP Forward View

- Within a number of disciplines the current workforce model is over reliant on temporary/agency staff to fill long term vacancies, this is being compounded by planning assumptions of increasing elective and non-elective demand. There are currently more than 600 vacant posts for qualified nurses in Staffordshire and Stoke-on-Trent. The use of agency and temporary staff to cover such gaps has become the norm, with the result that continuity of care is harder to achieve and costs have spiralled. As well as nursing vacancies, there are shortages in other key professional groups such as physiotherapists, speech and language therapists and radiographers, Medical consultants and middle grade doctors. Our acute trusts face problems recruiting consultants and middle grade doctors, especially in elderly care, radiology and acute medicine. New immigration rules have made overseas recruitment to fill these vacancies more difficult. There is an urgent need to consider the use of new and extended roles, such as physicians' associates, which are potentially more attractive to a wider range of professionals and can work with patients in a variety of settings.

- Care workers Staffordshire and Stoke-on-Trent social care services report significant difficulty recruiting and retaining care workers for both care homes and in the community. The introduction of the National Living Wage has had an impact on provider costs.

Implications for local providers (C.1.v)

The financial challenges that both health and social care commissioners have, has resulted in potential changes within local contracts impacting on local providers. Health and social care commissioners are sharing potential changes ensuring where possible that decisions impacting on the providers are made in conjunction with each other.

The implications of the local community offer and the opportunity it offers to improve outcomes has been set out in the STP case for change which has been shared with the health and wellbeing board. The potential reduction of social care services in 16/17 onwards is currently under assessment and will be shared with the health and wellbeing board, scrutiny and CCG governing bodies. This will also include an assessment of impact on the workforce.

Engagement of local housing authority representatives (C.1.vi)

The Disabled Facilities Grant is for the provision of adaptations to disabled people's homes to help them to live independently for longer. Following the approach taken in 2015-16, the Disabled Facilities Grant will again be included within the Staffordshire Better Care Fund. This reflects our strategic thinking about the use of home aids/adaptations, use of

technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing.

For 2016/17, the funding in the pooled fund allocated to Disabled Facilities Grants is £6.869m, a substantial increase from 2015/16 of £3.065m. Nearly £2m of this increase results from the concentration of the social care capital grant into the Disabled Facilities Grant. The aim of the Disabled Facilitates Grant is to support people to remain independent in their own homes and thereby reducing or delaying the need for care and support, and improving the quality of life of residents. The statutory duty on local housing authorities to provide aids and adaptations under the Disabled Facilities Grant to those who qualify will remain.

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.

As with all other funding pooled through the Better Care Fund the Disabled Facilities Grant plans will be jointly developed and agreed with all relevant partners of the Staffordshire Better Care Fund including the district and borough councils and may ultimately include investment of some of this funding in broader strategic capital projects whilst also recognising the statutory duty of district councils and borough councils around meeting criteria of the Disabled Facilities Grant including to provide adaptations to the homes of disabled people, including in relation to young people aged 17.

A Health and Housing partnership group has recently been formed bringing together partners across CCGs, Staffordshire County Council, Boroughs and districts and the voluntary sector. The group has undertaken a scoping exercise and has identified priority areas including hospital discharge and keeping people safe and independent in their own homes including warmer homes. Local housing representatives have been involved in developing and agreeing the plan, this has been to ensure a joined up approach to improving outcomes across health, social care and housing. The health commissioner lead is also a member of the health and housing partnership group and will ensure synergy between the two groups. In addition within Northern Staffordshire a local health economy/Stafford group has also been formed bringing key providers across health and housing to support the implementation of any delivery plans as a result of the work undertaken by the health and housing partnership group and the BCF.

The Disabled Facilities Grant will continue to passport through the Staffordshire Better Care Fund to the District and Borough Councils and overseen by the Health and Housing partnership Group.

8. National conditions

Maintain provision of social care services

Approach to supporting social care set out (C.2.v)

Definition of support set out and agreed (C.2.vi)

Consideration of impact of set definition (C.2.vii)

Comparison to 2015-16 set out (C.2.viii)

Consistency with DH guidance confirmed (C.2.viiii)

Protecting social care services is not the same as maintaining the current expenditure levels, or continuing the existing configuration of service delivery. Nor is it simply about a narrow provision of social care system in isolation from the wider health and social care system. We recognise the need to work collectively to join up our existing transformation plans and, using these as a foundation, developing a further ambition to establish truly integrated solutions that meet the needs of Staffordshire people.

As outlined in our Joint Health and Wellbeing Strategy (2013-18), we are agreed that protecting social care services in Staffordshire relates to ensuring that those in need continue to receive appropriate level of support they need, in a time of growing demand for health and social services and increasing budgetary pressures on councils and CCGs. We 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 early intervention will mean that individuals will be less likely to require longer/more complicated packages of support and care In many cases, this will require a new way of looking at ensuring people's needs are met, with consequent implications for service redesign.

There continue to be huge pressures on Adult Social Care budgets across the country as a result of significant and sustained year on year funding reductions to the County Council. The County Council has already made significant savings of more than £150m in recent years to enable social care outcomes to be maintained. Whilst this is a significant achievement, more savings will need to be delivered in the coming years.

In recognition of the substantial financial pressures on Adult Social Care some £12m additional investment was put in for 2015/16 and a further £6m for 2016/17. The council has also opted to undertake the 2% social care council tax levy in recognition of the continuing

severe pressures on Adult Social Care thereby avoiding deeper reductions to social care budgets to the value of c.£6m in 2016/17. The latest Medium Term Financial Strategy includes savings for Health and Care of £15m in 2016/17 rising to £31m by 2020/21.

Services are also now experiencing a range of new cost pressures such as the introduction of the National Living Wage and pension reforms. In recognition of the potential for this to have negative consequences for the NHS, one of the six national conditions for the Better Care Fund is that it is used to protect social care outcomes.

Funding allocated to the Better Care Fund under previous s256 transfers arrangements from NHS England (now via Clinical Commissioning Groups) to the County Council (£16.234m in 2015/16) and directly from the Clinical Commissioning Groups as part of the protection of social care arrangements in 2015/16 (£5m) has been used to enable the local authority to sustain the current level of eligibility criteria and hence to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs. In addition, funding has been deployed to ensure effective information and signposting is available to those who are not eligible for services under the care act.

In 2016/17 previous NHS s256 transfers of £16.514m will continue to support social care activity meeting the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14. However, the financial circumstances of the council mean that these funds are insufficient alone to maintain social care in its current form. 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.

Whilst there was an outline financial plan for the Staffordshire Better Care Fund - £6m expected to be delivered in 2015/16 (with bridging finance of £4m) has not materialised. In addition the cash discretionary contribution in 15/16 by Staffordshire CCGs (£5m) cannot be replicated in 16/17 onwards. This is primarily as a result of the financial difficulties being faced by Staffordshire Clinical Commissioning Groups. Discussions are still ongoing around the 2016/17 position between Staffordshire County Council and the Clinical Commissioning Groups supported by KPMG. As it currently stands there is no agreement around how the council deficit of £15m will managed however CCGs are committed to working with the council in order to mitigate any de-commissioning decisions that need to be undertaken.

Confirmation that an overview of funding contributions set out (A.3.iii)

Summary of BCF Expenditure

	Expenditure
Acute	£186,401
Mental Health	£2,980,324

Community Health	£62,625,516
Continuing Care	£9,797,650
Primary Care	£0
Social Care	£23,938,345
Other	£0
Total	**£99,528,236**

Please note that all of the values above are currently funding existing contracts including Continuing Health Care. Within 16/17 in line with the development of the schemes we will be developing business cases including reviewing current contractual arrangements and opportunities available to transform current practice.

Confirmation that plan includes consideration of changes and process (A.3.iv)

The pooled fund contributions for 2016/17 recognise the changes to the required minimum contributions for Staffordshire and national grant adjustments e.g. Disabled Facilities Grants and the social care capital grant including care act capital funding. The increase in the minimum contributions has been met in the main from re-designating the additional contributions. Aside from the above there is no further change to the pooled fund from 2015/16.

There is an expectation that the 2015/16 section 75 for the Staffordshire Better Care Fund will also in the main remain largely as is.

Confirmation that some assessment of the impact of changes has been conducted (A.3.v)

A desktop exercise has been completed which has allocated cash to schemes. As all funding is currently supporting existing contracts, any changes made will need to take into account any contractual obligations. In addition to this a full impact assessment will need to be undertaken before any formal decisions are made. This is in line with the 2015/16 s75 arrangements for risk share and funding transfers from the pooled fund and we envisage little change for 2016/17.

As the Better Care Fund will be part of the Sustainable Transformation Plan this is expected to be completed in line with national timeframes.

Agreement for the delivery of 7-day services across health and social care

Plan for providing 7-day services set out (C.3.i)

Some services are currently provided over 7 days, in a targeted and appropriate manner. The plan provides for monitoring and evaluation to determine which services can impact by enhanced coverage to demonstrate a real benefit to users and patients. This though will be

set within the context of available resources or disinvestments to achieve service redesign to affect enhanced coverage.

The GP forward view contains various commitments that will result in additional monies going into general practice, both over the short and long term. Whilst the GP Forward view does not state the level of capacity required on different days of the week and that it is a matter for local decision makers, 7 day working will be reviewed and the commitment of additional resources will support primary care.

A priority theme within the plan is the enhancement of reablement and intermediate care services which are based out of hospital to both prevent and avoid unnecessary admissions but to enable timely and appropriate discharges. The development of these services will consider the benefits of provisions across 7 days.

As described above the BCF plan places this at the heart of the change agenda that we are seeking to progress. This will be addressed in an integrated and coordinated manner as part of the enhanced community offer. The teams will be clinically based, coordinated by multi-disciplinary teams working to avoid hospital admissions and provide timely and appropriate discharges. This pathway will be complemented by integrated intermediate care services that will both prevent/avoid inappropriate admissions but assist discharge planning. The development of this position is dependent upon resources which will also apply to enhancement to 7 days a week coverage.

Approach to providing out of hospital service 7 days a week set out (C.3.ii)

The Local Health and Care Economy 7 day Services Group has been reviewed and refreshed and has stakeholders from:

- University Hospital of North Midlands (UHNM)
- Staffordshire & Stoke-on-Trent Partnership Trust (SSOTP)
- North Staffordshire Combined Healthcare Trust (NSCHT)
- South Staffordshire & Shropshire Healthcare Foundation Trust (SSSHFT)
- West Midlands Ambulance Service (WMAS)
- Stoke-on-Trent & Staffordshire Clinical Commissioning Group representatives (CCGs)
- Stoke-on-Trent & Staffordshire Local Authority representatives (LAs)

The Group is committed to the continued achievement of the 7 day working standards and sees this as a key improvement priority for the year ahead. The Vision set by the Group is:

'Providing the same level of health and social care services seven days a week across Staffordshire to achieve consistent outcomes

The Northern Staffordshire 7 day service envisages including acute services, mental health services, community services (bed and home based), GP's and social care services at each part of the patient journey to support and divert away from hospital services where an alternative location will be more beneficial.'

The group are currently undertaking a review of each organisation asking a set of key questions aligned to the Vision which will enable the group to develop a plan that will truly deliver 7 day services in key areas across the Local Health Economy.

In terms of contractual arrangements 7 day services are being factored into the reporting requirements across all health provider contracts. It will also be included in the SDIP's with each Provider where appropriate.

Impact of approach on discharge detailed (C.3.iii)

All acute providers are making appropriate progress towards 7 day working and have met their 2015/16 contractual obligations, through the 2016/17 contracting round our providers have been required to identify four additional conditions.

Increasing financial pressures (system-wide) will mean our potential to deliver the additional benefit 7 day services will be difficult to achieve.

However, the Pan Staffordshire group is firmly of the opinion that delivery of the standards is intrinsically bound with the necessary improvements that need to be made across a number of service area's and in particular, those associated with improved clinical outcomes and those associated with a reduction in emergency care usage.

Delivery plan set out (C.3.iv)

Over the coming months the 7 day services group have agreed that all stakeholders will systematically analyse their current 7 day services provision using the 7 day services self-assessment tool. From this each organisation will know their gaps in terms of provision. An action plan will then be formulated against the 4 core clinical standards with a view to achieving compliance by April 2017.

Key actions

- **June 2016** -Each organisation to assess their current 7-day service provision using self-assessment tool
- **October 16** -A gap analysis and action plan will be developed and agreed by each organisation setting out the vision over the next 3 years and specifically what will be achieved for 16/17.
- To the develop options to capitalise on 7 days services to inform 2017/18 commissioning.
- **October 16 to March 17**– Organisational monitoring of action plan through 7-day services working group with a view to achieving compliance with 4 clinical standards by March 17

This will take into consideration the requirements of the Better Care Fund National Conditions and how the plan will support preventing unnecessary non elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week together with supporting timely discharge of patients from acute physical and mental health settings every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care.

Going forward the Group will confirm the key services that each organisation will be required to deliver over seven days to ensure compliance of the ten standards over 2017/18.

Better data sharing between health and social care, based on the NHS number

Approach to ensuring right cultures, behaviours and leadership are place in place (C.4.i)

A solid foundation to the plans for data sharing is now in place due to the full alignment of the footprints for the Staffordshire and Stoke-on-Trent Sustainability Transformation Plan (STP) and Local Digital Roadmap (LDR). The overarching governance arrangement for the STP (Together we're Better Partnership) incorporates all Staffordshire and Stoke-on-Trent health and social care organisations, and includes the commitment to a work stream for digital services and information technology. This provides strong governance and leadership to develop shared information and integrated digital services that will enable service transformation in the area.

A revised approach is therefore being undertaken to develop local data sharing arrangements and integrated care record, focussing on the requirements of Staffordshire and Stoke-on-Trent rather than earlier arrangements that included several cross-border organisations. The emerging LDR will establish the priority of local development/milestones to support the transformation between 2016 and 2020, including the deployments and delivery plan to meet universal capabilities and requirements within the framework for Personalised Health and Care 2020 e.g. paper free services at the point of care.

To progress the content of the LDR, Staffordshire and Stoke-on-Trent information management specialists met in April 2016 where discussions took place about respective Digital Maturity Assessments, overall risks, challenges and solutions, plus how the strengths and abilities within each organisation can be utilised. A further two day workshop will now take place on 19th and 20th May 2016 to bring together Staffordshire/Stoke-on-Trent clinicians/practitioners and information management specialists, so that the priority and requirements within the route-map remain clinician/practitioner led and reflect their priorities, requirements and timelines.

Work is already taking place to develop an over-arching Data Sharing Agreement (DSA) for the Together we're Better Partnership, with all Staffordshire and Stoke-on-Trent organisations involved in workshops to develop the agreement. A period of consultation is currently taking place to refine the DSA (e.g. with Patient Engagement forums, Local Medical Committee) and full commitment and approval by organisations is planned in June/July 2016 through respective decision-making arrangements. Multi-tiered agreements for data sharing will then be developed to support operational work with timescales aligned with development priorities outlined in the Staffordshire Better Care Plan (for example the Enhanced Community Care Offer).

Use of NHS number as consistent identifier set out or plan in place (**C.4.ii)**

Use of the NHS number is central to delivering the local integrated care record and all organisations in our health and social care economy are committed to establishing a citizen's NHS number as the primary identifier. All NHS hospital sites currently use the NHS number in this way and are able to interact with the spine to retrieve demographics and/or the NHS number in real time. The North Staffordshire Combined Healthcare Trust plus South Staffordshire and Shropshire Trust aim to complete their implementation of Electronic

Patient Record systems in 2016, from which point the NHS number will be used as the primary identifier and citizen demographics/NHS numbers accessed via the spine.

Within 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, through the procurement of a new clinical system. This, together with monthly batch tracing of core systems, is expected to bring the proportion of records with valid NHS numbers to over 99%.

Approach to pursuing systems that speak to each other set out (**C.4.iii)**

All local health and social care organisations are committed to using systems that offer open APIs and standards, and are keen to explore the opportunities for greater systems integration and information sharing. All new system procurements within the NHS have up-to-date ITK compliance as a firm requirement within system specifications presented to the market, and the recent specification for replacement adult social care case management system also incorporated compliance with NHS interoperability standards.

The Staffordshire and Stoke-on-Trent roadmap to integrate care records will incorporate existing work that has taken place to provide the integrated record, and a number of principles have need established:

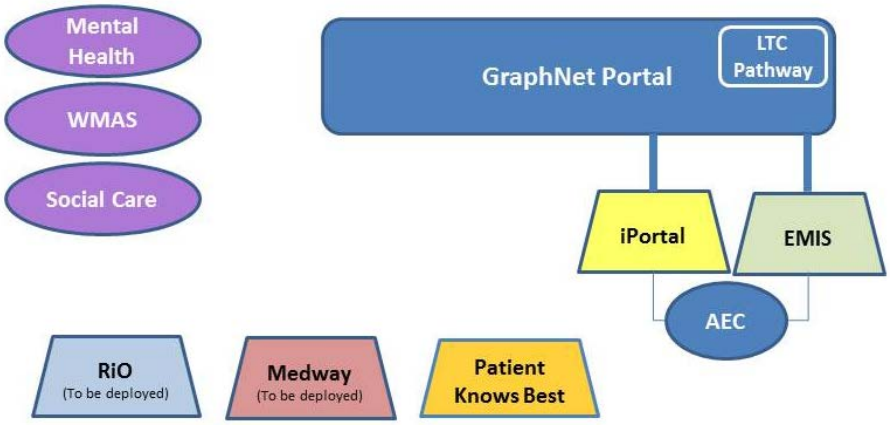
- Existing system will be used wherever possible with the focus on interoperability (e.g. EMIS) and use of portal platforms to integrate data
- A single clinical portal will allow professionals to access Information and the citizen they are working with in any place ad at the right time to support decision making
- Mobile working will be key to improving efficiency and the ability to make better decisions
- Only data required to achieve optimal decision making should move around the system but data held in a other systems should be capable of being accessed if required
- A single citizens portal will allow them to access their information and control their care
- An incremental approach to development will be taken
- Data is accurate and timely, and can be reported and available for analysis as required.

UHNS have already commenced and piloted an integrated record between GPs and acute services and this work will be built-on to progress the integrated record across all Staffordshire and Stoke-on-Trent health and social care organisations.

<u>Phase 1 – 201617</u>

The first adopter of the integrated care record (following recent pilot work) is the University Hospital of North Midlands (UHNM) and work is taking place throughout 2016/17 to provide this within the emergency services. Agreed GP data will be made available to UHNM from June 2016 with selected UHNM data available to GPs. The integrated record is being delivered through the Graphnet cross-organisational portal that draws data from the systems of different health services. The same portal (but outward facing) will ultimately provide the access route for external organisations (such as social care) to access health data. Work will also take place throughout 2016/17 to scope the implementation and deployment of the shared care plans for Long Term Conditions.

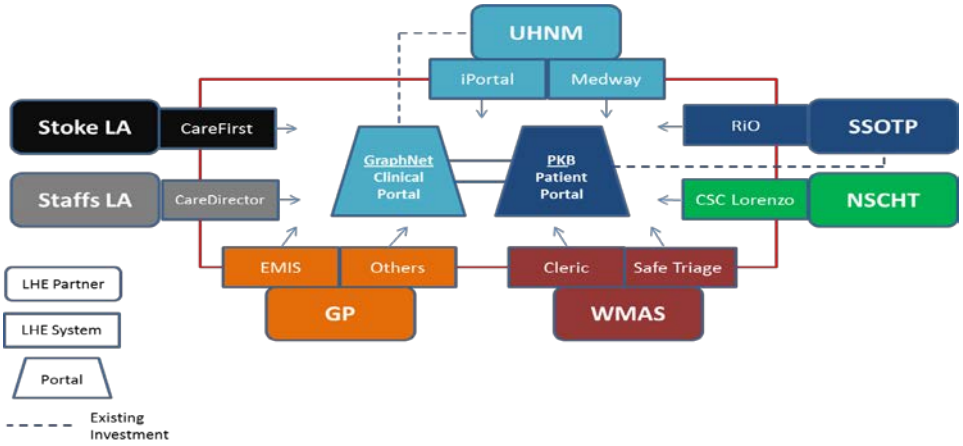
PHASE I 2016/17	□ Making GP data available in the new Ambulatory Emergency Centre □ Embedding UHNM data in GP systems □ Consolidating existing instances of GraphNet across the LHE □ Developing Shared Care Plans for management of Long Term Conditions (LTC)



Phase 2 – 2017/18/19

The second major phase will take place in 2017/18/19 to incorporate a patient portal (Patient Knows Best) with the integrated care record, and to scope the work required to extend the integrated care record to West Midland Ambulance Service, other providers and the local authorities. Greater detail about delivery milestones for Phase II will be developed and incorporated into the LDR.

PHASE II June 2017/18/19	□ Integration of a patient portal (Patient Knows Best) in the SSCR. □ Extension of the SSCR to include data from Staffordshire and Stoke-on-Trent Provider Trust, West Midlands Ambulance Service, Mental Health Providers and Stoke-on-Trent City Council/Staffordshire County Council



Critical success measures will include delivering the 10 Universal Capabilities by 2017/18, Paperless Plans at the Point of Care by 2020/21, plus delivery targets brought forward from previous work to provide the integrated care record.

IG controls for sharing information in line with guidance set out (C.4.iv)

The Partnership Trust has an established Information Governance and Information security service, with an approved three year strategy that sets out clear processes for the management of our data protection and information rights obligations. This strategy includes the Caldicott principles, and a GAP analysis was undertaken against the latest Caldicott Review to ensure compliance.

