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

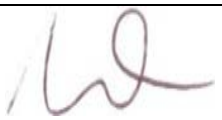
The CCGs together are coterminous with the County Council, subject to the usual differences between resident and registered populations

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-

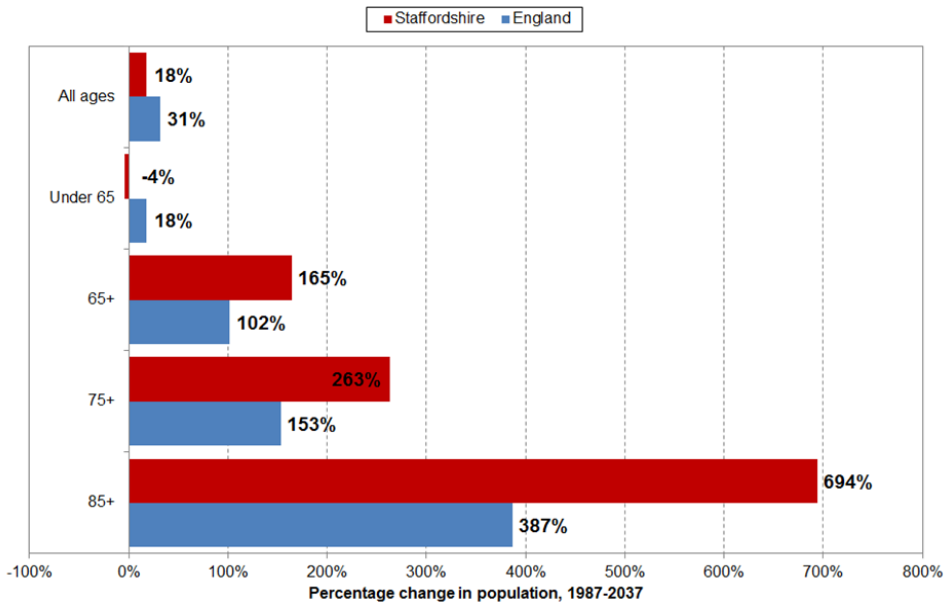
fold between 1987 and 2037. Over the same period, the number of working adults (who may be expected to care for their elderly relatives) will reduce.

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

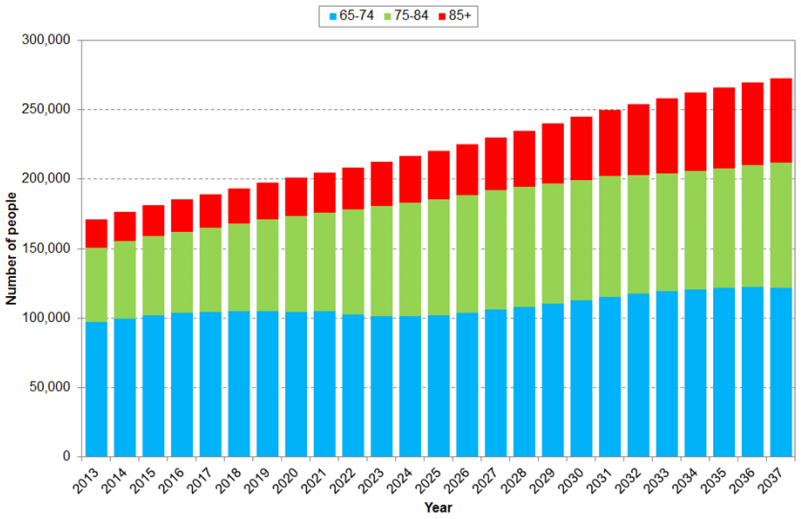
Future Change in Population

Percentage change by age group, 1987-2037

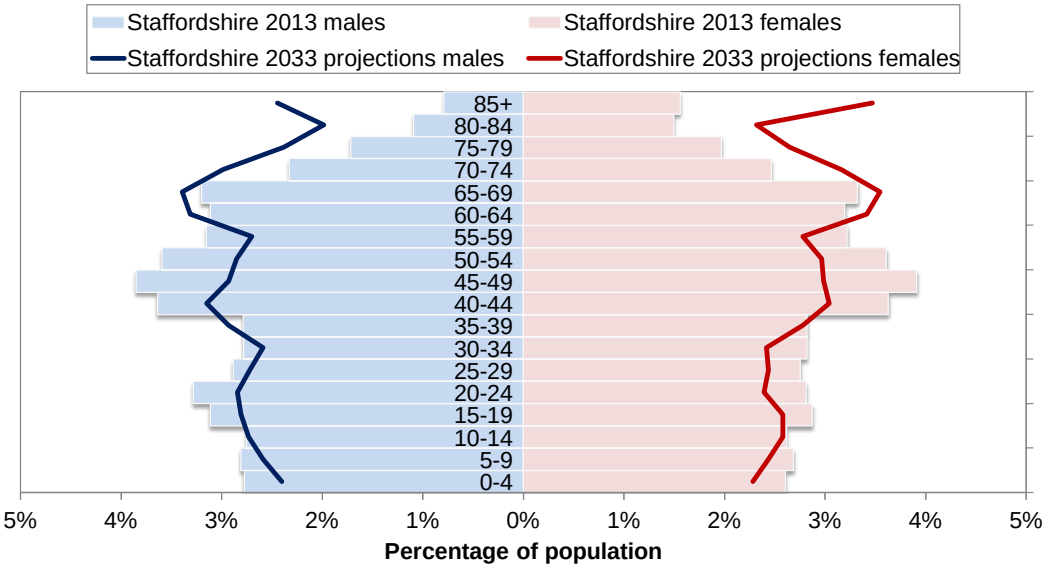


The impact on the care system of this decrease in the working age population will be exacerbated by the improving economic climate, such that people may have less time available in which to provide care to their own relatives and there will be greater employment competition for people who might otherwise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

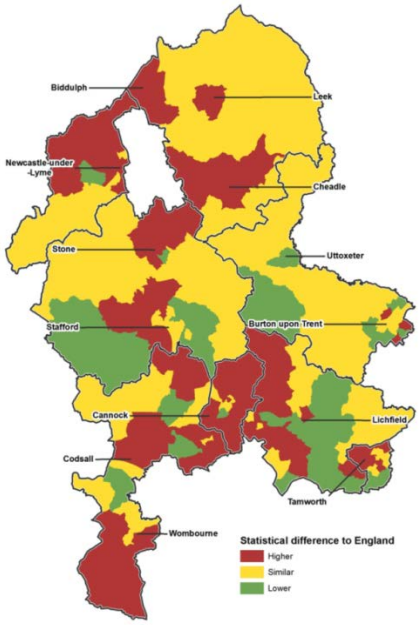
Current and projected numbers of selected health conditions and supported care arrangements for people aged 65 and over in Staffordshire

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

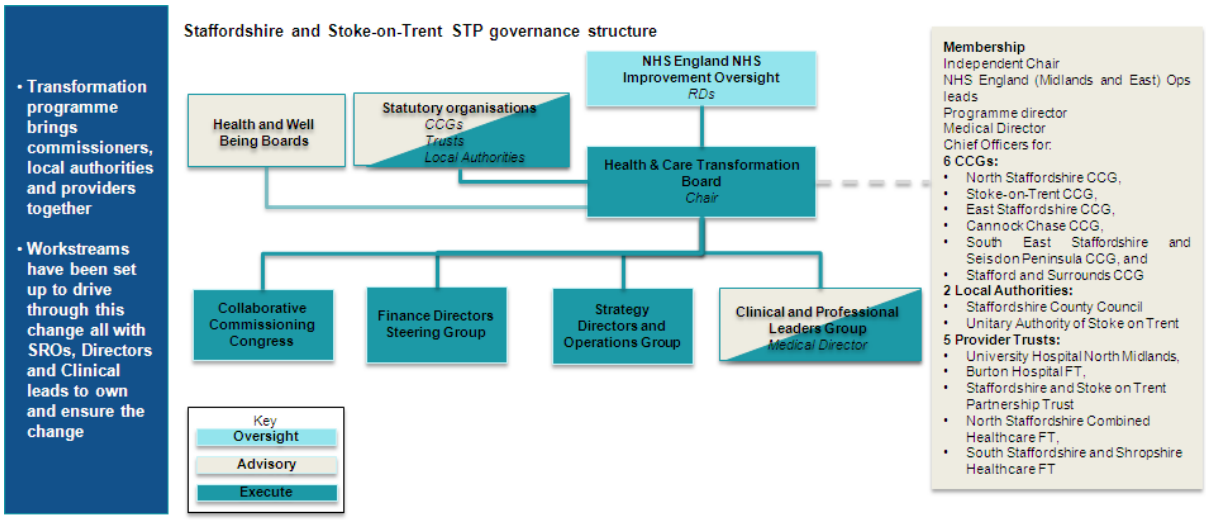
BCF governance and accountabilities set out (B.3.i)