Regular communications are issued to all staff including a monthly update email, articles in the Partnership Trust newsletter, an intranet page, videos and messages on Yammer. These promote the relevant guidance within the Partnership Trust's policies including the importance of information sharing.

A wide range of information governance training including a bespoke e-learning package which includes Caldicott principles and information sharing.

The Partnership Trust has a Fair Processing leaflet available in our public locations and on our website. Information is also provided in our website on how to access copies of personal

information, designated Caldicott Leads and Assistance throughout the organisation are trained on handling requests.

The information governance policy clearly sets out to staff the legal basis for sharing information, covers the importance of using anonymised or psuedonymised information wherever possible and includes a section on “Providing a Confidential Service” which explains the legal basis for sharing, the importance of seeking consent, consent in young people and capacity issues as well as the importance of information patients (fair processing) and individuals rights to decline to have information shared.

Approach to communication with local people on use of their data set out (C.4.v)

An iterative engagement exercise commenced April 2016 in Staffordshire and Stoke-on-Trent to help citizens understand how their information will be used and shared. This includes writing to households and providing newsletters as well explaining to citizens at the point of contact about shared uses of their information, which health and social care professionals are able to access it, plus their options to opt out with the potential implications of taking this approach. In the first instance this is to support the new information sharing arrangements within selected UHNM hospital units (GPs, A&E, Clinical Decision Unit, Surgical Assessment Unit, Acute Medical Unit), however the communications will continue throughout 2016/17 and 2017/18 to support the continued development of the shared care record across Staffordshire and Stoke-on-Trent.

A key element in the engagement and self-management of citizens to put them in control and at the centre of the care process is the provision of a patient portal (Patient Knows Best). This will be made available to patients in 2018 and will enable them to access their own health and care record, manage elements of their care, see who has accessed their records and for what purpose, and allow them to set preferences about which information they wish to share.

Link to overall impact on integration described (C.4.vi)

NHS numbers are already being used as the primary identifier where available but further work is required to ensure the NHS number is being used in all cases and in real time. The current community provider is commissioned to deliver both health and social care services. IT and governance arrangements have impacted on the ability for staff to share information about patients. This programme of work aims to address these issues to positively impact on the quality outcomes of patients.

Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Proportion of the local population that will be receiving case management and named care coordinator confirmed (C.5.i)

The importance of case management of delivering an anticipatory model of care is well evidenced. Commissioners have reviewed their current commissioning arrangements for case management and audited the current model of provision. Moving forward in 2016/17 primary care will be able to access a risk stratification tool that draws on acute and primary

care data. This has the ability to be refreshed far more regularly thus generating a far more dynamic patient list. The model of delivery for case management varies across Staffordshire depending upon the nature of the community and primary care infrastructure but all services have a consistent set of deliverables including multi-disciplinary teams, direct case management of a small number of patients identified through risk stratification and care planning agreed with patients, General Practitioners. The proportion of patients to be case managed has been set at 2% in Staffordshire. This will be reviewed as the enhanced community offer scheme develops.

Plans for joint assessment and care planning set out (C.5.iii)

In addition to case management two further elements of our anticipatory model of care will be the provision of joint assessments (health and social care) and care planning. To date, there have been differing solutions across Staffordshire. In recognition of the need for an agreed clinical model that takes account of best practice/ national guidance, IT and governance. A pan-Staffordshire Frail Elderly Strategy has been developed and the BCF provides the mechanism and infrastructure to deliver this strategy. Within the strategy all organisations have 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.

Furthermore, the Frail Elderly Strategy describes a continuum of care that focusses on the needs of individuals and takes account of the circumstances of the individual and their degree of vulnerability so that the best care is provided at the right time, in the right place by those best equipped to meet the person's needs where the intent is to respond to the acuity of the person supporting their independence and optimal recovery.

Interactions between clinicians and practitioners is promoted as a vehicle for continuous improvement, personal and organisational development and to encourage better networking, care planning and exchange of information leading to an improved patient experience and better patient outcomes.

The important place of information across the continuum is recognised and the health economy continues to enable the effective sharing of records, real time communication between primary, secondary, community and mental health including with equal standing local authority services (particularly social care) and the 3rd Sector.

The continuum of care outlined within the Frail Elderly Strategy is shown below:

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

Clinicians will generate a personalised shared Care and Support Plan (CSP) outlining treatment goals, management plans and plans for urgent care. In some cases it may be appropriate to include an end of life care plan. Where an older person has been identified as having frailty, systems will be established to share health record information (including the

CSP) between primary care, emergency services, secondary care and social services. Older people with dementia and frailty will have especially complex care needs, requiring a judicious approach to care planning.

Dementia identified as important priority, supported by care coordinators (C.5.ii)

Within Staffordshire work has been underway to increase diagnosis rates. The below figures show the current diagnosis rates across Staffordshire.

CCG Name	Diagnosis Rate E.A.S.1 CFAS II (aged 65+) March 2016	Diagnosis Rate E.A.S.1 CFAS II (aged 65+) Feb 2016	Dementia Diagnoses (aged 65+) March 2016	Dementia Diagnoses (aged 65+) Feb 2016	Dementia Diagnoses (all ages) March 2016
NHS CANNOCK CHASE CCG	66.2%	65.6%	1021	1012	1063
NHS EAST STAFFORDSHIRE CCG	68.9%	69.3%	1029	1035	1061
NHS NORTH STAFFORDSHIRE CCG	71.9%	71.5%	2043	2032	2093
NHS SOUTH EAST STAFFORDSHIRE AND SEISDON PENINSULA CCG	56.4%	55.3%	1641	1611	1699
NHS STAFFORD AND SURROUNDS CCG	55.5%	56.8%	1172	1201	1205

North Staffordshire CCG commission a range of secondary mental health services for patients with dementia both in hospital and in the community (including care homes). Investment in the memory clinic has been increased over the last 2 years to ensure that demand can be met as diagnosis rates have increased.

The community mental health team, community outreach team and care home liaison team provide services in the community to support patients in crisis / with complex dementia needs.

The CCG also commission a small amount of activity from a number of third / voluntary sector Providers – such as Approach dementia advisory service and Beth Johnson Advocacy service.

The CCG is currently piloting a dementia primary care liaison service in two of the 5 North Staffs localities. The service aims to:

- Support primary care staff to increase knowledge, skill and confidence re dementia
- Support for care homes in relation to behavioural management, medication issues, review of cognitive decline, support with continuing healthcare specialist assessments

- Support with dementia reviews in primary care
- Crisis management - rapid response during core working hours

Work is on-going across the CCGs in South Staffordshire to refine the care pathway for people with dementia to improve early identification of dementia and to ensure that appropriate advice and support if available post diagnosis. This pathway involves patients and their carer's, primary care, secondary care specialists, care facilitators, social care and voluntary and community organisations.

Plan with milestones included (**C.5.iv)**

A high level milestone plan is included on page 20. We acknowledge that there is further work to be undertaken across the County to ensure more detailed milestone plans are developed in line with the STP. Some of our schemes are very much in its infancy and as a result it is anticipated that the schemes will develop and evolve over a period of time, ensuring that continuous learning and development is embedded into practice.

Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Evidence of agreement provided (C.6.i)

There is on-going dialogue with acute and community NHS providers about the impact of the schemes and agreement about the model. The impact of potentially decommissioning a range of social care services has been communicated to the community NHS provider which is also the provider of older people's social work. Due to the reduction in funding available for older people's social work the current provider have indicated that they will withdraw from the social group contract on the 1st of April 2017. Work is underway to resolve where possible and develop sustainability plans.

Evidence of engagement and buy-in provided (C.6.ii)

As previously described the level of engagement on the specific schemes has varied, dependent upon the nature of the scheme and its level of maturity.

For example a workshop took place as part of the "Together Were Better" programme which included articulating the vision and case studies for an enhanced model of care focusing on which cohort of patients to focus on and how this could be developed and implemented over a period of time.

In addition, the system wide "Together Were Better" programme case for change which incorporates the community offer at the heart of the BCF has been shared with local politicians in accordance with the governance for the BCF.

Alignment to provider and longer term planning set out (C.6.iii)

Nationally there is a requirement to deliver a Sustainable Transformation Plan (STP) focussed on an agreed footprint i.e. Staffordshire and Stoke on Trent. STPs must be developed in a collaborative way with commissioners and providers, this is being coordinated through our STP programme, "together we're better" (TWB). The programme board is made up of commissioner and provider senior executives. An initial high level plan

was set out in April and a more detailed plan will be produced and submitted to NHS England for approval at the end of June. This plan will set out commissioner and provider joint plans for the next 5-years.

Approach to better integrating mental and physical health set out (C.6.iv)

Integration of mental and physical health is a priority within Operational Plans and the STP. A dedicated work stream led by an Executive Director from North Staffordshire and Stoke-on-Trent CCGs has been established. In addition parity of esteem is a priority in the 16/17 planning cycle and includes statutory reporting on Dementia, Early Intervention in Psychosis and Improved access to psychological therapies.

Explanation of alignment of CCG, BCF and provider plans set out (C.6.v)

All CCGs have written their 2016/17 operational plan. The plans form year one of the 5 year Sustainability and Transformation plan for Staffordshire. Whilst currently in draft form, many of its prerequisites have been used to inform the CCG priorities for 2016/17. These priorities also need to reflect our specific local challenges and how we will deliver the constitutional standards of the NHS and contribute to the NHS Mandate. Each of the operational plans demonstrates the alignment of the BCF schemes with the CCG priorities. Alongside the operational plans, CCGs and providers have submitted activity profiles outlining the levels of activity required to deliver the NHS constitutional standards, NHS mandate and other local priorities. This activity has also been contracted for via the 2016/17 NHS contracts between commissioners and providers. The underlying principles of each of the plans are focussed on a clinical and financially sustainable health and care system which is built upon a person centric integrated system, and both are supporting the drive towards implementation of the five year forward view.

Specifically within East Staffordshire Virgin Care has been commissioned as the prime contractor and system integrator of all adult unplanned care services, and will lead an integrated service network of providers and wider partners. They will implement the strategic model through integrated and collaborative leadership and through aligned goals and incentives; driving a transformation in care models and collaborative relationships. ESCCG and Virgin Care will be working collaboratively through the BCF to accelerate progress across Staffordshire through shared learning.

Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Approach to meeting national condition confirmed (**C.7.i)**

Summary of NHS commissioned out of hospital services spend from minimum BCF pool

	Expenditure – Minimum CCG contribution	Expenditure – Additional CCG contribution	Expenditure - Local Authority Services	Total OOH spend

Mental health	£2,980,324	£0	£0	£2,980,324
Community health	£30,609,516	£31,863,000	£0	£62,472,516
Continuing Care	£293,650	£9,504,000	£0	£9,797,650
Primary Care	£0	£0	£0	£0
Social care	£17,069,495	£0	£0	£17,069,495
Other	£0	£0	£0	£0
Total	£50,952,985	£41,367,000	£0	£92,319,985

Our BCF submission demonstrates 92.8% % of the pooled fund is related to out of hospital services. Our schemes prioritise out of hospital care but funding for schemes remains tied up in existing contracts until such time as these can be decommissioned. Business cases to be developed, will support transition of contract spend to deliver new services.

Figures in planning return match the explanation in the narrative plan (**C.7.ii)**

A range of NHS services are currently commissioned to support out of hospital services. Within the Staffordshire BCF plan this relates to all of the schemes, i.e. front door, enhanced care model, intermediate care/reablement and to support hospital discharge. From a financial perspective due to current contractual arrangements the pooled fund is currently mainly from continuing health care, however as we develop the schemes it is anticipated that the fund may change to reflect in year and future contractual changes.

Approach to setting risk share arrangements, including analysis of previous NEL performance, set out (C.7.iii) / Impact of trends and of schemes to avoid admissions both considered (C.7.iv)

A number of initiatives have been implemented designed to reduce the level of non-elective admissions.

These include promotional campaigns designed to encourage people to stay well by taking the right precautions and informing them of a range of healthcare options for when support is needed and is an alternative to A&E. (e.g. NHS111, Pharmacy First)

This has been supplemented by more targeted work (e.g. Acute Visiting Service) focused on those patients who would otherwise attend A&E and be likely to be admitted.

When comparing NEL activity to the same period in 2015/16, the first six months of the financial year saw a year on year reduction of 5.4%.

However as we progressed into the second half of the year, the level of NEL activity increased such that by the end of December there had been an erosion into the cumulative reduction and whilst activity was still below the comparable period last year on an overall basis, the margin had reduced.

This pattern has been sustained into the final three months of the year and is reasonably evenly distributed across all commissioners. February 2016 was a particularly difficult month with a 27% year on year increase. We have not seen the typical end of 'winter pressures' but instead seen high levels of activity sustained across all areas.

The final outturn position is expected to be an increase on 2014/15 of approximately 1%. Whilst this represents growth on the comparable period, the rate of growth is reduced from previous years and it can reasonably be said that the schemes designed to constrain growth have had some impact.

As all pooled resources were already committed to existing contracts any risk sat with the existing contractual arrangements.

Risk sharing arrangement set out with reference to guidance (C.7.v)

To be agreed but it is anticipated that it will fall under the same risk sharing arrangements as stated in the 15/16 section 75.

Impact on any schemes funded by the previous P4P fund set out (C.7.vi)

In 2015/16 there was no separate funding established from within the Staffordshire Better Care Fund pooled budget in relation to the £1billion. The arrangement of any P4P liabilities arising per the section 75 was that these would be met directly from the Clinical Commissioning Groups as additional spend. Therefore the removal of the P4P arrangement has no impact on funding of schemes.

Agreement on local action plan to reduce delayed transfers of care (DTOC)

Local DTOC action plan set out (C.8.i)

Within Staffordshire there are two SRG's both of which have developed an action plan to support the local health economy (Please see Annex 1). Within the East, DTOCS were high-lighted as a key issue and as a result a separate action plan has been developed. Within Northern Staffordshire/Stafford an action plan has been developed to support the health and social care system which includes DTOCS.

Local DTOC target set out with link to actions (C.8.ii)

Within East Staffordshire the DToC position was 10.9%. Work undertaken over the last 6 months has resulted in this decreasing to 6%. A further target has been set to achieve the 3.5%. Within Northern Staffordshire DToCs targets are part of a wider ECIP plan. Whilst previous performance for DToCs has been below the national target of 3.5%, recorded performance over the last 3 months at the acute provider has indicated a rise: 2.8% (Dec 2015), 3.5% (Jan 2016) and 4.3% (Feb 2016). A social care working group is currently being established to support the ECIP plan. It is anticipated that this group will be responsible for delivering against any specific DToC actions. Any health specific delays will be picked up through existing structures which oversee the social care working group. Both

the East Staffordshire and the Northern Staffordshire/Stafford action plans are owned by CCG, LA and relevant acute and community trusts with accountable leads identified.

Link between this action plan and SRG planning set out (C.8.iii)

As described above, the plans are overseen by the local SRGs and are reviewed in context of improving patient flow across the health and social care system. Particular for North Staffordshire there are three key work areas which support reducing avoidable admission, effective in-hospital management and timely and safe discharge: these being assess before admission, todays work today and D2A.

Confirmation provided that this aligns to CCG plans (**C.8.iv)**

Both the East Staffordshire DTOC action plan and the Northern Staffordshire/Stafford ECIP plan are reflected within CCG operating plans.

Consideration of risk share options included (**C.8.v)**

Local risk sharing agreements have been considered however due to existing arrangements this has not been implemented. Further work expected to take place as part of this work stream.

Engagement with providers on DTOC plan confirmed (C.8.vi)

Both plans have been developed with all key stakeholders as part of the SRG governance structure including relevant acute and community trusts.

Lines of responsibility, accountabilities, and measures of assurance and monitoring set out (C.8.vii)

For both plans, actions have named accountable leads and metrics have been agreed. A dashboard has been compiled within Northern Staffordshire/Stafford in order to effectively measure performance against the plan. Detailed work plans can be found in Annex 1.

Consideration of national guidance and best practice set out (**C.8.viii)**

A system diagnostic has been undertaken by the Emergency Care Improvement Programme (ECIP) has resulted in the following six key priorities being identified:

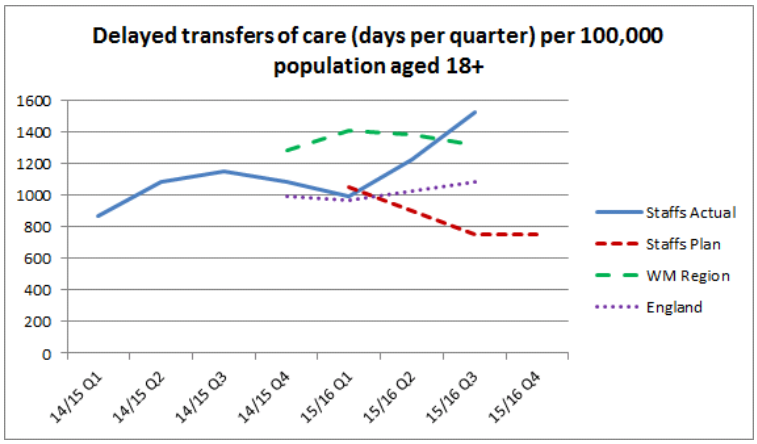
- Leadership
- MADE
- Ambulatory care
- SAFER
- Therapies
- Frailty and D2A

Working with ECIP all existing plans have therefore been rationalised and a framework developed to deliver improvement across the urgent and emergency care system. The framework for delivery includes assess before admission, todays work today and D2A. This supports DTOCS as part of the unmet demand. A range of schemes have been developed to support with the delivery of the framework with leads identified following best practice and is monitored by the SRG. For further information please see annex 1.

Engagement with independent and voluntary sector providers on DTOC plan confirmed (C.8.ix)

Engagement with independent and voluntary sector providers on DTOC plan has taken place. For example, in the East the Royal Voluntary Service are providing support to elderly people who live alone upon discharge from hospital. The aim of the scheme is to reduce isolation and ensure their home environment is safe and comfortable. The service has been supported by the independent transport provider NSL, who have ensured transport is available to take the team to the patient's home in a timely manner.

Work is also on-going around the development of a voluntary sector strategy to further support opportunities from integrated working between voluntary, independent and social care teams. A range of independent and voluntary sector providers are commissioned to support hospital discharge. Please see page 32 of annex 1 which describes the stakeholders involved in this scheme.



9. National metrics

Non-elective admissions (General and Acute)

Approach to setting NEA plan set out (E.1.ii)

The approach used to set non-elective plans is as follows:

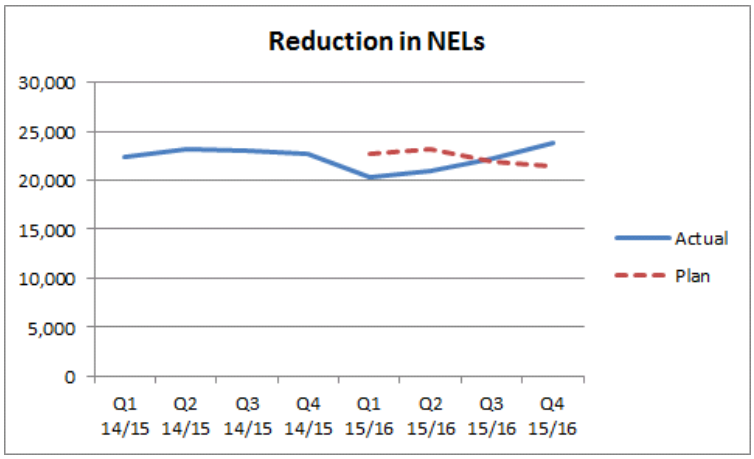
- Growth is applied to the forecast out-turn position for each acute provider reporting NEA activity
- The percentage growth is determined by calculating the difference in 2014/15 actual out-turn against 2015/16 forecast out-turn
- Any reductions against the 2015/16 plan are identified at a HRG level and applied as contract reductions.

There are currently no plans to reduce NEAs further in addition to the CCG operating plans. We have set an agreed NEA plan with NHS England and these have been applied to each acute provider and secured with the contract negotiation process. The BCF plan will contribute to the delivery of these plans.

Previous performance and impact of schemes set out (E.1.iii)

During 2015/16 there has been a significant level of NEL reductions against the anticipated levels which are not expected to be sustained over the longer term. In respect of 2016/17 CCGs have predicted NEL activity that either consolidates previous years reductions or demonstrates a small level of growth. In quantum across the Staffordshire CCGs it is not expected there will be further reductions on the levels seen in 2015/16. The schemes will be reviewed to ensure that expected system changes are driving reduced activity.

2014/15 Actual				2015/16 Plan				2015/16 Actual			
Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 14/15	Q2 15/16	Q3 15/16	Q4 15/16
22,365	23,170	23,087	22,681	22,691	23,182	21,857	21,491	20,264	20,987	22,183	23,894



Admissions to residential and care homes;

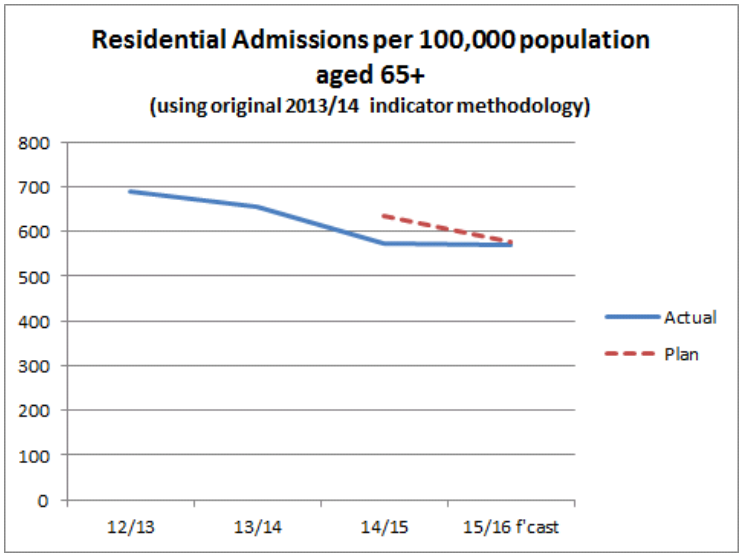
Approach to setting residential admissions metric plan set out (E.2.ii)

Staffordshire has a good record of reducing permanent admissions of older people to residential and nursing care since 2013.

The national methodology for reporting permanent admissions changed for 2014/15 making year-on-year comparisons difficult, but using the 2013/14 methodology we can demonstrate significant annual reductions:

2014/15 Actual				2015/16 Plan				2015/16 Actual			
Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 14/15	Q2 15/16	Q3 15/16	Q4 15/16
642 (quarterly figures not available)				577* (annual)				651 (Forecast for year)			

* The 2015/16 plan rate excludes full cost payers as it was set before the ASCOF methodology was changed). The remaining figures include full cost payers. If we exclude full cost payers from the 2015/16 actual we report a rate of 569 which is on target.



In 2016/17 we are looking to continue progress in achieving reductions in admissions. Benchmarking against 'nearest neighbour' comparator authorities shows that Staffordshire is not yet within the best quartile, and when comparing against all authorities nationally we are at the median level, suggesting that considerable scope to reduce admissions further still remains and that our BCF Plan figure of 586 per 100,000 is ambitious yet achievable.

Previous performance and impact of schemes set of (E.2.iii)

Investment in ExtraCare housing in Staffordshire means that this can increasingly be used as a more efficient alternative to residential care for those with relevant care needs. At present only a minority of ExtraCare housing in Staffordshire is being used by people with care needs and we have set a priority for 2016/17 to get maximum benefit from these schemes in order to reduce long term residential admissions. We anticipate this will achieve a significant proportion of the planned reductions in 2016/17.

Additionally the use of telecare and telehealth solutions when constructing a care package can reduce risk's which will contribute to delaying the need for an admission to residential care.

Our aim to reduce admissions is shared across the wider health community, with a particular emphasis on reducing permanent admissions to residential care directly from a hospital bed. As a partnership we endorse ways of working which support people to be given the opportunity to regain maximum independence and the overriding principle that people should not be making decisions about their long term care whilst undergoing a crisis. We are providing significantly enhanced support to carers through the establishment of our new Carers' Hub to ensure that informal care outside permanent residential settings is sustainable for as long as possible.

Key to the success of our plans is cultural change in the workforce, prioritising the making of the right early interventions to reduce the risk of an admission. This is backed up by ensuring we have the right secondary interventions in place to avoid an unnecessary admission, for example during a crisis. We are working to develop the local care market to ensure we have residential and domiciliary care providers who can deliver services that will

assist someone on their recovery pathway, rather than unnecessarily hastening them into a permanent residential care bed.

Effectiveness of reablement;

Approach to setting reablement metric plan set out (E.3.ii)

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

The focus of reablement is moving towards step-up and hospital admission avoidance. This alongside a more effective and efficient discharge process is expected to lead to a reduction in the number of people discharged from hospital directly into a reablement service. Due to the technical definition of the ASCOF measure, this means that fewer episodes of reablement will now qualify to be captured in this indicator. This does not imply a reduction in reablement activity as this will be balanced by an increase in preventative and targeted reablement that is not captured in this measure. The reablement offer for Staffordshire is essential to an affordable adult social care service.

Previous performance and impact of schemes set out (E.3.iii)

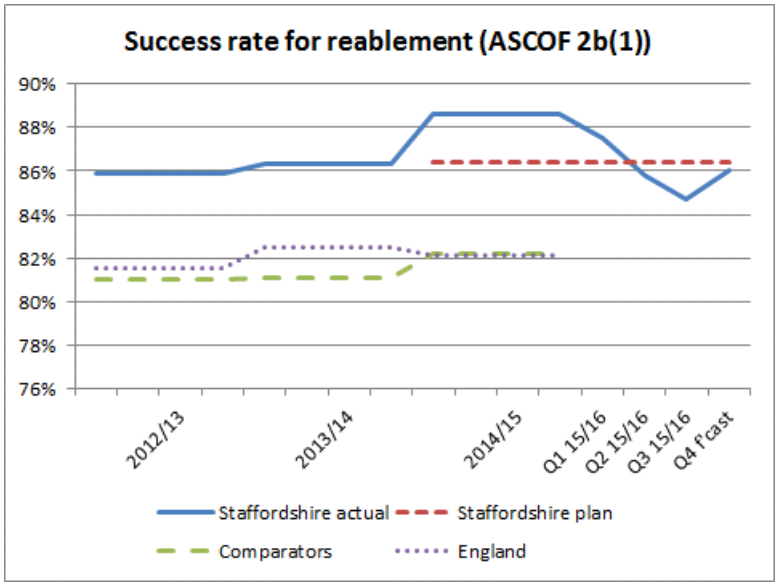
Staffordshire has an excellent track record of successful reablement on hospital discharge, having consistently outperformed the national and comparator averages:

ASCOF 2B(i) results

	Staffordshire	Comparators	England
2012/13	85.9%	81.0%	81.5%
2013/14	86.3%	81.1%	82.5%
2014/15	88.6%	82.2%	82.1%

Whilst we are unlikely to match the outstanding result of 2014/15 this year, results in 2015/16 to date suggest a final result of close to 86%, and by targeting our reablement activities appropriately we expect to maintain this performance going forward.

2014/15 Actual				2015/16 Plan				2015/16 Actual			
Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 14/15	Q2 15/16	Q3 15/16	Q4 15/16
88.6% (quarterly figures not available)				86.4%				87.5%	85.8%	84.7%	TBA


Success rate for reablement (ASCOF 2b(1))
90%
88%
86%
84%
82%
80%
78%
76%
2012/13
2013/14
2014/15
Q1 15/16
Q2 15/16
Q3 15/16
Q4 f'cast
Staffordshire actual
Staffordshire plan
Comparators
England

Annex 2: Detailed Scheme Descriptors

1. Scheme name
1 - Front Door
2. What is the strategic objective of this scheme?
To create a hub of IAG that enables citizens to access the right support at the right time. • Implementation of a new sustainable model that includes a professional support team. • To reduce the number of citizens being referred to formal or statutory assessment. • To create a first point resolution service with a timely response to customer queries. • Encourage self-help & support utilising and developing the tools and services available to provide robust preventative interventions
3. Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted
The scheme uses good quality Information and advice (Telephony and web based) and targeted professional support alongside a range of self-help and digital support tools. This is then supported by process improvements to simplify and improve user experience, streamline customer journeys and support frontline practitioners to utilise the available resources and in turn ensure consistency of approach and good practice. The delivery of this scheme focusses on two core projects: **1. Professionalised Front Door** Following implementation of the Care Act 2014 and the creation of the SSOTP Transformation Programme it was agreed that the Front Door Pathway should be re-designed, to enhance the Staffordshire Cares offer through the introduction professional support within the contact centre environment. SSOTP and SCC accountable leads coproduced the model to facilitate better outcomes for the customer, ensuring the needs of service users are met but also supporting self-funders, carers and frontline workers to make informed decisions about their health, care and support needs/ options through an easily accessible, robust and professional front door service for Staffordshire. The patient cohorts in scope for the Project was any citizen over the age of 18 who presents with an indication need at Staffordshire Cares who may benefit from the new ways of working. **2. Primary and Secondary Care Self-help and independence Pilots.** We have developed a pilot with a GP surgery to provide Information and advice and low level assistive technology (AT) to patients as part of consultations, home visits and Healthcare assistant appointments to encourage use of the tools available in Staffordshire (Staffordshire cares, Staffordshire Marketplace, supported self-assessment, ask sara) and have developed a “Box of Trix” which includes top 10 most useful/ used pieces of assistive technology to support self-care and independence funded by the local CCG which are to be distributed to every practice in the CCG area alongside training and support from SCC and demonstration video’s showing how to use the equipment. The surgery has added “quick picks” to their EMIS system which allows GP’s to identify when Early/ self-help Information, Advice & Guidance

(IAG) has been given to the patient or AT has been discussed and demonstrated. This pilot is now being rolled out to 2 other surgeries in the locality with the aim of having it in all 20 practices by December 2016.

In secondary care we are taking a similar approach but working closely with discharge facilitators/ liaison teams in hospitals to dispense relevant IAG and low level assistive technology to enable people to return home in a timely and appropriate manner, ensuring they have the necessary low level help to support ongoing independence. For this group a different "box of Trix" has been developed on advice from the teams themselves with regards to their knowledge of what patients struggle with on leaving hospital and common causes for re-admission e.g. incorrect use of medication, dehydration, falls etc.

3.Primary & Community Care Practitioner Information & Advice line

Staffordshire Cares is an easier way to find trusted sources of information and advice for people of all ages in one place through a single telephone number, interactive website and local Access Points

This project extends the use of the Staffordshire Cares telephony based information and advice service offered by the contact centre by targeting practitioners within Primary care and community settings across the County through training and tailored communications campaigns. Supporting the use of one number which in turn ensures consistency of approach and the quality of information advice and guidance offered.

The aim of this project is to give practitioners a "go to" place for non-clinical advice. This is an enhanced offer for healthcare practitioners as a range of digital self-help and advice tools are now available, as part of the Staffordshire Cares "Family", to help identify and provide support with "non-medical" issues which impact on people's health and ability to remain independent. These tools can be used by Staffordshire Cares advisors with practitioners or patients over the telephone (supported Digital) where they are not confident with online resources or if I.T. Literate and keen on self-service, they can advise of the availability of such tools on the Staffordshire Cares website, those most suited to their enquiry and provide advice on how to access them. A follow up call can also be offered to identify where resources have been helpful and identify where additional information and advice may be required. Key resources offered through the Staffordshire Cares Family are:

- **The Staffordshire marketplace -** An online directory of over 1400 local care, support and wellbeing services, activities and events across Staffordshire aimed at the whole family.
- **Ask Sara** – Ask SARA is a guided advice tool giving expert information and advice on daily living equipment for older and disabled people*.*
- **Me, Myself & I -** A fun and interactive game to help people say what is important to you and help you find the information, advice and services you need.
- **Social Care Self-assessment** - Social Care self-assessment/ Eligibility checker to help people understand support needs, information and services available to support with this, potential eligibility for social care support and how to make a referral.
- **Staffordshire's Healthy Hub –** Help to find information, advice and services on improving your lifestyle and create a personalised brochure that people can download, print or email.
- **Equipment & Living Aids Catalogue** – A product showroom which lists equipment and products to meet a wide variety of mobility and daily living needs. People can browse and search for products with an added option to buy direct from the retailers.

These resources can also be utilised by staff on hospital wards as part of discharge planning or in residential and nursing care settings as part of risk assessment/ care planning process to support people to return home from hospital quicker and reduce admissions for example by using ask Sara to identify what people are struggling with then go on equipment catalogue/ marketplace directory to show people

where and how to source items or use daily living fact sheet on Staffordshire Cares to get advice on buying equipment and find local suppliers.

4. As part of the BCF we will be evaluating the impact of these projects and how they could potentially be rolled out across Staffordshire.

3. The delivery chain

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

Project Group reports into Programme Board which is a Partnership Board consisting of SCC and SSOTP representatives. The Project Group consists of -

County Commissioner – SCC, Area Manager – SSOTP, Accountable Leads Head of Customer Services, SCC, Operations Manager, SCC, Team Manager, SCC, OT, SSOTP, SW, SSOTP.

Key partners in the delivery projects are:

East staffs CCG – Senior Commissioning Manager, UHNM Trust (Discharge facilitators, Sustainability lead, commercial developments), Burton Hospitals NHS Foundation Trust (Lead Discharge Nurse), Staffordshire University (Research), VAST, Peel Croft Surgery.
Staffordshire Cares/ SCC Customer services

4. The evidence base

Please reference the evidence base which you have drawn on

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

Learning approach adopted was action orientated and iterative. We agreed to test and learn as we go, with a view to roll/out where success was realised. The approach mitigated a “learning lag” as time was critical to realising performance and financial objectives.

The individual primary and secondary care pilots where developed collaboratively with the participating partners and used as “proof concept” and are being monitored and assessed in terms of both outputs and potential benefits and outcomes by Staffordshire University with the aim of rolling them out to additional primary and secondary care settings across the county.

Staffordshire Cares collects a wide variety of data will regards to call numbers, reasons for call, average length of calls and resulting actions (see attached) which will be used as a baseline for demand analysis on the service post implementation of the targeted communications and training/ briefing sessions with practitioners. Customer feedback and case studies are sought on an ongoing basis to understand user experiences, needs and identify potential gaps in provision. Business design work will be undertaken to understand peak times for enquiries, service capacity issues using call abandonment rates and training needs for advisors based feedback from users and practitioners. Regular Reflection Session were organised to capture, learn from and apply best practice to enhance the outcomes. We adopted a task and finish activity approach for removing barriers to the process.

Before implementing the Pilot analysis was undertaken to review the volume and type of calls in Staffordshire Cares to understand potential impact any proposed model could be.

5. Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
This scheme has an existing budget that is not currently included within the BCF pool.
6. Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Depending on what option is decided moving forward (in addition to the CSF and Measures below) they should reduce the dependency of service users on statutory services, manage demand at an earlier stage and release operational capacity within SSoTP, primary and secondary care by increasing the number of people accessing universal and community services and assistive technology in order to meet their needs and desired outcomes.
7. Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Robust measures were agreed and reporting mechanism in place to track and report against the critical success factors below. Regular “Reflection Sessions” were scheduled with the working group and practitioners within the work area to feedback and collate lessons learnt from the pilot. This was used to evolve and further develop the pilot over the 6 month period.
8. What are the key success factors for implementation of this scheme?

Critical Success Factors for the Project were:

- Reductions in SSOTP of statutory assessments.
- Reduction in hospital admissions
- Reduced length of stay in hospital attributed to IAG/ AT measures in place
- Citizens to remain as independent for as long as possible.
- Reduction in the number of repeat contact.
- Ensuring there is an appropriate response to Safeguarding.
- Citizens have access to AT, Prevention and Reablement without going through a lengthy process.
- Increased use of social capital.
- Ability to identify and feedback unmet need.
- Staff having confidence and clear understanding of what constitutes an appearance of need and preventative approaches

As a result the Project Team was tasked with baselining and tracking several performance measures throughout the Project Lifecycle. The measures agreed at Programme Board were:-

- Number of contacts referred for assessment by financial year end (<6541)
- % of initial contacts deflected to primary and secondary prevention (>66%)
- % of Referrals to SSOTP that end in No Further Action (<25%)

Front door

Milestone	Start Date	End Date
Introduction of Call Back Service within SC	May-15	Jul-15
Scripts strengthened at Front Door	May-15	Jul-15
"Ask Sara" Self-Assessment Tool Live	May-15	Ongoing
E-Marketplace Developed	May-15	Ongoing
OT In Contact Centre	Jun-15	Aug-15
Mechanisms in place to capture active learning via Pilot	Jun-15	Aug-15
Bespoke IAG CRM System Developed	Jun-15	Ongoing
IFA Helpline in place	Jun-15	June 16
Solla Care advice standard achieved (Staffordshire Cares Advisors)	Jun-16	Ongoing accreditation scheme
Professional support embedded in Staffordshire Cares	Jul-15	Sep-15
Pilot underway and impact analysis undertaken	Jun-15	Mar-16
Options paper	Mar-16	May-16
Implementation	Apr-16	Jun-16

Primary and Secondary Care Self-help and independence Pilots

Milestone	Start Date	End Date
GP Pilot	Nov-15	Sept -16
UHNM Long term Care Project (Discharge Lounge Pilot)	Feb - 16	Feb - 17
Burton Hospital – Discharge Liaison Pilot	Feb -16	Feb -17
Pilot Evaluation	Oct - 16	Nov - 16

Roll out of GP pilots to identified Localities	Sept-16	Ongoing
Roll out secondary Care Pilot to remaining settings	Sept 16	Ongoing
Bespoke IAG CRM System Developed	June-15	Ongoing
IFA Helpline in place	June-15	June 2016

Primary & Community Care Practitioner Information & Advice line

Milestone	**Start Date**	**End Date**
Baseline data	Mar 2016	May 2016
Scheme KPI's and Outcome measurements agreed	May 2016	June 2016
Revised SLA in place with Contact centre	June 2016	April 2017
Staffs Cares Advisors briefed and trained	June 2016	ongoing
Pathways created within CRM to track usage	June 2016	July 2016
Targeted promotion/ GP adoption strategy rolled out across all CCG areas	June 2016	March 2017
Targeted Communications campaign	June 2016	March 2017
Business Design/ service capacity work	Oct 2016	Feb 2017
Final evaluation and Recommendations	Feb 2017	March 2017

1. Scheme name

2 – Enhanced community care model

2. What is the strategic objective of this scheme?

Increase independent living & self-management and reduce and shorten hospital admissions by strengthening community based prevention, support, health and care networks. This is complementary in nature to a person-centred model for integrated care and support, based around registered populations and natural communities, which promotes the health, well-being and resilience of local people. The essence of this approach will:

- Improve identification of local populations and their associated profiles allied to health and wellbeing risks.

- Creating efficient and effective interventions and pathways that reduce dependency upon secondary services and keep people's care as close as possible to home. This will include maximising opportunities for Technology Enabled Care Services, utilisation of integrated community equipment services, set within efficient and effective care coordination that promotes choice and control within local community settings.

- Delivering interventions at the right time in the right place by the right skill set, maintaining people at their highest level of independence. Integrated Intermediate Care and Reablement is a cornerstone of care and support that is asset based focused upon realising people's potential for continued independence, either with no support or just enough support to promote continued independence.

- Where people require on-going support due to the long term nature and complexity of their needs, we will seek to further enhance effective care coordination and delivery of provisions. Improve the experience of local citizens and their carers. Improved outcomes for carers will have a positive impact on reduced non elective admissions, delayed transfers of care and admissions to residential and nursing homes.

3. Overview of the scheme

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

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

Establish new ways of working, united by our strategic objectives, but building on a range of enhanced community care initiatives already in place across Staffordshire. Embracing diverse approaches to different population groups and supporting autonomous working and development of teams, but embedding continuous learning and evaluation within each team, together with robust methods to share learning, understand impact and thereby rapidly evolve enhanced community care across the whole of Staffordshire.

Natural 'communities of care', based on populations of 30-50,000, will be identified across the county around which place based enhanced community care can be developed and delivered. Each team will be tasked to identify the first 200 people with whom they will work to achieve the strategic objectives outlined above. The cohorts may vary from team to team, but each will need to explain their choice and provide a

rationale for their chosen skill and team mix and interventions they then apply to achieve maximum 'added value' and impact on their cohort of people.

System leadership, co-ordination and expertise in learning, evaluation and workforce development will be continuously provided by a central Programme Management Office. A robust business plan and governance process will accommodate a diverse range of activities but effectively hold teams and the system to account for achieving the required pace of evolution and level of impact.

The overall aim of embedding continuous Plan – Do – Study – Act cycles at the heart of team development is to move away from the management of a complex adaptive system in a largely reactive way in which cause and effect, intended and unintended consequences are impossible to determine, towards a complex evolving system where proactive and more predictable change predominates.

In summary our approach will build a holistic local integrated service which is capable of flexing to fully meet the health and social care needs of a local population. The key elements to the proposed approach/model are:

- An integrated core team of health and social care professionals co-located.
- Specialist services available to support the core team to meet individual's needs in community wherever possible.
- Direct partnership work with primary care.
- Closer partnership working with voluntary sector and the local community.
- An emphasis upon the strengths that people have and reinforcing their assets, and critical to supporting self-management with be technology enabled care solutions, integrated community equipment services, access to robust information and advice and services that promote enablement, Reablement and intermediate care to realise and maximise potential for independent living.
- Accurate and up to date information and advice available in a timely manner to aid self-management. This will in turn reduce, prevent and delay the need for high intensity services.
- As indicated above frontline practitioners are charged with fully developing the model by learning what is required to fully meet local need.

Our approach will reinforce a coordinated, complementary and comprehensive model that will afford the following:

- Prevention and self-care – helping people to self-manage their own health and care needs, empower them to make choices about their care and ensure the right services are available to all our communities. This will include making best use of technology enabled care services (TECS) and assistive technologies. This will involve a collaborative partnership approach to making the best use of TECS to support people and their carers recognising the benefits of an integrated approach to implementation at scale and pace. TECS supports our goals to reduce admissions and readmissions to hospital and long term care among older people as well as support to people of all ages to take greater responsibility for their own health and wellbeing and that of their families. We can build TECS into the increased adoption of personal health and care budgets to improve person centred outcomes and support self-care. Assistive technology funding will also continue to support the 'Live at Home' facilities, which allow people to try out assistive technologies through demonstration sites, working with the community groups and provider agencies. In many cases these are jointly delivered with partner agencies, such as local telecare providers, carer support groups and Staffordshire Fire and rescue service.
- Integrated teams of specialist health and social care professionals – teams comprising community

nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, lead psychiatrist, pharmacy, geriatricians, GPs, the voluntary sector and specialists in palliative care and domiciliary care. They will ensure joined up care for service users and patients, especially those who are vulnerable or have complex needs. An example of the joined up nature of services is the integrated commission to provide community equipment services(ICES), which enables health and social care prescribers across all acute and community providers to have access to a catalogue of aids and equipment. They can draw down items suited to support the needs of people who are either finding it difficult to remain living independently at home or who are about to be discharged from hospital. Items may be provided on a permanent basis or for a time limited period to support rehabilitation. The service also offers the potential to support self-assessment by individuals and the deployment of aids and equipment directly rather than as part of a formal assessment of health and social care needs again promoting greater self-management.

- Enhanced community services – for people in their own homes, in GP surgeries and local, community hospitals. The Carers Scheme is part of a range of complementary enhanced community services. At the core of this service is the Carers Hub, which is a one stop shop for carers seeking information, advice and guidance or looking for help and support. The hub is run by People Plus who have a contract with the aim of significantly increasing the numbers of carers receiving support to a minimum of 8000 in the first year. They are able to offer all carers who contact them a universal assessment in line with the requirements of the Care Act. The service is now also able to offer a Personal Wellbeing Budget and this allows carers to access a direct payment to meet their eligible needs when they cannot be met by services already provided. Hub staff have also received training on the benefits of assistive technology and the budget can be used to purchase such equipment. Other commissioned services exist to support carers, this includes crossroads and respite and emergency respite.

- Access into and out of specialist inpatient care – this will see an enhanced approach to step up and step down care and a coordinated Intermediate Care and Reablement tier of support for health and social care needs. There are four elements within the intermediate tier of support for health and social care – Crisis response (health), Home based intermediate care (health), Bed based care (community hospitals/care homes 0 health and social care) and Reablement service (care). Health and social care will work together to ensure that individuals receive a coordinated personalised care tailored to their needs and aspirations to maximise their independence and wellbeing by:

    - Up-skilling frontline staff through training and professional development to take an appropriate and proportionate approach to assessing individual's 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 enabling individuals to take informed risks about how their care is delivered supporting choice and control.
    - Gateway criteria will prioritise intermediate care provision for people based on need rather than diagnostic condition who – are at risk of admission to hospital, which could be avoided through this provision; are at risk od a delay in their discharge from hospital which could be facilitated through this provision; are at risk of admission to a residential/nursing care home; have a health related need and meet the DH intermediate care definition; require a level of intervention that cannot be met by core services; minimises the time that support is offered and will be reviewed in a timely manner.

4. The delivery chain

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

The Enhanced Community Care programme will be accountable to the Transformation Board, comprised of Commissioner Accountable Officers and Provider Chief Executives. A central Enhanced Community Care PMO will form part of the transformation team and will provide co-ordination, expertise and support

to teams working across the county. The programme will be clinically led by the Medical Director of the Transformation Programme and be clinically assured through the Clinical Leaders group, a formal subcommittee of the Transformation Board. Senior practitioner / manager partnerships from every CCG and Provider organisation involved in the programme will be identified and enabled to work in collaboration and in partnership across organisational boundaries to deliver the strategic objectives employing the new ways of working described above. Commissioners and Providers will be co-responsible for delivery and to ensure an equal working partnership with local authorities, and the voluntary and charitable sectors.

In addition we will develop a high level performance/outcomes framework that will distil key indicators and measures to provide assurance that we are impacting from a whole systems perspective.

A bespoke performance monitoring framework will also be developed for this scheme, data collection methods will be refined in tandem with the roll-out of our data sharing arrangements (overtime our approach will include measurement and comparison of GP attendance, A&E attendances and non-elective admissions, admissions to residential and nursing home care, complementary indicators allied to technology enabled services, assistive technologies, enablement, reablement and intermediate care and carers related support services. In addition we will continue to develop and apply an approach which logs whether/how people's personal outcomes are met, and records user feedback at the end of interventions.

5. The evidence base

Please reference the evidence base which you have drawn on

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

Right Care Programme

House of Care

5yr Forward View

NHSE quick guide to better use of care at home

Future hospital commission 2013

Monitor 2015. Moving healthcare closer to home: a literature review of clinical impacts

Monitor 2015. Moving healthcare closer to home: implementation considerations.

As part of our vision and approach we are championing new models of care which see services move away from hospitals and provide care closer to home or sustain people independence within their own home. The approach reinforces the following evidence base and are described as follows

- Fully integrated provider of out of hospital care with a clear and robust governance structure and its own organisational capacity.
- Built around the registered list, focused upon population health and self-care, to enable greater scale and scope of service that dissolve traditional boundaries between primary and secondary care.
- Making the most of digital technologies, with joined up electronic health records for its registered populations, risk stratification and patient population's segmentation, and targeted services for different groups of users/patients.
- New skills and roles for multi-disciplinary community teams.
- Based on population sizes of at least 30 to 50,000.
- Carers UK National Carers Survey: The state of caring and Personal social services National Survey of Adult Carers in England. Locally the Carers Conversation led by Health Watch.

6. Investment requirements

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

The enhanced Community Offer will involve a stock take of current service operations, understanding and developing improved care pathways that will refocus and redesign community services, as described, but the re-engineering of services will seek implementation of the enhanced community Offer within existing resources, recognising the current financial context. Discussions are in train to understand the financial position going forward.

7. Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The model of enhanced community care will aim to achieve the following outcomes for individuals:
Maximise independence after illness or disability through working within a rehabilitation, Reablement and enablement philosophy to return people to optimal levels of functioning, supporting them to remain at home for as long as possible.

- Enhanced quality of life, supporting individuals to make the most of their capacity and potential.
- Empowering people and their carers to take personal responsibility and agree goals for their period of Reablement/intermediate care.
- Increased self-management/management of conditions with an increased focus on service users strengths and support networks already available.
- Delayed and reduced need for care and support, ensuring people receive tailored support/access to appropriate technologies, in the most appropriate setting enabling them to manage their conditions independently.
- Increased confidence, people using the service given the opportunity to shape their individual support and how it is delivered.
- Increased assurance to carers and families, by a trusted environment for individual enabling them to make informed choices about the care they receive.
- Faster recovery from illness.
- Improved/maintained health and emotional wellbeing through increased independence, choice, control, dignity and quality of life.
- More effective use of resources, ensuring limited resources are targeted at those who need them.

8. Feedback loop

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

Continuous feedback and learning will be embedded as described in section 3. Cause and effect in regard to whole system metrics such as admission rates, length of stay, delayed transfers of care and other delays are notoriously difficult to establish, so in addition to monitoring these, part of the learning and evaluation process will involve the development of more meaningful metrics which accurately capture effective admission avoidance activities and improved self-care and self-management.

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

Adequate resourcing of teams and PMO
Effective system leadership to enable strong partnerships and collaboration across the whole system
Effective working across organisational boundaries
Clear leadership and accountability within teams drawn from multiple different employing organisations
Robust work-planning to build in the required time for continuous learning and feedback.
A step change in clinical and care decision making to improve risk management in community settings.

Enhanced community care model

Milestone	Start Date	End Date
Property rationalisation considered across NEB locality for co-location of teams	Feb-16	Mar-16
Task and finish groups identified to enable practitioners to improve integrated working.	Jan-16	Jun-16
Operational delivery groups formed to develop relationships across sectors and start shaping local delivery.	Jan-16	Apr-16
Governance across Staffordshire under the together we're better transformation programme to be confirmed.	Jan-16	Mar-16
Dedicated operational resource secured and in place to provide leadership to social care teams.	Feb-16	Mar-16
Data sharing agreement and memorandum of agreement developed and agreed by partners.	Feb-16	Apr-16
Mapping exercises undertaken to identify baseline information for the locality teams.	Feb-16	Feb-16
Evaluation of Community Wellbeing model and Vanguard sites visited to understand key learning points and consider for the local model and its implementation.	Jan-16	Apr-16
Interdependencies and other key work streams across the local health economy to be understood to enable the models implementation.	Feb-16	Mar-16
Integrated systems, processes and pathways to be developed by practitioners with localities.	Feb-16	Jun-16
Communication and engagement plan considered to ensure key stakeholders are aware of the early implementer sites and the intended outcomes.	Feb-16	Apr-16
Implement new ways of working across the NEB locality.	Apr-16	May-16
Evaluate the learning from the locality prior to considering future commissioning intentions and potential roll out.	Apr-16	Sep-16

1. Scheme name:

3 – Reablement/ intermediate care

2. What is the strategic objective of this scheme?

Effective alignment of intermediate care and reablement across health and social care. This needs to challenge all existing models and consider new delivery vehicles and options.

There will be a model of Intermediate care which will maximise independence, support the recovery from illness and actively enable people to return to optimal levels of functioning. This includes, but is not limited to the treatment and support of people in times of health or social care crisis to avoid hospital admission and to support people following an inpatient episode.

3. Overview of the scheme:

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

- What is the model of care and support?
- Which patient cohorts are being targeted?
- In the template could you reference where possible how the scheme will help support/align to the enhanced community offer

There are currently four key elements within the intermediate tier of support for health and care needs:

- Crisis response (health)
- Home based intermediate care (health)
- Bed based care (community hospitals or care homes – health and care)
- Reablement services (care)

Staffordshire and Stoke currently have a range of commissioned services that fit within this tier ranging across:

- Step up
- Step down
- Community intervention service
- Living independent services

The current user group is mainly older people with multiple long term conditions, frailty and complex life predicaments who are at a crisis in their health and /or care needs.

After an escalation in health and/or care needs individuals are supported to return to a level of stability achieving maximum possible independence and their wellbeing objectives.

Health and Social Care will work together to ensure that individuals receive a co-ordinated personalised care tailored to their needs and aspirations to maximise their independence and wellbeing by:

- Upskilling front line staff through training and professional development to take an appropriate and proportionate approach to assessing individual's 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 enabling individuals to take informed risks about how their care is delivered supporting choice 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 that of a reablement culture to maximise independence and wellbeing.

Current Financial Recovery Plans and Medium Term Financial Savings plans set out a vision for health and social care to achieve increased efficiency and cost reduction. However, through the delivery of the schemes described within the better care fund, health and social care will deliver integrated pathways of care which will enhance current plans and articulate a shared vision across the local health economy.

If we strip away the segregation of having a health or a care need, we get to an "offer" which requires:

- The rationale of providing a direct alternative to hospital/nursing/residential care by:

    - preventing admission
    - expediting discharge
    - and offering the opportunity for rehabilitation following an exacerbation or crisis.

  Every case should meet this test.

- An immediate response to someone in crisis (which is a health crisis, or an eligible social care crisis) – this needs to be less than 2 hours. Only 10% of people who get this response ever need a hospital admission.

- This response needs to be 7 days a week and offered for extended hours dependant on need.

- Stop providing for people who would otherwise get better on their own; and for people whom the current teams support who do not have rehabilitative potential e.g. long term complex care; maintenance packages of care. The service specification currently under development for this service has been amended to state that this provision can only be used for maintenance packages as a provider of last resort where the provision cannot be sourced from the independent market. There is a domiciliary care project team working up the options for recommissioning of domically care which will take this issue into account in order to free up this capacity for reablement/intermediate care.

- The targeting of people - not an open door. The gateway criteria will prioritise Reablement Care provision for people who:

❖ Are at risk of admission to hospital which could be avoided through this provision.
❖ Are at risk of a delay in their discharge from hospital which could be facilitated through this provision.
❖ Are at risk of admission to a Residential Care Home which could be avoided through this provision.
❖ Have requested an assessment for a Social Care provision, the intensity of which could be reduced through the provision of this service, or no longer required because they are likely to recover during this intensive period of support.
❖ Are already in receipt of Social care eligible domiciliary care, the intensity of which could be reduced through the provision of this service, potential reducing high cost care packages.
❖ Are currently living in a Residential Care Home and who have the potential to return to independent living in the Community following a period of Reablement/ Intermediate Care.
❖ Have a health-related need and meet the DH intermediate care definition :

- "a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living".

❖ Are identified as 'end of life' and have an urgent need for short term health or social care. E.g. Intravenous antibiotics for a chest or urinary tract infection to avoid hospital admission or carer breakdown
❖ Require a level of intervention (either in terms of frequency, intensity or complexity) that cannot be met by core services with the overall goal being to prevent admission (to hospital or long term care) or facilitate safe discharge
❖ Minimising the time that support is offered rather than maximising the 6/12 week time limit. Intermediate care offers 13 contacts on average, versus 36 hours of enablement.
❖ Individuals will receive a timely review of their needs to ensure that they are reabled to reach maximum independence, this may result in a reduction of support as independence increases or a level of maintenance support is established.

Although the focus of the Staffordshire BCF submission is the frail elderly population, this scheme will benefit the adult population of Staffordshire.

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

Whilst existing arrangements operate in parallel currently, commissioners will work with providers to ensure the integrated model of care is embedded within practice across all parts of the county. The commissioning organisations will be:

- Staffordshire County Council
- Stafford and Surrounds and Cannock Chase CCGs
- Cannock Chase CCG
- North Staffordshire CCG
- East Staffordshire CCG
- South East Staffordshire and Seisdon Peninsula CCG

Key providers include:

- Staffordshire and Stoke on Trent NHS Partnership Trust
- Primary Care
- GP First
- Voluntary Sector
- University Hospital of North Midlands
- Burton Hospitals Foundation Trusts
- Royal Wolverhampton Hospital Trust
- North Staffordshire Combined Healthcare Trust
- South Staffordshire and Shropshire Foundation Trust

The work would also recognise what's happening with reference to the SSOTP transformation programme – year 2 plan:

- This links to the 'Best value review of social care reablement service' with some already identified expected savings. These two projects have been aligned and will be project managed under one work-stream.
- This work also links to the front door work stream taking place under SSOTP one of the aims is as

follows; Citizens to have access to AT, prevention and reablement without going through a lengthy project. So it would be necessary to ensure that appropriate link exist between services and projects.

- It is also imperative that close links are made to the SSOTP workforce programme in order to ensure the services have the correct staff in place, fully trained to deliver these services.

Delivery of this scheme will be project managed via the SCC Transformation project manager and will incorporate continuous learning.

5. The evidence base:

Please reference the evidence base which you have drawn on

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

Staffordshire currently has an 'integrated' health and social care provider, in the form of SSoTP. However, work by this provider is commissioned separately by health and social care commissioners. There is national acknowledgement that deeper integration of health and social care is required to deliver better outcomes for individuals and deliver the required financial savings for health economies.

The National Audit of Intermediate Care categorises reablement as services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals. Reablement workers support and enable independence with individuals with personal care, with daily living activities and other practical tasks and encourage service users to develop the confidence and skills to carry out these activities themselves and continue to live at home.

A quality, outcome focused reablement service can reduce dependency on social care services. By ensuring more people are enabled rather than being put into long term care services unnecessarily, this will improve outcomes for individuals enabling them to remain/become more independent rather than the current model of dependency on services.

Integration:

- Intermediate care is at the forefront of the integration agenda with the NHS and Local Authorities having worked together to commission and provide intermediate care services for many years.

Patient experience:

- The results showed a very high level of satisfaction with services, and in particular, the proportion of service users who felt they were treated with dignity and respect was more than 89%. 75% of patients reported feeling less anxious as a result of their experiences.

Demand and Capacity:

- There is no evidence in the 2014 audit of a national trend towards materially higher investment levels in intermediate care, although two areas have invested significantly more than average in home based services. Around one-third of home based capacity and two-thirds of bed based capacity is being used for step-down care. In this year's sample, reablement services reported a shift towards step-down care with 44% of referrals coming from acute trusts compared to 35% in 2013.

Use of resources:

- Reablement length of stay remains consistent with NAIC 2013 findings at 32.7 days.

Dependency and outcomes:

- The average dependency level of service users on admission to bed based services has increased. However, the vast majority of service users experience a positive outcome with 92% of service users in home based care and 94% in bed based care maintaining or improving their level of functioning across a range of everyday activities.

The Care Act 2014 requires integration, cooperation and partnerships. For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing. The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families. Sections 3, 6 and 7 of the Act require that:

- Local Authorities must carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services.
- Local Authorities and their relevant partners must cooperate generally in performing their functions related to care and support.
- Local Authorities and their partners must cooperate in performing their respective functions relating to care and support and carers wherever they can.

The Care Act states that "Intermediate care" services should be provided to people, usually older people, after they have left hospital or when they are at risk of being sent to hospital. These individuals do not have to have eligible needs for care and support. Intermediate care should be provided for a limited period to assist a person to maintain or regain the ability to live independently.

Early or targeted interventions such as a period of reablement and providing equipment or minor household adaptions can delay an adult's needs from progressing. The Local Authority (LA) may 'pause' the assessment process to allow time for the benefits of such activities (prevention) to be realised, so that the final determination of need is based on the remaining needs. If the LA believes that a person may benefit from short term reablement services, it may put that in place and complete the assessment following the provision of that service.

Where a person is provided with any type of service, or supported to access any facility or resource as a preventative measure, the LA should also provide the person with information in relation to the measure undertaken. The LA is not required to provide a care and support plan or a carer's support plan ('as per requirements associated with an assessment of need') where it only take steps under section 2 of the Care Act; however, it should consider which aspects of a plan should be provided in these circumstances, and should provide such information as is necessary to enable the person to understand:

  - what needs the person has or may develop, and why the intervention or other action is proposed in their regard;
  - the expected outcomes for the action proposed, and any relevant timescale in which those outcomes are expected; and
  - What is proposed to take place at the end of the measure (for instance, whether an assessment of need or a carer's assessment will be carried out at that point

- The National Service Framework for Older People - DH, (2001)
- High Quality Care for All NHS Next Stage Review Final Report - DH, (2008)
- Focus on: Frail Older People - NHS Institute for Innovation and Improvement (2009)
- NHS & Social Care Outcomes Frameworks

- NICE Guidance and recommended pathways http://guidance.nice.org.uk/
- Map of Medicine pathways provided by the NHS Institute for Innovation and Improvement http://eng.mapofmedicine.com/evidence/map/index.html
- Applicable National Service Frameworks http://www.nhs.uk/NHSengland/NSF/pages/nationalserviceframeworks.aspx
- Applicable recommendations made by Sir Robert Francis QC Report 6th February 2013 http://www.midstaffspublicinquiry.com/
- Intermediate Care – Halfway home - DH, (2009)
- Care Closer to Home/Our Health Our Future review -Lord Darzi report, DH (2007)

6. Investment requirements:

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

The intermediate care/reablement scheme will involve a stock take of current service operations, understanding and developing improved care pathways that will refocus and redesign community services, as described, but the re-engineering of services will seek implementation of the enhanced community offer as a key component, within existing resources, recognising the current financial context. Discussions are in train to understand the financial position going forward.

7. Impact of scheme:

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The service aims to achieve the following outcomes for individuals:

- Maximise independence after illness or disability through working within a rehabilitation, re-ablement and enablement philosophy to return people to optimal levels of functioning, supporting them to remain at home for as long as possible.
- Enhanced quality of life, supporting individuals to make the most of their capacity and potential.
- Empowering people and their carers to take personal responsibility and agree goals for their period of reablement/ Intermediate care.
- Increased self-care/management of conditions with an increased focus on service users' strengths and support networks already available.
- Delayed and reduced need for care and support- ensuring people receive tailored support/ access to appropriate technologies, in the most appropriate setting enabling them to manage their conditions independently.
- Increased confidence; people using the service can regain skills they may have lost.
- Increased Choice and Control; people are given the opportunity to shape their individual support and how it is delivered.
- Increased reassurance to carers and families, by providing a trusted environment for individuals enabling them to make informed choices about the care they receive.
- Faster recovery from illness.
- Improved /maintained health and emotional well-being through increased independence, choice, control, dignity and quality of life.

Commissioner outcomes:

- More effective use of resources; ensuring limited resources targeted at those who need them.
- Reduction in long term demand for domiciliary care; fewer inappropriate referrals into maintenance packages.
- Increase in preventative solutions thus reducing the long term cost of health and social care e.g. increased use of Assistive Technologies (AT); improved evidence of AT within support plans.
- Raising awareness and understanding of the benefits of AT to help people self-care.
- Hospital admission avoidance through provision of Step-up care, and assisting hospital discharge through Step-down care.
- Reablement philosophy embedded in care pathways to increase independence and reduce dependency on services and 'delay' the need for care.
- Increased levels of Service User satisfaction, ensuring that people are at the heart of any decision that affects their life.
- Improved performance in relation to:
- Effectiveness of reablement ; outcomes based on evidence of effectiveness
- Prevent unnecessary Emergency admissions
- Enable timely discharge for social care related delayed hospital discharges
- Prevent/ reduce premature admissions to residential and nursing care Shorter lengths of stay within the acute and community trust setting
- Reduced numbers of re-admissions within 30 days for patients

Savings from this scheme would be generated by:

- Increasing effectiveness of services so making sure the services work with the right people at right time and to increase responsiveness to crisis.
- Making sure that the unit cost of the various services is a low as possible making use of integration possibilities and opportunities to outsource provision to independent sector.
- Managing/rationing the demand into the service so it only does what it should be doing –i.e. targeting the right cohort of people at the right time.
- Increasing income from charging users of the service where appropriate; charging for maintenance, and considering social eligibility charging for reablement.
- Reduction in secondary care admissions particularly for ACS conditions

8. Feedback loop

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

Monthly monitoring of Key Performance Metrics against agreed targets:

Metrics

• **Decrease in Admissions to residential and care homes**

The rationale of providing a direct alternative to hospital/nursing/residential care by preventing admission, expediting discharge and offering the opportunity for rehabilitation following an exacerbation or crisis.

LGA Adult Social Care Efficiency Programme - Developing more integrated services. Northumberland have saved £5 million through their integrated model of care with Northumbria Health Care Foundation Trust. The approach has seen a 12 per cent reduction in residential care while demand for domiciliary care has been maintained at a constant level despite demographic pressures. Richmond's integrated reablement service has saved £2.1 million over the three years, reducing demand for council services, avoiding admissions to hospital and reducing the length of time people stay in hospital.

• **Effectiveness of reablement - Increase in number of individuals successfully reabled (14/15 outturn – 3,081)**

This tier of response is half the size it needs to be based on national averages and assumptions that 30% of (older) people can be supported other than at A&E, and that 25% of older people admitted could be discharged earlier. This isn't about costing more – it is stopping a higher cost elsewhere in the system, and not providing a response to everyone – especially where the evidence suggests there is no benefit.

The targeting of people - not an open door : who would otherwise need a hospital bed, a community hospital bed, a care/nursing home bed, a high cost care package, and those who meet eligibility criteria (for social care).

- **Decrease in Delayed transfers of care**

An integrated and effective intermediate care and reablement service would add additional service capacity to the community offering the opportunity to expedite more hospital discharges. Agreement on local action plan required to reduce delayed transfers of care.

- **Patient / service user experience - Individuals reporting a positive experience of care**

A new measure of the effectiveness of the service in supporting people to maintain their independence has been added to Domain 2. This measure will provide evidence of a good outcome in delaying dependency or supporting recovery – short-term support that results in no further need for care.

Placeholder measure 2E remains, to support the interpretation of the new measure of the effectiveness of reablement services. This is intended to support a more rounded view of the success of short-term support in supporting people to recover their independence. It has been agreed that it would be most desirable to include a measure which asks those in receipt of short term services about their outcomes, and/or the quality of services they received.

- **Reduced readmissions within 90 days**
  Percentage of Older people still at home 91 days after discharge from hospital into reablement (ASCOF 2B (1) – (14/15 outturn 87.9%)
- **More patients supported to remain at home following a rehabilitation/reablement intervention**
  Older people still at home and needing no ongoing social care services 91 days following receipt of the service. (14/15 outturn 54.8%).
- **Reduced number of individuals receiving intensive care packages**
  Percentage of people receiving reablement where the immediate outcome was no support or low level support (ASCOF 2D) (14/15 outturn 69.1%)
- **Reduced length of stay in both acute and community hospitals**
- **Reduced number of readmissions to hospital within 30 days**
- **Reduced number of secondary care admissions for ASC conditions**

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

<u>What Needs to Change:</u>

There needs to be a whole system culture shift so that asset based assessment, Assistive Technology and reablement/intermediate care are an integral part of the assessment process embedded throughout. This asset based approach, including Assistive Technology will enable people to self-care, without the need for

on-going support. These changes will impact on Social Care staff undertaking assessments and sourcing care packages, therefore staff will need to have the correct process to follow and to feel confident that they can challenge and escalate decisions they think are incorrect.

The main proposal for this tier is that changes are enacted which:

- Target the right people who can recover in the best possible way (outlined in section 3).
- Create a new care pathway for all older people, where support at the least intrusive intervention is a default.
- Within that pathway, implement a Discharge to Assess approach with going home as the default practice. Promoting a "home first" philosophy.
- Introduce "eligibility" for social care support (rather than the current open door approach).
- Stop providing support within this tier for people who will get better, who need long term care or whom do not have current rehab potential anyway; introduce gateway criteria as outlined in section 3.
- Address the misinforming of expectations about what an "entitlement" is and what is "free" across the whole workforce.
- Introduce the appropriate mechanisms to charge for chargeable services and collect the income due.
- Work towards every area offering effective crisis response within 2 hours, across an extended day for 7 days per week which GP's, social care, and ambulance services.
- Structure the intermediate tier as an integral part of new and emerging integrated local teams of multiple practitioners.
- Remove maintenance support from the existing Reablement service; understanding where else this support can be provided for e.g. frameworks, block purchase support, develop care in hard to reach areas.
- Change the length of support from an entitlement culture of 6/12 weeks to a needs led bespoke response per patient/person.
- Quantification of need/demand for specific interventions, as well as sufficient community capacity to accommodate demand.

Reablement/ Intermediate care

Milestone	Start Date	End Date
Financial modelling	Mar-16	May-16
Productivity benchmarking & comparison (KPMG)	Mar-16	May-16
Approval (Programme Board)	Apr-16	Jun-16
Implementation Plan	Apr-16	Jun-16
Mapping As Is - LIS/Cis	Apr-16	Jun-16
Confirm funding streams	Apr-16	Jun-16
SCC advice re period of reablement (6 weeks or 12 weeks)	Mar-16	May-16
Look at best practice	Mar-16	May-16
Remodel reflecting approach to maintenance care	Mar-16	May-16
Option appraisal	May-16	Jul-16

Approval (Programme Board)	May-16	Jul-16	
Implementation Plan	Jun-16	Aug-16	
Procurement Process	Jun-16	Aug-16	

1.Scheme name

4 - Discharge /delayed transfer of care

2. What is the strategic objective of this scheme?

There is an increasing cohort of frail elderly and older people with Long Term Conditions (LTC) including dementia, being admitted to acute facilities. These patients are placing an increased demand and stretch on health and social care services both in the acute and community settings. The complexity of this cohort of people has an impact on timely and seamless discharges across the Staffordshire Health Economy. There is a significant increase in health and social care assessments, delayed transfers of care (DTOC), packages of care (POC) and demand enablement beds both health and social.

The complexity of discharges and longer Length of Stay (LoS) has had a major impact on our healthcare system particularly since January 2016 and a subsequent negative impact on the A & E Constitutional standards. However this picture is reflected across the West Midlands.

There is National evidence to say that older people decompensate on admission and in particular with a longer length of stay. The result of which can lead to the person not regaining their pre-hospitalisation mobility and status resulting in the need a higher domiciliary care package or for a permanent change of residence such as Nursing Home. A good example of this is the case highlighted Nationally of Mrs Andrews story.

The strategic objective of this scheme is to apply the Home First principle which includes:

- Reduction in the number of DTOCS to below the national target of 3.5% where applicable and maintain position in context of unmet need performance. (Current performance for DTOCS in Northern/Stafford is 2.9% Dec 2015 and East 6.0% Jan 2016)
- Develop Discharge to Assess (D2A) pathways
- Improve the Fast Track pathway (patients requiring palliative care)
- Improve discharge process across organisational boundaries with a designated lead for discharge

3. Overview of the scheme

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

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

The themes of discharge are consistent throughout Staffordshire and in acute trusts over the borders, including delays as a result of patient choice, long waits for assessments (health or social), limited capacity to provide care packages, nursing/residential home placement, housing issues and capacity/availability of community teams.

For Northern Staffordshire/Stafford the delivery of whole system urgent care presents a significant challenge to all stakeholder organisations. The urgent care system has consistently failed to achieve the national target of seeing 95% of patients within 4 hours, with a significant number of 12 hour trolley breaches.

There have been a number of diagnostics undertaken within the health economy to understand the reasons for the challenges within the urgent and emergency care system.

As the A&E trajectory had not been achieved further diagnostics on the system have been undertaken by Dr Ian Sturgess. This resulted in the development of high impact interventions designed to resolve the issues identified in the economy. More recently a system diagnostic by the Emergency Care Improvement Programme (ECIP) has resulted in the following six key priorities being identified:

- Leadership
- MADE
- Ambulatory care
- SAFER
- Therapies
- Frailty and D2A

Working with ECIP all existing plans have therefore been rationalised and a framework developed to deliver improvement across the urgent and emergency care system. The framework for delivery includes assess before admission, todays work today and D2A. This supports DTOCS as part of the unmet demand. A range of schemes have been developed to support with the delivery of the framework with leads and is monitored by the SRG.

For East Staffordshire in September 2015 DTOC performance declined to 10.9% with most of the delays due to social care (77%) and 15% due to health and 8% due to both. A recent West Midlands Quality Review reinforced the view that there is an increasing cohort of frail older people, with comorbidities, including dementia, being admitted to Burton Hospital Foundation Trust. These patients are placing an increased demand on health and social care services in terms of undertaking timely assessments and ensuring that there is sufficient capacity commissioned in the community and independent sector to meet both their simple and complex discharge needs.

As part of a wider Staffordshire system plan to maintain flow an action plan specifically to address DTOC issues was produced following a cross economy workshop at the beginning of November. It articulates how Eastern Staffordshire SRG plan to achieve the 3.5% target by April 2016 which equates to 15 people medically fit for discharges, who are taking up a hospital bed due to delays elsewhere in the system.

The general cohort of the patients this impacts on are the frail elderly and patients with long term conditions who will be the main focus of this scheme.

The objectives are:

- Patients are able to return to their usual residence with or without support
- Improved clinical patient outcomes to include reduction in induced immobility, hospital acquired infections
- Rapid access to rehabilitation (health) beds for intensive therapy input
- Improved patient and family experience – patients are only moved once
- Optimal care to meet the current needs of the patient in a seamless and coordinated manner
- Fewer people accessing long term care
- Improved discharge flow and processes to include integration of teams and a designated lead each patients discharge
- Patients who are at ‘End of life’ can exercise choice and are able to die at home

The Outcomes are:

- Reduction in numbers of DTOC
- Reduction in LoS
- Reduced Excess bed days

- Improved bed utilisation hospital and community
- Reduction in hospital acquired infections
- Improved rehabilitation potential and reduction in decompensation
- Increased number of palliative patients are able to die at home or place of choice

The model of care will be that of 'Home First' and will include the following areas:

- Discharge to assess pathway (D2A) including a Dementia pathway
- Community Rehabilitation – increased capacity and capability
- Redesign of Fast Track discharge pathway/processes
- Redesign of the discharge team model with integration across organisational boundaries
- Improved pathway for patients admitted from Nursing /residential care home to include the 'Trusted Assessor ' model
- Step up/step down – pathway

4. The delivery chain

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

The Northern (includes South West) Systems Resilience Group (SRG) meets on a fortnightly basis and has members from all key stakeholders from Health & Social Care who oversee the local health economy (LHE) ECIP plan.

Governance Structure

Delivery of their actions is supported through a PMO with a number of specific working groups responsible for the delivery of this scheme across UHNM including both County and Stoke hospital sites. The strategic oversight of the plan is undertaken by the Northern Delivery Group/SRG, the tactical by the Integrated Operational Group and operational by the Delivery Groups. The delivery groups are responsible for work associated with delivering the key priority areas of assess before admission, todays work today and D2A.

Critical Success Factors

For the three priority areas (listed above), 35 critical success factors have been developed. Each action has in place a:

- Accountable Lead;
- Operational Lead;
- Time for completion;
- Metrics to determine impact.

This scheme seeks to reduce the disparity between hospital sites and have an overall model which may have slight differences due to service provision.

Within Eastern Staffordshire a similar structure is in place with the System Resilience Group (SRG) being chaired by the Accountable Officer from East Staffordshire CCG overseeing the delivery of the DTOC plan. A System Resilience Operational Group (SROG) is in place to provide a forum for open discussion and to facilitate collaborative working across the health and social care economy. The SROG reports directly to the SRG and the Chair of the SROG is a member of the SRG.

The SROG has instigated Task and Finish Groups to focus on key pieces of work that would support better flow, address currently issues in the system and provide support to the system. The Task and

Finish Group leads are accountable to SROG.

Key stakeholders include:

- UHNM
- Burton Hospital Foundation Trust
- RWHT
- Staffordshire County Council
- SSoTP
- Virgin Care
- Health care professionals across the pathway
- CCG Directors and Unplanned care leads
- Quality lead

Levels of Discharge and DTOC has a direct dependency on Intermediate Care services (where there is a health need) and/or community social support services (where there is a social care need) therefore this scheme is dependent on/part of Intermediate Care/Reablement Scheme (scheme no. 3).

5. The evidence base

Please reference the evidence base which you have drawn on

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

DTOC Roadshows - A total of 8 interventions were outlined to have been developed through last year's Helping People Home team's work, of which "Change 4: Home First/ Discharge to Assess" is a recommendation.

The NHS Outcomes Framework 2014/15

NICE Commissioning guide
Older People in Acute Settings, NHS Benchmarking, April 2015.

Improving Patient Flow, Health Foundation, April 2013.
NHS England (2015) Transforming urgent and emergency care services in England.

Evidence suggests that there is a significant relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. Gill et al (2008) observed that 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over the age of 80.

Professor Ian Philp has put forward 4 key principles to improve care for older people as follows:

- 'choose to admit' only those frail older people who have evidence of underlying life-threatening illness or need for surgery – they should be admitted, as an emergency, to an acute bed.
- provide early access to assessment, ideally within the first 24 hours, to set up the right clinical management plan.
- 'discharge to assess' as soon as the acute episode is complete, in order to plan post-acute care in the person's own home.
- provide comprehensive assessment and re-ablement during post-acute care to determine and reduce long term care needs.

6. Investment requirements

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

The discharge scheme will involve a stock take of current service operations to support discharge, understanding and developing improved care pathways within existing resources, recognising the current financial context. Discussions are in train to understand the financial position going forward.

7. Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved patient and family experience
- 'Home First' principle
- Increased number of palliative patients are able to die at home or place of choice
- Reduction in numbers of DTOC
- Reduction in LoS
- Reduced Excess bed days
- Improved bed utilisation
- Reduction in hospital acquired infections
- Improved patient flow across the health and social care system
- Improved patient outcomes as people will be support to access the right care at the right time.
- There will be fewer assessments and removal of duplication within the system
- A reduction in readmissions
- Increased emphasis on re-ablement and rehabilitation
- Improved patient experience and outcomes
- A reduction in need for social care funded long term residential and nursing care
- A reduction in high level of social care packages
- Reduced need / expenditure at Continuing Health Care (CHC) levels.

8. Feedback loop

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

All progress and outcomes of the scheme will be monitored at a project and programme level and reported up to the SRGs until the new model becomes business as usual. The NHS service improvement methodology will be applied and all redesign areas will be tried and tested using the 'Plan, Do, Study and Act' (PDSA) cycle. Where an action or step in the pathway is not working then it will be tweaked as per the evidence gained from the review (PDSA cycle).

Once business as usual activity and outcome measures will be formulated and fed back to commissioners via contract monitoring mechanisms and outcomes reporting.

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

- Improved patient and family experience
- Reduced number of DTOC (to maintain or reduce to the national target of 3.5%)

- Improved Patient Outcomes
- Reduction in LoS
- Increased number of patients discharged to usual residence

Discharge/ Delayed transfer of care

Milestone	Start Date	End Date
Roll out exemplar ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in acute hospitals	Nov - 15	Jan-16
Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in community hospitals	Nov - 15	Jan-16
Roll out Exemplar Ward (safer bundle) principles, where appropriate, in the mental health trust	Dec - 15	Feb-16
Align and improve discharge processes for South Staffordshire patients treated at Royal Stoke	Jan - 16	Mar-16
Plan for discharge within 48 hours for emergency admissions	Jan - 16	Mar-16
To have accurate and timely information related to discharge of patients with complex needs and use it to forward plan	Dec - 15	Feb-16
Establish a multi-agency accelerated discharge team	Dec - 5	Feb-16
Medical ownership of speciality outlier	Sep - 15	Nov-15
Develop 'without prejudice' agreements between health and social care to enable patients to move into a care home placement for assessment	Jan - 16	Mar-16
Work with Care Homes to assess previous residents within 24 hours	Feb - 16	Apr-16
Roll out of trusted assessor model across the health and social care economy	Feb - 16	Apr-16
Develop a single health and social care direction of choice policy	Jan - 16	Mar-16
UHNM will operate 3 community hospitals for step down and the management of patients from admission to final destination	Jan - 16	Mar-16
Reduce the number of care packages held open when people are admitted to hospital	Feb - 16	Apr-16
Increased supply of domiciliary care within North staffs	Dec - 15	Feb-16
Reduce the amount of time taken for residential and nursing care	Dec - 15	Mar-16
Increase capacity in Domiciliary care	Nov - 15	Jan-16

7 Day Services

Assess before Admission

Exemplar Front Door

Aims: To develop a model of care for adults patients who require urgent assessment and possible intervention, which facilitates rapid assessment and decision making at the appropriate stage in the patients journey, rather than defaulting to an emergency admission. Provide immediate assessment intervention from expert team for frailty. Embed and Expand emergency ambulatory pathways designed to avoid admission. Right Care, right time by right person with right skills in right place.

Outcomes: Enhanced patient experience. Seamless pathways which avoid hospital admission. Improved care coordination across all settings supporting right care, right place, right person. Development and enhancement of existing FoH initiatives. Improved patient flow. Improved discharges. Increased transfer to ambulatory pathways. Hot Clinic Provision

Benefits: Contribute to the delivery of A&E 4 hour target. Increased patient satisfaction. Less outliers. Decreased admission rates by age by head of population. Increases number of patient on ambulatory pathways. Reduced conversion to in-patients. Avoid decompensation of patients from hospital admission.

Frailty

Step Up

Ambulatory Pathway

Today's Work Today

Review of cross economy bed based Services

SAFER

Aims: All patient to have a Consultant Review before midday. All patient will have an EDD based on medically suitable for discharge status agreed by clinical teams.
To increase the flow of patients at the earlier opportunity. 33% of patients will be discharged from base inpatient wards before midday. Weekly systematic review of patients with extended lengths of stay.
Outcomes: Structure to the days to day running of the ward. Consistent organised and disciplined approach. Efficient use of time and resources. Care coordinated appropriately. Required capacity created for incoming patients.
Benefits: Improved care coordination and standardisation of approach. Well planned, informed and timely discharge. Less Outliers. Patients will be less likely to be cared for in crowded wards and departments.

Therapies

Aims: Realigning service models. Appropriate therapy resource in the right environment. Reduce the level of decompensation in a bed based service.
Outcomes: Improved patient Flow. Improved discharges. Improve the services provided as part of Assess before admission. Active intervention and reablement reduce decompensation and maximise independence
Benefits: Reduction in NH/RH home placements needed. Reduction in the hours of Dom Care needed. Reduce reliance on bed based services. Increased patient satisfaction. Redirection to lower level of care. Contribute to A&E 4 hour target.

Discharge to Assess

Home First

Aims: Discharge to assess with Home First principles. Reduced impact on independence and future quality of life. Decreased risk of harm.
Outcomes: Enhanced patient experience. Decrease in the number of patients admitted to long term care. Active intervention and reablement reduce decompensation and maximise independence. Improved patient flow.
Benefits: Contribute to A&E 4 hour target. Increased patient satisfaction. Less outliers. Redirection to lower level of care. Reduced LoS. Reduction in NH/RH home placements needed. Reduction in the hours of Dom Care needed. Reduce reliance on bed based services

Step Down

Aims: Address Staff capacity, capability and engagement shortfalls. Create appropriate infrastructure and estate. Embed effective governance and achieve compliance. Achieve quality and safety standards. Meet national performance standards. Achieve financially stability
Outcomes: develop Collaborative working and partnerships. Develop existing community services, Develop seamless integrated services, improve patient experience. Appropriate utilisation of resources.
Benefits: Contribute to A&E 4 hour target. Increased patient satisfaction. Less outliers. Redirection to lower level of care. Reduced LoS

Escalation Planning

Workforce Development and OD

ICT Enabling schemes

Capacity and Demand Modelling

Communications and Engagement

These projects will help with admission avoidance

These projects will help with bed based services sustainability

These projects will help with hospital flow

Assess before Admission

Actions highlighted in pink are actions contributing to the MFFD & DTOC plan

On Track
Off track but recoverable/impact expected but not fully achieved or demonstrated
Off track/impact not realised or not demonstarted

Scheme	Relates to UCRP Action Number:	Critical Success Factors	Accountable Lead	Operational Lead	Short / Medium / Long Term	The Metrics	RAG Time	RAG (Impact)	RAG (Risk)
Exemplar Front Door	**22**	Extend the SPEED Team	Helen Lingham	Gill Adamson	Short Term - 31.03.16	• Reduction of 7 avoided admissions per day from 01.12.15 • Reduction of 10 avoided admissions per day from 31.03.16			
	35	Increase the number of patients conveyed by WMAS to FOH	Paul Jolley	Natalie Cotton	Short Term - 01.03.16	• Delivery of 40 net divert to FOH/UCC per day. Attainment of ED SLA, on a monthly basis		Avg. 42 diversions per week (Q3 Avg)	Capacity for clinical handover
	36	Direct booking in to UCC from the NHS 111 service	Paul Jolley	Tim Jones	Short Term - 01.03.16	• Delivery of 40 net divert to FOH/UCC per day. Attainment of ED SLA, on a monthly basis		Avg. 42 diversions per week (Q3 Avg)	Obtaining formal agreement for implementation
	38	Development of Liaison Psychiatry to 24/7 at RSUH	Sandra Chadwick	Jane Barnes / Ron Daley	Short Term - 30.01.16	• 24 hour access to specialist MH assessment in ED and Acute wards • Effective MH interventions in ED and Acute			
Frailty	**27**	Improve patient experience by changing the pathway for care of the Frail Elderly patients presenting at UHNM	Helen Lingham	Gill Adamson	Short Term - 01.12.15	• AMU transitions direct to Elderly Care Wards • Increased capacity in the ED by 0.5% • 2% reduction in AMU occupancy			
	28	Re-specify the FEAS to provide in-reach to portals	Sandra Chadwick	Dave Sanzeri	Short Term - 11.01.16	• 10% reduction in NEL admission for over 75's Pan Staffordshire (5% for Northern Staffordshire - already delivering some impact) Pan Staffordshire this equates to 5976 NEL reduction (Northern Staffordshire impact 794 and contribute to the avoidance of 4771 NEL) TBC reference to ECIP			
	29	Re-specify the FEAS to provide GPs with a same day / next day service	Helen Lingham	Ian Donnelly	Short Term - 05.10.15				
	30	Re-specify the FEAS to provide GP support for anticipatory planning including Comprehensive Geriatric Assessment (CGA)	Helen Lingham	Ian Donnelly	Short Term - 30.01.16				
	18/20	Expand the Nursing Home project	Sandra Chadwick	Dave Sanzeri	Short Term - 30.12.15	• Reduction in NEL by 520 per year FYE over 38 Nursing Homes			
Step up	**37**	Further increase the clinical portfolio of the FOH/UCC	Paul Jolley	Natalie Cotton	Long Term - 01.02.16	• Increased capacity of the FOH/UCC (quantitative KPIs to be determined)			Procurement timescales and agreeing the agreed option
	19	Implement the specialist Integrated Long-Term Condition Pilot, to establish UHNM as the lead for the community-based integrated Long-Term Conditions service delivered by Specialist nurses under clinical governance of the UHNM consultants	Helen Lingham	Dave Sanzeri	Medium / Long Term - 24.12.15	• Reduction of 1300 NEL admission in 2015/16			
	21	Increase capacity for Step up Intermediate Care	Becky Scullion	Christine Wheeler	Short Term - 30.12.15	• 3009 step up Intermediate Care Packages available FYE in 16/17. Overall step-up/stepdown case load increased to 113 by December 2015 continual review and promotion of service to GPs and Nursing Homes			
	31	Reduce the number of High Volume Users (Frequent Attenders)	Paul Jolley / John Ox	Leanne Sheppard	Medium Term - 31.03.16	• Reduction in 1 NEL admission/ per month / per practice			
	32	Implement a clinical reappraisal mechanism for green ambulance and ED disposition, from the NHS 111 Service	Paul Jolley	Tim Jones	Medium Term - 01.09.14	• Delivery of 84 diversions per week (as reported via the NHS 111 Sitrep) • ED and ambulance dispositions to be maintained at or below the national average on a monthly basis			
	33	Maximise Utilisation of the Walk in Centres	Mandy Donald	Cath Skerratt	Short Term - 31.12.15	• Divert 2-3 patients each day to walk in centres			
	34	Maximise utilisation of step up beds	Kieron Murphy	Lisa Hulme	Short Term - 31.12.15	• Increase referral to step up			
Ambulatory Pathway		AEC Model & Short Stay	Ian Donnelly	Amanda Wilding	Short Term - 19.02.16	• Paper to SRG on 11/02/16			

Today's Work Today

On Track
Off track but recoverable/impact expected but not fully achieved or demonstrated
Off track/impact not realised or not demonstarted

Actions highlighted in pink are actions contributing to the MFFD & DTOC plan

Scheme		Relates to UCRP Action Number:	Critical Success Factors	Accountable Lead	Operational Lead	Short / Medium / Long Term	The Metrics	RAG Time	RAG (Impact)	RAG (Risk)
Cross Economy bed based services	SAFER	**9**	Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in Acute Hospitals	Helen Lingham	Judith Earl	Short Term - 30.11.15	• 50% improvement productive patient days caused by internal delays • Reduction in the number of stranded patients over 70 years 10+ days • Increase in the number of discharges to pre admission place of residence • Achieve 30% of patients discharged before 12:00. Achieve 35% of patients discharged before 13:00			
		10	Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in Community Hospital	Mandy Donald	Lisa Hulme	Short Term - 30.11.15	• 50% improvement productive patient days caused by internal delays • Reduction in the number of stranded patients over 70 years 10+ days • Increase in the number of discharges to pre admission place of residence • Achieve 10% of patients discharged before 13:00 from identified benchmark			
		11	Roll out Exemplar Ward (Safer Bundle) principles, where appropriate, in the Mental Health Trust	Andy Rogers	Jane Munton-Davies	Short Term -20.12.15	• To reduce the number of stranded patients over 70 years 10+ days • To increase the number of discharges to pre-admission place of residence • To increase the number of earlier in the day discharges			
	Therapies		Review of Therapy service to be undertaken Plan for improvement to Therapy Service's to be developed	Liz Rix	TBC	Short Term - 31.03.16 Medium Term -	TBC			

Discharge 2 Assess

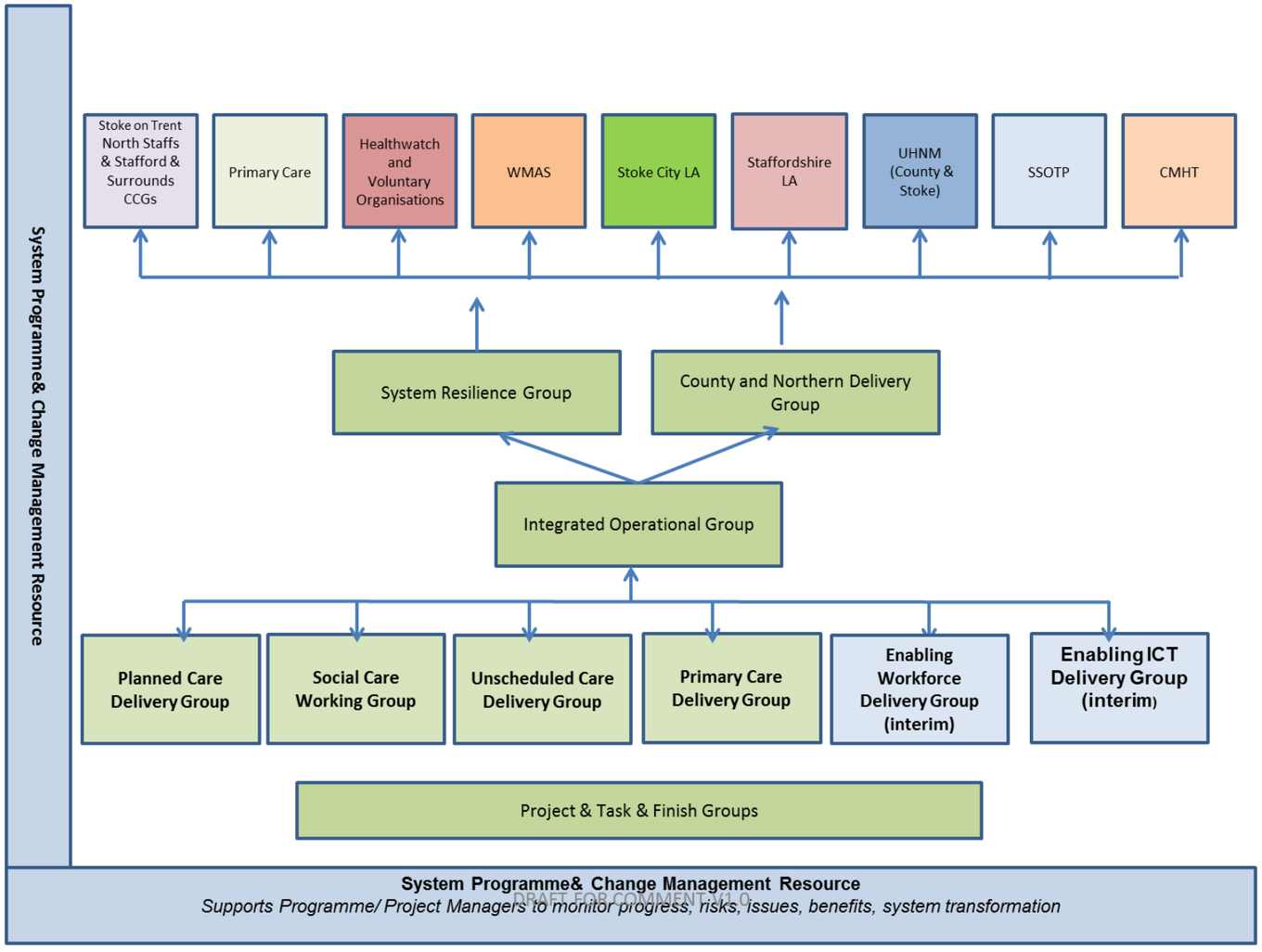
Actions highlighted in pink are actions contributing to the MFFD & DTOC plan

On Track
Off track but recoverable/impact expected but not fully achieved or demonstrated
Off track/impact not realised or not demonstarted

Scheme	Relates to UCRP Action Number:	Critical Success Factors	Accountable Lead	Operational Lead	Short / Medium / Long Term	The Metrics	RAG Time	RAG (Impact)	RAG (Risk)
Home First	**3**	Align and Improve discharge processes for South Staffordshire patients treated at Royal Stoke	Rob Lusuardi / Claire MacKirdy	Alex Bennett / Nicky Cooke	Short Term - 30.01.16	• Monitor Progress and Delivery through DOG and SRG • Pathway Implemented • CIS support in place • Reduction in MFFD and DTOC			
	2	Plan for Discharge within 48 hours for emergency admissions	Helen Lingham	Gill Adamson	Short Term - 18.01.16	• Increase in the number of patients discharged against initial EDD • Discharge plans in notes • Reduction in MFFD and DTOC			
	4	To have accurate and timely information related to discharge of patients with complex needs and use it to forward plan	Gill Adamson	Carla Bickley	Short Term - 21.12.15	• Reduction in MFFD and DTOC			
Step Down	**7**	Establish a multi agency accelerated discharge Team	Gill Adamson	Carla Bickley	Short Term - 01.12.15	• To contribute to the benefits and productivity assumptions detailed in the step down business case • Reduction in MFFD and DTOC			
		Medical Ownership of Speviality Outlier	John Oxtoby	Ian Donnelly	Short Term - 30.09.15	• Reduction in MFFD and DTOC			
	8	Develop 'without prejudice' agreements between health and social care to enable patients to move in to a care home placement for assessment	Dave Sanzeri	Bev Jocelyn	Medium Term - 30.01.16	• Reduction in number of patients having assessment carried out in acute setting by incremental change to be agreed from Jan to March 2015 • Increase in the number of patients having assessments carried out in own home, care home or step up bed to be agreed from Jan to March 2015 • Reduction in MFFD and DTOC			
	12	Work with Care Homes to assess previous residents within 24 hours	Helen Trousdale	Becky Bowley / Bev Jocelyn	Short / Medium Term	• Reduction in LOS in hospital setting • Reduction in MFFD and DTOC			
	16	Roll out of Trusted Assessor model across the health and social care economy	Helen Lingham	Gill Adamson	Short / Medium Term - 27.02.16	• Reduction in MFFD and DTOC			
	17	Develop a Single Health and Social Care Direction of Choice Policy	Sandra Chadwick	Sharon Maguire	Short / Medium Term - 31.01.16	• Reduction in MFFD and DTOC			
	23	UHNM will operate 3 community hospitals for step down and the management of patients from Admission to final destination	Helen Lingham	Gill Adamson	Short / Medium Term - 31.03.16	• 146 Community Hospital beds available from 31 march 2016 • 1405 Step Down Intermediate Care packages available from 31 March 2016 • Reduction in MFFD and DTOC			
	13	Reduce the number of care packages held open when people are admitted to hospital	Simon Robson / Helen Trousdale	Becky Bowley	Short / Medium Term	• Release of Domicillary Care capacity • Number of patients taken out of hospital with enablement packages • Reduction in MFFD and DTOC			
	24	Increase supply of domiciliary care within North Staffs through the	Helen Trousdale	Bev Jocelyn / Rosanne Corran	Short Term - 14.12.15	• Each rota to provide 112 hours of care (inc travel) per week • Maximum number of people in each rota will be 5 at any one time			
	25	Reduce the amount of time taken for residential and nursing care	Helen Trousdale	Bev Jocelyn / Rosanne Corran	Short Term - 14.12.15	• Assessments completed within 24 hours • Estimated could support up to 200 patients to be discharged			
	26	Increase capacity in Domiciliary Care	Simon Robson	Becky Bowley	Short / Medium / Long Term - 01.11.15	• Increase capacity to 1600 hours a week • Support reduction in MFFD and DTOC • Additions 175 hours in CWS per week provided			

SYSTEM DASHBOARD AS AT 06/03/16

Area	Indicator	Target	4 Week Average	13 Week Average	TREND 52 Weeks
ABA - Pre Hospital	NHS 111 calls	tbc	5,610	5,926	
ABA - Pre Hospital	Step-Up Community hospital admissions	19	29	24	
ABA - Pre Hospital	Step Up Schemes to Intermediate Care Activity	38	40	42	
ABA - Pre Hospital	WMAS - Diversions	tbc	359	315	
ABA - Pre Hospital	WMAS - Comveyances	tbc	1,239	1,259	
ABA - Pre Hospital	Care Home Scheme	tbc	4	7	
ABA - ED / Portals	A&E Attendances RS ED Type 1	2275	2,575	2,533	
ABA - ED / Portals	4 Hour % Performance RS ED Type 1 only	95%	65.1%	67.0%	
ABA - ED / Portals	4 Hour % Performance County	95%	83.8%	85.9%	
ABA - ED / Portals	4 Hour % Performance - UHNM ALL Types	95%	77.7%	78.8%	
ABA - ED / Portals	A&E time to initial assessment (95th %ile - minutes)	<=15 mins	39	37	
ABA - ED / Portals	A&E median time to treatment (minutes)	<=60 mins	262	248	
ABA - ED / Portals	Admission Conversion %	30%	35.2%	37.0%	
ABA - ED / Portals	12 Hour Trolley Waits - zero tolerance	0	-	4	
ABA - ED / Portals	Front of House Activity	210	395	360	
ABA - ED / Portals	RAID - A&E Emergency Portal referrals seen within 1 hour		91.0%	92.3%	
ABA - ED / Portals	RAID - Referrals in FEAU, other portals & urgent wards seen within 4 hours		100.0%	100.0%	
ABA - ED / Portals	RAID - All other referrals seen on same day or within 24 hours		95.0%	91.0%	
Todays Work Today - Flow	Number of Emergency Admissions		1,509	1,536	
Todays Work Today - Flow	LoS <24 hours for % of Emergency Admitted patients	30%	41.2%	41.1%	
Todays Work Today - Flow	LoS <2 days for % of Emergency Admitted patients	60%	59.4%	59.0%	
Todays Work Today - Flow	LOS <7 days for 80% of Emergency Admitted patients	80%	82.6%	82.6%	
Todays Work Today - Flow	LOS <10 days for 90% of Emergency Admitted patients	90%	88.1%	88.3%	
Todays Work Today - Flow	Stranded Patients - Non Elective, LOS >=10 days, Age >70	150	237	220	
Todays Work Today - Flow	Occupancy - *Total 3 Bed Pools*	92%	97.2%	95.0%	
Todays Work Today - Flow	Medically Fit (MFFD) Average Daily - Royal Stoke	67	131	119	
Todays Work Today - Flow	Average Days in Hospital (Elective & Non-Elective)	tbc	13.6	13.0	
Todays Work Today - Flow	Community Beds: Number of patients in Beds	258	244	253	
Todays Work Today - Flow	Community Beds: Average Length of Stay	tbc	27	32	
Discharge - Acute	Discharges - PRE NOON	35%	21.6%	21.4%	
Discharge - Acute	Discharges - PRE 4pm	70%	56.7%	57.7%	
Discharge - Acute	Discharges - Home First (back to usual residence) AGE >70	90%	84.9%	85.2%	
Discharge - Acute	Discharges - Complex	215	176	175	
Discharge - Acute	Discharges - Simple & Timely	740	830	817	
Discharge - Acute	Discharges - Emergency Portals		541	546	
Discharge - Community	Discharges - Step Down Intermediate Care Referrals	16	18		



Eastern Staffordshire Resilience Group (SRG)
Delayed Transfers of Care Recovery Plan
March 2016

1. Introduction

A recent West Midlands Quality Review reinforced the view that there is an increasing cohort of frail older people, with comorbidities, including dementia, being admitted to Burton Hospital Foundation Trust. These patients are placing an increased demand on health and social care services in terms of undertaking timely assessments and ensuring that there is sufficient capacity commissioned in the community and independent sector to meet both their simple and complex discharge needs.

The national benchmark for DToCs is 3.5% with a stretch of 2.5%. This plan is part of a wider Staffordshire system plan to maintain flow and has been aligned with the plans of North Staffs SRG. It articulates how Eastern Staffordshire SRG plan to achieve the 3.5% target by April 2016 which equates to 15 people medically fit for discharge, who are taking up a hospital bed due to delays elsewhere in the system.

2. Current Performance and Progress

In September 2015 our DTOC performance declined to 10.9% with most of the delays due to social care (77%) and 15% due to health and 8% due to both. Since September performance has gradually improved. We launched an Action Plan following a cross economy workshop at the beginning of November. All schemes agreed have now been mobilised and the combined impact of these has had a positive impact on our performance.

DToC Performance

Sept 2105	Oct 2015	Nov 2015	Dec 2015	Jan 2016
10.9	8.9	9.0	6.9	6.0

Delayed transfers of care (DToC) have over the last year had a major impact on our healthcare system and BHFT continue to report this has subsequent negative impact on the Urgent Care performance targets, although this is not immediately recognised by patterns in performance.

A&E 4 Hour Wait Performance

Sept 2105	Oct 2015	Nov 2015	Dec 2015	Jan 2016
98.05	95.09	95.16	92.02	89.89

Anecdotal feedback from staff at Queens is that the high volumes of people combined with high levels of acuity may have inadvertently led to improvements in DToC performance due to people not being well enough to be discharged from hospital and requiring a longer length of stay. We continue to monitor this.

Eastern Staffs SRG continue to give DToCs a targeted focus, as we are acutely aware this is subjecting our patients to a sub optimal system.

3. Gaps / Issues

- **Inadequate Social Care Assessment Capacity / Lack of Integrated Working between Community and Acute Teams**

Our assessment capacity is unable to keep up with the number of patients requiring social care assessment. Referrals to the hospital discharge team have grown by 30% in the last 3 years. SSOTP have significantly redesigned how they work and in Partnership with Queens Hospital have reduced the number of referrals requiring higher level of domiciliary care support.

Social Worker representation on Ward Board meetings was not standard on all wards. This leads to further delays in social care assessment, leading to decompensation in some elderly patients who then require higher levels of post referral social care support. Faster discharge planning will reduce length of stay and subsequent high level of domiciliary care support needed upon discharge.

- **Increase in Demand**

The Care Act has potentially increased the numbers of people seeking assessment and the parameters by which assessments take place has changed (Wellbeing now being the primary criteria rather than previous 'substantial/critical criteria') making it more difficult to 'screen out' cases prior to a full assessment. Carers assessments are now mandated post Care Act where previously were good practice only. The Care Act means that weekends are in scope for DTOC reporting.

Changes SSOTP have put in place with partnership with Queens have put further demands on social workers time, e.g. to attend ward boards. This is the right thing to do but takes more time out of the working day.

Not only has demand grown but complexity has also increased including

- Patients with safeguarding concerns
- Patients who are homeless
- Patients who do not have capacity to make their own decisions

- Patients who have not been in receipt of any care prior to admission/not known to services presenting with complex needs
- Patients in need of a full statutory assessment for long term residential/nursing places

- **Insufficient Brokerage**

Sourcing care packages in a timely fashion is a challenge. The Social Care broker only brokers domiciliary care for clients eligible for social care funding of care. Currently Care Home Select has been providing brokerage support for self-funders and for supporting family choice of residential/nursing settings. Brokerage is largely a 5 day week function.

- **Inadequate Domiciliary Care Provision, particularly in Certain Areas**

The available of Staffordshire County council have reviewed our social care provision and provided an 8% increase in provision with 10 additional providers on their newly launched framework. This additionality has however not resolved the issues around sourcing domiciliary care in certain "hard to place areas". The community provider report that this is due to the opening of major supermarkets which has had an impact on availability of domiciliary care workers in these areas.

Our community provider report that their re-ablement teams are blocked by people being supported at home while awaiting longer term packages of care.

- **Inefficient Assessment/discharge pathways**

There has been no discharge to assess pathway implemented in this economy. Members of the SRG are in agreement that we need to move towards a discharge to assess model..

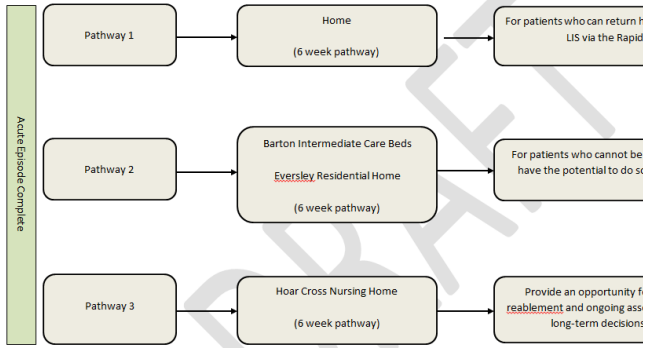
4. <u>Updated Action Plan March 2016</u>

The schemes implemented from the November cross economy workshop have been mobilised and have had significant impact, however, to maintain continued improvement we have identified, agreed and commenced to mobilise new work streams.

Ref	Scheme	Anticipated Impact (1-5)	Implementation Date
1	**Planned Discharge from Admission with Clear Clinical Plans** Over Christmas we commissioned an independent review of discharge processes	**4**	**Commenced 20th Feb – Planned completion 30 April 2016**

	and pathways which has led to further work on refining discharge pathways. Allocated Social Worker on all Ward Board meetings is now becoming standard in addition to the therapy input. This is constrained by capacity challenges described above. This is facilitating more proactive discharge planning as standard practice on wards where this has been implemented. We are focussed on developing proactive management of ward board rounds with full engagement by all partners, agreeing who is responsible for specific actions and making decision on the process and timing of discharges and transfers. The implementation of CRU software on all boards at SSoTP will further support the transformation of ward boards. This has been further supported with the implementation of the discharge coordinator role. We are ensuring patients and carers are involved at all stages of discharge planning and that they are provided with information to enable care planning decisions and choices to be made. We are also developing community discharge pathway on a page to include out of areas patients. Further supporting this is “Home First” training which is being led by our Community Provider. Uptake of this training has been low to begin with due to increased demand and capacity of ward staff, however, we aim to improve this.		

	This model is implemented in some wards and is being replicated across the whole of the Trust.		
2	**Early Senior Review** BHFT have been using SAFER working however over Christmas the independent review of processes and pathways found that this best practice was not standard on all wards. We identified 1 ward who had senior clinician leading ward board meetings, and their meetings always had social care and therapy representation. We are now using this as best practice model for the rest of the trust (this is part of the work described in 1 above).	**4**	**Commenced in January, Roll out will continue into April and May 2016**
3	**Move out When Medically Optimised** We have mobilised pilot Discharge to Assessment pathways. This work has been shared with Virgin and the wider Staffordshire economy to ensure alignment with longer term and larger scale plans. The 'enhanced discharge pathway' will focus on Ward 20, Queens Hospital site. The 8am ward 'board round' will be supported by a Rapid Discharge Assessor and social worker who will, with the agreement of the nursing and therapy team, identify those patients who are not yet ready to be discharged directly home but who have the potential to do so if given additional rehabilitation and support by the LIS Team. The prominence being on identifying these patients 'up stream', proactively manage the	**5**	**Planned mobilisation by 21st March 2016.**

	patient pathway to facilitate a more timely discharge and reduce inter-ward transfers. This in turn would improve patient flow, patient experience and support the ward staff in their decision making about availability of services in the community.  This work is aligned to Virgin Care plans who are working with us to mobilise this as a pilot in the short term, which is in line with their longer term plans.		
4	**Coordination and Improved Flow** a. SSoTP have a single point of access which currently - Takes all referrals from Queens for patients who need a District Nurse on discharge to try and reduce the number of cases where receipt of referrals were delayed or omitted on discharge - Providing rapid assessment for social	**4**	**SSoTP SPA mobilised November 2015.** **Virgin SPA planned mobilisation May 2016**

	care needs for people in the community – with a view to preventing crises and maximising independence. Virgin Care's clinical design centres on care coordination for high risk patients which include co-morbid, frail and frequent admissions. Work is on-going with SSoTP and Virgin Care around how integrated points of access may work in the future. Care coordination is an assessment-based approach to integrated health care in which an individual's needs are assessed, a comprehensive care plan is developed with the patient defining their own outcomes, and services are coordinated and managed by skilled case managers. Particular emphasis placed on reducing unnecessary hospital attendance and admission, and on accelerating discharge. The care coordination 'hub' also acts as a single point of access for clinicians and patients requiring help. Services provided by care co-ordination are:		

	• Service “orchestration” with single point of contact for patient and clinicians • Patient-centred care plan coordination post ALL care encounters for high risk patients – to ensure timely scheduling and order completion for tests, procedures, and medications, including arrangement of transportation and health coaching • Admission and discharge notification and transition planning with GP and community-based providers to ensure care plan continuity • Redirection to urgent care where appropriate • Access to rapid assessment and services in the community • Community-based diagnostics and testing (improved experience & adherence) • Remote monitoring of activity, vital signs, symptom tracking and social and environmental factors in the home • Outcome measurement • Centralised scheduling and registration (long term goal) b. We are improving communications with and referral to patient's identified community pharmacy to access services		

	such as Medicines Use Review or New Medicine Service to both support immediate medication needs and ongoing Medicines Optimisation. c. We are currently promoting the use of assistive technology with discharge teams. To further support this our patient transport provider are engaging handyman ACA's and stocking some standard daily living aids such as grab rails, coded lock entry etc. This means that people who require patient transport and who would benefit from aids and adaptations will receive these sooner. Discharge teams will engage with the patient transport provider to advise which patients will be going home that require additional assistance ie changes to their home or extra care. The transport provider will then ensure ACA Handymen is on board with the required aids when the patient is collected from hospital. The ACA handyman is then dropped off with the patient and remains in their home for that first vulnerable hour (Or SO) during which time they fit the various living aids and ensure the heating is on the patient had a warm drink and food and is settled in and understands how to use their new equipment and is comfortable with it. Once clear they radio back in to base and make themselves available for their next job.		

5. High Level Performance Trajectory

We have kept our trajectory which was agreed in November 2015 as we have maintained this in December and January.

DToC Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April
3.5%	7.5%	7.0%	6.5%	5.0%	3.5%

Topic:	**Assessment of CCG Commissioning Intentions and CCG Annual Reports**
Meeting:	**Health and Well Being Board**
Date:	**9/06/2016**
Authors:	**Jon Topham**
Report Type:	**For discussion**

1. Introduction

1.1 The Staffordshire Health and Wellbeing (HWB) Board is supported to manage its cycle of business by the HWB Intelligence Group. In May 2016 the Group evaluated the CCG commissioning intentions for the HWB Board. This paper outlines the summary of the evaluation.

2. Recommendation

2.1 That the Board note the paper

2.2 That the Board consider the questions raised by this paper:

Recommendation 1: CCGs agree a timeline with the Board to agree when Commissioning Intentions are received

Recommendation 2: The Board should receive a report on Commissioning Intentions prior to their implementation

Recommendation 3: Identify with CCGs whether we need to develop a subset of the JSNA that will support development of CCG commissioning intentions

Recommendation 4: The HWBB in future asks CCGs to show how they reflect the views of Patients and Public in the commissioning process

Recommendation 5: The HWBB ask the CCGs to engage in early dialogue with partner organisations in the development of Commissioning Intentions

Recommendation 6: The HWBB asks CCGs in future, to show how their Commissioning Intentions meet the Living Well Strategy

Recommendation 7: That the HWBB asks CCGs, in future, to show how their Commissioning Intentions address Health Inequalities

Recommendation 8: The HWBB asks the Healthy Staffordshire Select Committee to annually assess Commissioning Intentions and the Annual Reports.

Topic:	**Assessment of CCG Commissioning Intentions and CCG Annual Reports**
Meeting Date:	**09 June 2016**
Authors:	**Jon Topham Locality Public Health Commissioning Lead**
Board Member	**Richard Harling**

1. INTRODUCTION

1.1. The Staffordshire Health and Wellbeing (HWB) Board is supported to manage its cycle of business by the HWB Intelligence Group. In May 2016 the Group evaluated the CCG commissioning intentions for the HWB Board. This paper outlines the summary of the evaluation.

1.2. As previously stated the HWB Intelligence Group exercises this responsibility on behalf of the HW Board in:

- Reviewing the plans of the Clinical Commissioning Groups as to whether these contribute to the delivery of the JHWS
- Review how far a CCG has contributed to the delivery of the JHWS and to performance assess how well their duty has been discharged in terms of having regard to the JSNA and JHWS.
- To ensure patient and public voice is heard as part of the Health and Wellbeing Boards decision making

2. The Plans Evaluated

2.1. The following **Commissioning Intentions** have been received

South East Staffordshire & Seisdon Peninsula • Shropshire and South Staffordshire Foundation Trust • Heart of England Foundation Trust • George Eliot NHS Trust
Cannock • The Dudley Group NHS Foundation Trust • Walsall Healthcare NHS Trust
Stafford and Surrounds • The Royal Wolverhampton NHS Trust
North Staffordshire • Combined Healthcare • SSOTP • UHNM

East Staffordshire

- Delivering the 5 Years Forward View in East Staffordshire

3. Evaluation of Commissioning Plans

3.1. The Commissioning Intentions from North Staffordshire, South East Staffordshire and Seisdon Peninsula, Cannock Chase and Stafford and Surrounds all followed the same format and have similar commissioning intentions.

3.2. No Commissioning Intentions have been received from East Staffordshire CCG but the forward view indicates the broader context in East Staffordshire

3.3. The priority workstreams are common across all CCGs as part of operational and financial recovery plans. These priorities are :

Commissioning High Value Interventions	• Decommissioning and disinvestment from interventions and services of limited clinical value • Providing patients with support to stop smoking or lose weight prior to elective surgery in order to improve outcomes
Elective Services	• Pathway redesign reducing the level of inappropriate and unnecessary elective referrals • Community based assessment & treatment services • GP referral review • Consultant to consultant referral review • fundamental redesign of follow up care
Reconfiguration of the urgent and emergency care system	• Reducing unnecessary and avoidable emergency admissions • Maximising the contribution of community hospitals and MIUs to reducing acute service utilization
Frail Older People	• Building on the improvements we have made in care for patients with dementia and the elderly with frail and complex needs
Long Term Conditions	• Transform services for those with long term conditions improving quality, co-ordination of care and efficiency • Strengthening approaches to risk stratification and case management • Scaling up self-management and use of technology
New Models of Care	• Building provider alliances with a focus on out of hospital care co-ordination and delivery • Developing capability and capacity in Primary Care to form new federations and partnerships with other out of hospital providers • Investigating the potential for provider alliances to deliver under outcomes based, capitated contracts with aligned incentives for high value interventions and reduced system cost • Clinical networks for surgery which create sustainable models of provision
Mental health	

3.4. The priority workstreams are identified in 9 common commissioning schedules

- High Value Interventions
- Elective Care
- Reconfiguration of the Urgent and Emergency Care System
- Frail Older People

- Long Term Conditions
- New Models of Care
- Mental Health Services
- Medicines Optimisation
- Other Services

3.5. Other local bespoke schedules are also attached and include: acute services; Acute, Community and Mental Health Services for East Staffordshire CCG; Dementia, Cancer and End of Life Care

3.6. The Commissioning Intentions reviewed are for the current year 2016/17 and this review is effectively retrospective

Recommendation 1: That CCGs agree a timeline with the Board to agree when Commissioning Intentions are received

Recommendation 2: That thee Board should receive a report on Commissioning Intentions prior to their implementation

3.7. We have reviewed the Commissioning Intentions using the template previously used by the Intelligence Group, and agreed by the HWB Board. The review is based on 5 key questions

Use of Evidence
Alignment to the Living Well Strategy
Impact on Population Health and Reducing Health Inequalities
Monitoring and Evaluation
Effective use of resources

3.8. Based on analysis of the Commissioning Intentions a summary of key points are given against each question

3.8.1. Use of Evidence

- Most documents make reference to national learning, NICE guidance, partnership working and Impact assessments
- There appears to be little use of local intelligence or benchmarking within the Commissioning Intentions although there is evidence of their use in the Annual Reports.
- There is no reference to the JSNA in the commissioning Intentions, although the Intelligence Group felt that this was because the JSNA only provides high level needs data and is probably therefore less relevant for specific CCG Commissioning Intentions.

Recommendation 3: Identify, with CCGs, whether we need to develop a subset of the JSNA that will support development of CCG commissioning intentions

- The Commissioning Intentions do not make reference to being informed by Patient and Public Voice, engagement, or Healthwatch, although they do in Annual Reports. There is reference to collecting

patient satisfaction data as part of quality metrics, but it is not evident that the commissioning intentions are informed and influenced by patients and the public

Recommendation 4: That the HWBB, in future, asks CCGs to show how they reflect the views of Patients and Public in the commissioning process

- There is evidence of NHS to NHS interactions within the commissioning intentions and much of what is written is predicated on a more joined up system. It is less clear what influence local partners and the third sector have had in informing the Commissioning Intentions as part of wider system leadership and strategic planning

Recommendation 5: That the HWBB ask the CCGs to engage in early dialogue with partner organisations in the development of Commissioning Intentions

3.8.2. Alignment to the Living Well Strategy

- Whilst most annual reports mention both the Health and Wellbeing Board and the Living Well Strategy, it is less clear that commissioning Intentions take account of either the HWBB or the Living Well Strategy.
- Many of the priorities outlined in the Commissioning Intentions do align with Living and Ageing Well, for example Mental Health, Frail Elderly, Long Term Conditions.
- The commissioning Intentions are mainly about secondary care and shifting to community and primary care based provision. There is a focus on early intervention, and prevention, particularly with regard to Long Term Conditions, but no mention of how this will be achieved. For example are there opportunities to shift primary prevention interventions into the secondary care space?

Recommendation 6: That the HWBB asks CCGs, in future, to show how their Commissioning Intentions meet the Living Well Strategy

3.8.3. Impact on Population Health and Reducing Health Inequalities

- Some key vulnerable patient groups are mentioned, for example Learning Disabilities and Mental Health.
- However there is little reference to health inequalities in terms of socio-economic status.
- We know that the inequalities gap is not improving, and we know that demands on services are likely to be higher from particular sections of the community. It is not clear from the Commissioning Intentions how the CCG will support and monitor their contribution to reducing health inequalities across Staffordshire.
- Whilst the commissioning intentions do, in most cases, relate to outcomes it is not always clear how CCGs will monitor them.

Recommendation 7: That the HWBB asks CCGs, in future, to show how their Commissioning Intentions address Health Inequalities

3.8.4. Monitoring and Evaluation

- Clear reference is given to data collection and that there is a long established mechanism for monitoring activity and quality metrics.
- There was less reference to longer term outcomes and how these would be monitored.

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3.8.5. Effective Use of Resources

- There is a clear emphasis on a shift to the community.
- However there is no evidence that resources are being shifted into prevention.
- It is not clear from the documentation how the changes will make the system more affordable

4. **Evaluation of Annual Reports**

4.1. This section provides a high level summary of some of the key messages emerging collectively from the Staffordshire CCGs Annual Reports and how their activity links to the Board's Living Well Strategy, the prioritisation of prevention and early intervention and the focus on patient voice.

4.2. The Board has a role in ensuring CCGs plans link to the Health and Wellbeing Strategy and to that end a narrowly defined role in being consulted as part of the preparation of the annual reports. In undertaking a high level assessment of the annual reports, analysis was based on the extent to which linkages could be drawn to:

- the alignment with the Board's Living Well Strategy, and fit with the Board's preventative agenda, and
- the mechanisms through which customer experience has, and is, informing planning.

4.3. It was the view of the Intelligence Group that the methodology for assessing Health & Wellbeing Strategies was less relevant for retrospective annual reports. So this section will give a short overview of the key themes that emerge from the annual reports

4.4. The following **Annual Reports** have been received and reviewed; East Staffordshire; South East Staffordshire & Seisdon Peninsula; Cannock; Stafford and Surrounds and North Staffordshire (draft)

4.5. All Annual reports cover a retrospective summary of performance, and relevant financial information and all CCGs recognise the difficult financial circumstances that they find themselves managing.

4.6. In contrast to the Commissioning intentions, more focus in given in the annual reports to Patient and Public Engagement, reference is made to Patient Participation Groups; lay members; use of social media, Citizens Juries; Network Groups and Patient Boards.

4.7. Reference to the HWB Board was made in all annual reports

4.8. Reference to populations demography and statistics and to the JSNA was mentioned in all annual reports

4.9. All of the annual reports highlight progress on key commissioning priorities that link to supporting groups prioritised in the Living Well Strategy. Examples include:

- East Staffordshire CCG reflect on three key achievements; the improving lives long term conditions programme; the quality programme that has improved quality amongst its providers; and improving performance
- North Staffordshire CCG cover achievements in a number of areas, the list includes; the development of a transformational plan for Child and Adolescent Mental Health; integrated services for Children with special educational needs; medicines optimisation; rapid access to residential and care homes; cancer and end of life service improvements; and the front of house urgent care centre designed to divert non urgent care from the urgent care service
- South East Staffordshire and Seisdon Peninsula CCG refer to a number of achievements including; case management in primary care; redesign of local dementia services; the introduction of an integrated specialist dietetic service; expansion of community based physiotherapy, orthopaedic and pain management services; and acute visiting service that provides rapid response for patients requiring a home visits
- Both Cannock Chase CCG and Stafford and surrounds refer to similar achievements, including; disinvestment from Procedures of Limited Clinical Value; dementia care; and developing capability and capacity in primary care

4.10. All CCGs made reference to partnership working both across the health economy and with partners, in particular the County Council. All reports mentioned the BCF

Recommendation 8: The HWBB asks the Healthy Staffordshire Select Committee to annually assess Commissioning Intentions and the Annual Reports.

5. RECOMMENDATIONS

5.1. The Board agree the recommendations that arise from this report

Topic:	**Performance and outcomes report – May 2016**
Date:	**9th June 2016**
Board Member:	**Richard Harling**
Author:	**Kate Waterhouse**
Report Type	**For information**

1 Purpose of the report

1.1 The performance and outcomes report brings together key outcome measures from the national outcome frameworks for the NHS, adult social care and public health alongside some local defined outcomes within the Living Well strategy.

1.2 In September 2015, the Health and Wellbeing Board agreed to receive an updated summary report on a quarterly basis as a 'for information' item.

1.3 The full quarterly report continues to be published shortly after the Board meeting and is available on the Staffordshire Observatory website acting as a key component of the Staffordshire Joint Strategic Needs Assessment (http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx)

2 Summary

2.1 In line with national trends, healthy life expectancy in Staffordshire continues to fall below retirement age with a 12 year gap between the most deprived and least deprived communities.

2.2 Based on updated data from this quarter Staffordshire continues to perform well on childhood immunisations and tooth decay in children aged five. The challenges in Staffordshire include: lower than average breastfeeding prevalence rates; higher than average numbers of children being admitted to hospital for accidental injuries or long-term conditions; higher than average numbers of people admitted to hospital for alcohol-related conditions; continued low uptake of seasonal flu vaccination amongst older people; numbers of delayed transfers of care continuing to increase and end of life care measured by the proportion of people dying at their usual place of residence continuing to be below the England average. There have also been improvements in the dementia diagnosis although the rate remains below England. The number of people admitted to hospital for chronic ambulatory care sensitive (ACS) conditions has also improved although Staffordshire residents who are admitted for acute ACS conditions continues to be higher than average.

working together for better health

Health and wellbeing outcomes and performance summary report for Staffordshire May 2016

Staffordshire Observatory

Staffordshire County Council

Summary performance

Staffordshire's health and wellbeing strategy, Living Well, included an outcomes framework based on selected indicators from the national outcomes frameworks for public health, National Health Service and adult social care as well as measures from the Clinical Commissioning Group and children's outcomes frameworks.

This outcomes performance summary report presents data against indicators that were identified within the Living Well strategy where data is currently routinely available. Data sources for some of the other indicators are yet to be developed. The indicators are grouped under life course stages: start well, grow well, live well, age well and end well alongside a small section on overarching health and wellbeing. The full report will be published on the Staffordshire Observatory website shortly after the Health and Wellbeing Board meeting as part of the Joint Strategic Needs Assessment process at http://www.staffordshireobservatory.org.uk/publications/healthandwellbeing/yourhealthinstaffordshire.aspx.

Performance against indicators are summarised into whether they are a concern for Staffordshire (the indicator performs worse than the national average), of some concern (similar to the national average or trend has been going in the wrong direction over a period of time) or little concern where the performance is better than England. ***Indicates where data has been updated or is a new indicator***

	Summary	Of concern for Staffordshire	Some concern for Staffordshire	Little concern for Staffordshire
Overarching health and wellbeing	There are significant health inequalities across Staffordshire for key health and wellbeing outcomes which are in the main underpinned by determinants of health.		▪ Life expectancy at birth ▪ Inequalities in life expectancy ▪ Healthy life expectancy	
Start well	Breastfeeding rates in Staffordshire remain worse than average. Whilst the proportion of children living in poverty is lower than England, a significant number of start well indicators remain a concern in some areas, particularly where there are higher proportions of families living on low incomes.	▪ Breastfeeding rates	▪ Infant mortality ▪ Smoking in pregnancy ▪ Low birthweight babies	▪ Children in poverty ▪ Childhood vaccination coverage ▪ Tooth decay in children ▪ School readiness
Grow well	There are a large number of child health outcome indicators where Staffordshire is not performing as well as it could. In particular there is concern around educational achievement for some groups and healthier lifestyles. Unplanned admissions to hospital are also higher for this age group.	▪ Children with excess weight ▪ Chlamydia diagnosis ▪ Hospital admissions caused by unintentional and deliberate injuries in children and young people ▪ Unplanned hospitalisation for asthma, diabetes and epilepsy ▪ Emergency admissions for lower respiratory tract infections	▪ Pupil absence ▪ GCSE attainment ▪ 16-18 year olds not in education, employment or training ▪ Under 18 alcohol-specific admissions ▪ Smoking prevalence in 15 year olds ▪ Emotional wellbeing of looked after children ▪ Teenage pregnancy ▪ Child admissions for mental health for under 18s ▪ Hospital admissions as a result of self-harm (10-24 years)	

	Summary	Of concern for Staffordshire	Some concern for Staffordshire	Little concern for Staffordshire
Live well	There are concerns with performance against healthy lifestyle indicators such as excess weight, physical activity and alcohol consumption. In addition performance on prevention of serious illness could also be improved as Staffordshire has significantly lower numbers of NHS health checks to the target population. There are also concerns for outcomes for people with learning disabilities to participate in life opportunities which enable them to live independently. The number of people who self-harm is also higher than average.	▪ Employment of vulnerable adults ▪ Vulnerable adults who live in stable and appropriate accommodation ▪ Domestic abuse ▪ Alcohol-related admissions to hospital ▪ Excess weight in adults ▪ Physical activity amongst adults ▪ Recorded diabetes ▪ NHS health checks ▪ Hospital admissions as a result of self-harm	▪ People feel satisfied with their local area as a place to live ▪ Self-reported wellbeing ▪ Sickness absence ▪ Violent crime ▪ Utilisation of green space ▪ Statutory homelessness ▪ Healthy eating: adults eating at least five portions of fruit or vegetables daily ▪ Diabetes complications ▪ Successful completion of drug treatment	▪ Re-offending levels ▪ Road traffic injuries ▪ People affected by noise ▪ Adult smoking prevalence
Age well	More people in Staffordshire live in fuel poverty whilst in older age fewer Staffordshire residents over 65 take up their flu vaccination or their offer of a pneumococcal vaccine which may be contributing to excess winter mortality. The majority of age well indicators associated with the quality of health and care in Staffordshire perform poorly, for example more people are admitted to hospital for conditions that could be prevented or managed in the community. In addition those that are admitted to hospital are delayed from being discharged.	▪ Fuel poverty ▪ Pneumococcal and seasonal flu vaccination uptake in people aged 65 and over ▪ People receiving social care who receive self-directed support and those receiving direct payment ▪ Unplanned hospitalisation for ambulatory care sensitive conditions ▪ Delayed transfers of care	▪ Social isolation ▪ Social care/health related quality of life for people with long-term conditions ▪ People feel supported to manage their condition ▪ Permanent admissions to residential and nursing care ▪ Emergency readmissions within 30 days of discharge from hospital ▪ Reablement services ▪ Estimated diagnosis rate for people with dementia ▪ Falls and injuries in people aged 65 and over ▪ Hip fractures in people aged 65 and over	
End well	Staffordshire performs better than average for the majority of mortality indicators with fewer people than average dying from preventable causes before the age of 75, in particular from cardiovascular, cancer or respiratory diseases. However end of life care, winter deaths, early death rates from liver disease, infectious diseases and suicides remain of concern for the County. There are also significant inequalities in mortality across Staffordshire both amongst vulnerable groups and between districts.	▪ Excess winter mortality ▪ End of life care: proportion dying at home or usual place of residence	▪ Under 75 mortality from liver disease ▪ Mortality from communicable diseases ▪ Suicide ▪ Excess mortality rate in adults with mental illness	▪ Preventable mortality ▪ Mortality from causes considered amenable to healthcare ▪ Under 75 mortality from cancer ▪ Under 75 mortality from cardiovascular disease ▪ Under 75 mortality from respiratory disease

Table 1: Summary of health and wellbeing outcomes

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
1.1a	No	Life expectancy at birth - males (years)	2012-2014	79.7	79.4	Stable
1.1b	No	Life expectancy at birth - females (years)	2012-2014	83.1	83.1	Stable
1.2a	No	Inequalities in life expectancy - males (slope index of inequality) (years)	2012-2014	6.4	9.2	Stable
1.2b	No	Inequalities in life expectancy - females (slope index of inequality) (years)	2012-2014	6.4	7.0	Stable
1.3a	Yes	Healthy life expectancy - males (years)	2012-2014	63.6	63.4	Stable
1.3b	Yes	Healthy life expectancy - females (years)	2012-2014	62.6	64.0	Stable
2.1	No	Child poverty: children under 16 in low-income families	2013	14.1%	18.6%	Stable
2.2	No	Infant mortality rate per 1,000 live births	2012-2014	4.6	4.0	Stable
2.3	Yes	Smoking in pregnancy	2015/16 Q1-Q3	11.2%	10.6%	Stable
2.4a	No	Breastfeeding initiation rates	2015/16 Q1	69.1%	73.8%	Stable
2.4b	Yes	Breastfeeding prevalence rates at six to eight weeks	2015/16 Q1-Q3	30.3%	42.9%	Worsening
2.5a	No	Low birthweight babies (under 2,500 grams)	2014	7.1%	7.4%	Stable
2.5b	No	Low birthweight babies - full term babies (under 2,500 grams)	2014	2.3%	2.9%	Stable
2.6a	Yes	Diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (Hib) at 12 months	2015/16 Q1-Q3	97.3%	93.0%	Stable
2.6b	Yes	Measles, mumps and rubella at 24 months	2015/16 Q1-Q3	96.1%	91.3%	Improving
2.6c	Yes	Measles, mumps and rubella (first and second doses) at five years	2015/16 Q1-Q3	93.1%	87.5%	Improving
2.7a	No	Children aged three with tooth decay	2012/13	4.0%	11.7%	n/a
2.7b	Yes	Children aged five with tooth decay	2014/15	17.8%	24.7%	Improving
2.8	No	School readiness (Early Years Foundation Stage)	2014/15	70.0%	66.3%	Improving
3.1	No	Pupil absence	2013/14	4.4%	4.5%	Improving
3.2	No	GCSE attainment (five or more A*-C GCSEs including English and mathematics)	2014/15	56.1%	53.8%	Stable
3.3	No	Young people not in education, employment or training (NEET)	2014	4.5%	4.7%	Improving
3.4	Yes	Unplanned hospital admissions due to alcohol-specific conditions (under 18) (rate per 100,000)	2012/13-2014/15	36.4	36.6	Stable
3.5	No	Smoking prevalence in 15 years olds	2014/15	7.9%	8.2%	n/a
3.6a	No	Excess weight (children aged four to five)	2014/15	23.1%	21.9%	Stable
3.6b	No	Excess weight (children aged 10-11)	2014/15	33.5%	33.2%	Stable
3.7	Yes	Emotional wellbeing of looked after children (score)	2014/15	14.6	13.9	Stable
3.8a	Yes	Under-18 conception rates per 1,000 girls aged 15-17	2014	25.5	22.8	Stable
3.8b	Yes	Under-16 conception rates per 1,000 girls aged 13-15	2012-2014	5.6	4.9	Stable
3.9	No	Chlamydia diagnosis (15-24 years) (rate per 100,000)	2014	1,699	1,984	Stable
3.10a	Yes	Hospital admissions caused by unintentional and deliberate injuries in children under five (rate per 10,000)	2014/15	175	137	Stable
3.10b	Yes	Hospital admissions caused by unintentional and deliberate injuries in children under 15 (rate per 10,000)	2014/15	121	110	Stable
3.10b	Yes	Hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (rate per 10,000)	2014/15	128	132	Stable
3.11	Yes	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (ASR per 100,000)	2014/15	362	326	Stable

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
3.12	Yes	Hospital admissions - lower respiratory tract in under 19s (ASR per 100,000)	2014/15	440	382	Stable
3.13	Yes	Child admissions for mental health for under 18s (ASR per 100,000)	2014/15	88	87	Stable
3.14	Yes	Hospital admissions as a result of self-harm (10-24 years) (ASR per 100,000)	2014/15	432	399	Stable
4.1	Yes	Satisfied with area as a place to live	Mar-16	86.8%	85.5%	Stable
4.2a	No	Self-reported well-being - people with a low satisfaction score	2014/15	4.6%	4.8%	Stable
4.2b	No	Self-reported well-being - people with a low worthwhile score	2014/15	3.9%	3.8%	Stable
4.2c	No	Self-reported well-being - people with a low happiness score	2014/15	9.9%	9.0%	Stable
4.2d	No	Self-reported well-being - people with a high anxiety score	2014/15	19.0%	19.4%	Stable
4.3	Yes	Sickness absence - employees who had at least one day off in the previous week	2011-2013	2.4%	2.4%	Stable
4.4a	No	Gap in the employment rate between those with a long-term health condition and the overall employment rate	2014/15	9.6%	8.6%	Stable
4.4b	No	Proportion of adults with learning disabilities in paid employment	2014/15	2.6%	6.0%	n/a
4.4c	No	Proportion of adults in contact with secondary mental health services in paid employment	2014/15	12.8%	6.8%	Worsening
4.5a	No	People with a learning disability who live in stable and appropriate accommodation	2014/15	52.2%	73.3%	n/a
4.5b	No	People in contact with secondary mental health services who live in stable and appropriate accommodation	2014/15	66.8%	59.7%	Worsening
4.6	Yes	Domestic abuse (rate per 1,000)	2014/15	20.5	20.4	Improving
4.7	No	Violent crime (rate per 1,000)	2014/15	12.3	13.5	Worsening
4.8	No	Re-offending levels	2013	22.8%	26.4%	Stable
4.9	Yes	Utilisation of green space	2014/15	18.2%	17.9%	Stable
4.10	No	Road traffic injuries (rate per 100,000)	2012-2014	22.0	39.3	Stable
4.11	No	People affected by noise	2013/14	5.5	7.4	Stable
4.12	No	Statutory homelessness - homelessness acceptances per 1,000 households	2014/15	1.4	2.4	Worsening
4.13a	No	Smoking prevalence (18+)	2014	13.7%	18.0%	Stable
4.13b	No	Smoking prevalence in manual workers (18+)	2014	22.3%	28.0%	Stable
4.14	Yes	Alcohol-related admissions (narrow definition) (ASR per 100,000)	2015/16 Q3 provisional	740	641	Stable
4.15	No	Adults who are overweight or obese (excess weight)	2012-2014	68.6%	64.6%	n/a
4.16	Yes	Healthy eating: adults eating at least five portions of fruit or vegetables daily	2015	52.7%	52.3%	Stable
4.17a	No	Physical activity in adults	2014	54.1%	57.0%	Stable
4.17b	No	Physical inactivity in adults	2014	28.5%	27.7%	Stable
4.18	No	Diabetes prevalence (ages 17+)	2014/15	6.9%	6.4%	Worsening
4.19	No	Diabetes complications (ASR per 100,000)	2012/13	66.1	69.0	Stable
4.20a	Yes	NHS health checks offered (as a proportion of those eligible)	2013/14-2015/16 Q3	56.2%	51.7%	Improving
4.20b	Yes	NHS health checks received (as a proportion of those offered)	2013/14-2015/16 Q3	23.7%	25.0%	Improving
4.20c	Yes	NHS health checks received (as a proportion of those eligible)	2013/14-2015/16 Q3	42.1%	48.3%	Stable
4.21	No	Hospital admissions as a result of self-harm (ASR per 100,000)	2014/15	207	191	Stable
4.22a	Yes	Successful completion of drug treatment - opiate users	October 2014 to September 2015	7.3%	6.8%	Stable

Indicator number	Updated	Indicator description	Time period	Staffordshire	England	Direction of travel
4.22b	Yes	Successful drug treatment exits - opiate users	2015/16 provisional	6.0%	6.9%	Stable
5.1	No	Fuel poverty	2013	11.3%	10.4%	Improving
5.2	No	Social isolation: percentage of adult social care users who have as much social contact as they would like	2014/15	41.8%	44.8%	n/a
5.3	No	Pneumococcal vaccine in people aged 65 and over	2014/15	64.8%	69.8%	Stable
5.4	Yes	Seasonal flu in people aged 65 and over	2015/16 provisional	69.8%	71.0%	Worsening
5.5	No	Social care related quality of life (score)	2014/15	18.9	19.1	n/a
5.6	No	Health related quality of life for people with long-term conditions (score)	2014/15	0.75	0.74	Stable
5.7	No	People feel supported to manage their condition	2014/15	66.8%	64.4%	Stable
5.8a	No	People receiving social care who receive self-directed support	2014/15	64.4%	83.7%	n/a
5.8b	No	Proportion of people using social care who receive direct payments	2014/15	25.4%	26.3%	n/a
5.9a	Yes	Acute ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2014/15	1,354	1,277	Stable
5.9b	Yes	Chronic ambulatory care sensitive (ACS) conditions (ASR per 100,000)	2014/15	737	807	Improving
5.10	Yes	Delayed transfers of care (rate per 100,000 population aged 18 and over)	2015/16 provisional	16.9	12.3	Stable
5.11	No	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes (rate per 100,000 population)	2014/15	642	669	n/a
5.12a	No	People aged 65 and over who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	2014/15	88.6%	82.1%	Stable
5.12b	No	Proportion of older people aged 65 and over who received reablement / rehabilitation services after discharge from hospital	2014/15	1.5%	3.1%	Worsening
5.13	No	Readmissions within 30 days of discharge from hospital	2011/12	11.9%	11.8%	Stable
5.14	Yes	Estimated dementia diagnosis rate	2015/16 provisional	63.4%	66.3%	Improving
5.15	No	Falls admissions in people aged 65 and over (ASR per 100,000)	2014/15	2,149	2,125	Stable
5.16	No	Hip fractures in people aged 65 and over (ASR per 100,000)	2014/15	598	571	Stable
6.1	No	Mortality from causes considered preventable (various ages) (ASR per 100,000)	2012-2014	176	183	Stable
6.2	No	Mortality by causes considered amenable to healthcare (ASR per 100,000)	2012-2014	106	112	Stable
6.3	No	Under 75 mortality rate from cancer (ASR per 100,000)	2012-2014	133	142	Stable
6.4	No	Under 75 mortality rate from all cardiovascular diseases (ASR per 100,000)	2012-2014	71	76	Stable
6.5	No	Under 75 mortality rate from respiratory disease (ASR per 100,000)	2012-2014	27.7	32.6	Stable
6.6	No	Under 75 mortality rate from liver disease (ASR per 100,000)	2012-2014	16.0	17.8	Stable
6.7	No	Mortality from communicable diseases (ASR per 100,000)	2012-2014	61.9	63.2	Stable
6.8	No	Excess winter mortality	August 2014 to July 2015 provisional	27.8%	27.4%	Worsening
6.9	No	Suicides and injuries undetermined (ages 15+) (ASR per 100,000)	2012-2014	9.1	8.9	Stable
6.10	No	Excess mortality rate in adults with mental illness	2013/14	338	352	Stable
6.11	Yes	End of life care: proportion dying at home or usual place of residence	2015/16 Q2	43.1%	45.9%	Stable

STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

FORWARD PLAN – June 2016

This document sets out the Forward Plan for the Staffordshire Health and Wellbeing Board.

Health and Wellbeing Boards were established through the Health and Social Care Act 2012. They were set up to bring together key partners across the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch to lead the agenda for health and wellbeing within an area. The Board has a duty to assess the needs of the area through a Joint Strategic Needs Assessment and from that develop a clear strategy for addressing those needs – a Joint Health and Wellbeing Strategy. The Board met in shadow form before taking on its formal status from April 2013.

The Forward Plan is a working document and if an issue of importance is identified at any point throughout the year that should be discussed as a priority this item will be included.

Councillor Councillor Alan White and Dr Charles Pidsley
Co- Chairs

If you would like to know more about our work programme, please get in touch with, Chris Weiner, 01785 278422

Date of meeting	Item	Details	Outcome
9 June PUBLIC BOARD MEETING	**Healthy Housing** Report Author: Lead Board Member: Tony Goodwin	This item was deferred from the 10 March 2016 meeting.	
	Update on Board Membership Report Author: Lead Board Member: Richard Harling	Needs to be reviewed	
	Staffordshire Transformation Programme update Report Author: Penny Harris Lead Board Member:	Update on the progress with development of the Sustainable Transformation Plan	
	Better Care Fund (BCF) Update Report Author: Lead Board Member: Alan White	At the March 2016 meeting a verbal update was provided. The second submission of the BCF plans for 2016-17 is on 21 March 2016. The Board must have oversight of the BCF.	
	CCG Commissioning Intentions & Annual Reports Report Author: Lead Board Members: Charles Pidsley, Mo Huda, Mark Shapley, John James, Paddy Hannigan	CCGs are required to provide an annual report to the NHS Commissioning Board. Detailed scrutiny of the annual reports sits with the CCGs Governing Body, its auditors and ultimately the NHS Commissioning Board as opposed to the Health and Wellbeing Board. The Board has a role in ensuring CCGs plans link to the Health and Wellbeing Strategy and to that end a narrowly defined role in being consulted as part of the preparation of the annual reports.	
	CCG Commissioning Intentions Report Author: Lead Board Members: Charles Pidsley, Mo Huda, Mark Shapley, John James, Paddy Hannigan	This item has been amalgamated with the CCG Commissioning Intentions above The Board has a role to ensure alignment of strategies/plans to the Board's strategy.	
	Health and Wellbeing Board Intelligence Group Update Report Author: Chris Weiner Lead Board Member:	In late 2014, the Health and Wellbeing Board agreed the establishment of a Health and Wellbeing Board Intelligence Group. The Board had sight of the progress of business for 2015/16 in September 2015 and has quarterly updates on outcomes and performance.	
	Personal Health Budgets – The Local Offer **Report Author: Tina Groom**	A personal health budget (PHB) is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. This has to be communicated and approved by the local Health and Wellbeing Boards and a Local Offer agreed ready for 1st April 2016. The offer requires submission at both Staffordshire and Stoke-on-Trent Health and Wellbeing Boards.	
	FOR INFORMATION: Annual reports of Staffordshire Safeguarding Children Board 2014/15 and 2015/16 Report Author: John Wood Lead Board Member: Mark Sutton	Deferred to 8 December Public Board	
8 September PUBLIC BOARD MEETING	**Pan Staffordshire Local Transformation Plan** Report Author: Lead Board Member: Penny Harris	At the March 2015 meeting Board Members requested that the Board be kept up to date with progress.	TBC

Date of meeting	Item	Details	Outcome
	Health and Wellbeing Board Annual Report and Plan for 2016/17	A progress against the Board's key duties was presented in September 2015.	
	Health and Wellbeing Board Intelligence Group Update Report Author: Chris Weiner Lead Board Member:	In late 2014, the Health and Wellbeing Board agreed the establishment of a Health and Wellbeing Board Intelligence Group. The Board had sight of the progress of business for 2015/16 in September 2015 and has quarterly updates on outcomes and performance.	
	Annual Report of the Director Public Health Report Author: Lead Board Member: Richard Harllng	Deferred to 8 December Public Board Board Members are asked to note the content of the report and to consider its actions and next steps in response to the report recommendations	
	Update on the work of Staffordshire Families Strategic Partnership Board Report Author: Lead Board Member: Helen Riley	Deferred to 8 December Public Board	
8 December PUBLIC BOARD MEETING	**Annual report of Staffordshire and Stoke on Trent Adult Safeguarding Partnership 2015/16** Report Author: John Wood Lead Board Member: Alan White	The Annual Report 2014/16 was presented to the Board for information in December 2015.	
	FOR INFORMATION: Annual reports of Staffordshire Safeguarding Children Board 2014/15 and 2015/16 Report Author: John Wood Lead Board Member: Mark Sutton	Deferred to from 9 June Public Board – 2013/14 report was presented to the Board for information in January 2015 For information the 2015/16 annual report is in the compilation stage. It will not be available until later this year. It is likely to be September/October time to allow for the report to go through the required approval processes.	
	Update on the work of Staffordshire Families Strategic Partnership Board Report Author: Lead Board Member: Helen Riley	It was agreed at the March 2016 meeting that the Board approve the working protocal between the Board, the FSBP and Staffs Safeguarding Children Board and that update from the FSPB would be provided on the strategic intent, integrated commissioning protocols, delivery plans, outcomes framework and progress on the Children and Families Transformation Plan.	
	Health and Wellbeing Board Intelligence Group Update Report Author: Chris Weiner Lead Board Member:	In late 2014, the Health and Wellbeing Board agreed the establishment of a Health and Wellbeing Board Intelligence Group. The Board had sight of the progress of business for 2015/16 in September 2015 and has quarterly updates on outcomes and performance.	
	Annual Report of the Director Public Health Report Author: Lead Board Member: Richard Harllng	Deferred to 8 December Public Board	
9 March PUBLIC BOARD MEETING	**Health and Wellbeing Board Intelligence Group Update** Report Author: Chris Weiner Lead Board Member:	In late 2014, the Health and Wellbeing Board agreed the establishment of a Health and Wellbeing Board Intelligence Group. The Board had sight of the progress of business for 2015/16 in September 2015 and has quarterly updates on outcomes and performance.	

Board Membership

Role	Member	Substitute Member
Staffordshire County Council Cabinet Members	**CO CHAIR - Alan White** – Cabinet Member for Health, Care and Wellbeing Ben Adams – Cabinet Member for Learning and Skills Mark Sutton – Cabinet Member for Children and Young People	David Loades – Cabinet Support Member for Social Care and Wellbeing
Director for Families and Communities	Helen Riley – Deputy Chief Executive and Director for Families and Communities	Mick Harrison – Head of Care and Interim Head of DASS
Director for Health and Care	Richard Harling – Director of Health and Care	Chris Weiner- Head of Public Health Progs and Planning
A representative of Healthwatch	Jan Sensier – Chief Executive, Healthwatch Staffordshire	Robin Morrison – Chairman Engaging Communities
A representative of each relevant Clinical Commissioning Group	Mo Huda – Chair of Cannock Chase CCG Paddy Hannigan– Chair of Stafford and Surrounds CCG John James – Chair of South East Staffs and Seisdon Peninsula CCG **CO CHAIR - Charles Pidsley** – Chair of East Staffs CCG Mark Shapley - Chair of North Staffs CCG	Andrew Donald – Accountable Officer Andrew Donald Andrew Donald Tony Bruce – Accountable Officer Marcus Warnes – Chief Operating Officer
NHS England	Ken Deacon – Medical Director, Shropshire and Staffordshire Area Team	Fiona Hamill – Locality Director

Staffordshire's Health and Wellbeing Board has agreed to the following **additional representatives** on the Board:

Role	Member	Substitute
District and Borough Elected Member representatives	Roger Lees – Deputy Leader South Staffordshire District Council Frank Finlay – Cabinet Member for Environment and Health	Brian Edwards Gareth Jones
District and Borough Chief Executive	Tony Goodwin – Chief Executive Tamworth Borough Council	Rob Barnes – Director of Housing & Health Tamworth
Staffordshire Police	Jane Sawyers – Chief Constable	Nick Baker – Deputy Chief Constable
Staffordshire Fire and Rescue Service	Glynn Luznyj – Director of Prevention and Protection	Jim Bywater
Together We're Better - Staffordshire Transformation Programme	Penny Harris – Programme Director	Bill Gowan – Medical Director

Calendar and Board Meetings

(at 3pm and at Rudyard and Trentham Rooms, Staffordshire Place 1 unless otherwise stated)

9 June 2016

8 September 2016

8 December 2016

9 March 2017