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:

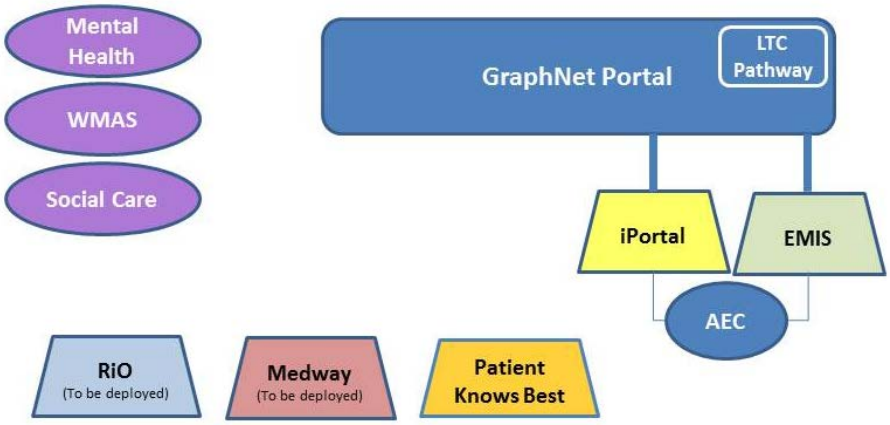
- Existing system will be used wherever possible with the focus on interoperability (e.g. EMIS) and use of portal platforms to integrate data
- A single clinical portal will allow professionals to access Information and the citizen they are working with in any place ad at the right time to support decision 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.

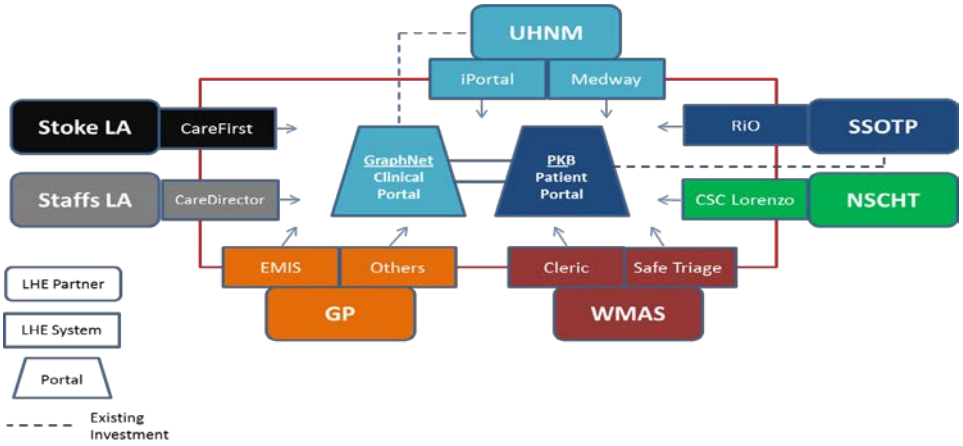
PHASE I 2016/17	□ Making GP data available in the new Ambulatory Emergency Centre □ Embedding UHNM data in GP systems □ Consolidating existing instances of GraphNet across the LHE □ Developing Shared Care Plans for management of Long Term Conditions (LTC)



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:

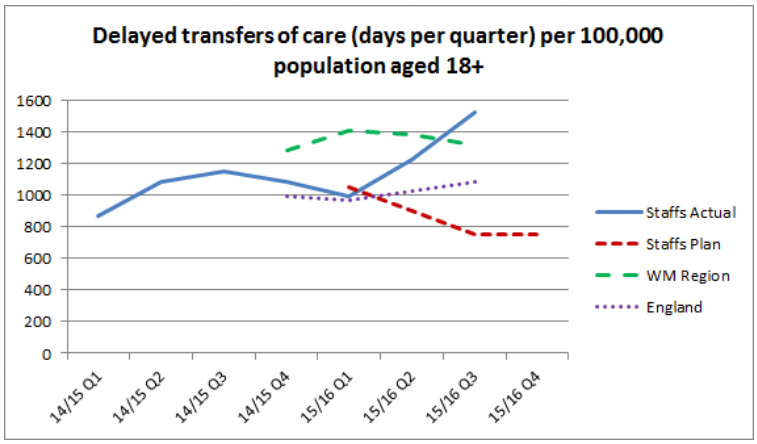
- Leadership
- MADE
- Ambulatory care
- SAFER
- Therapies
- Frailty and D2A

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:

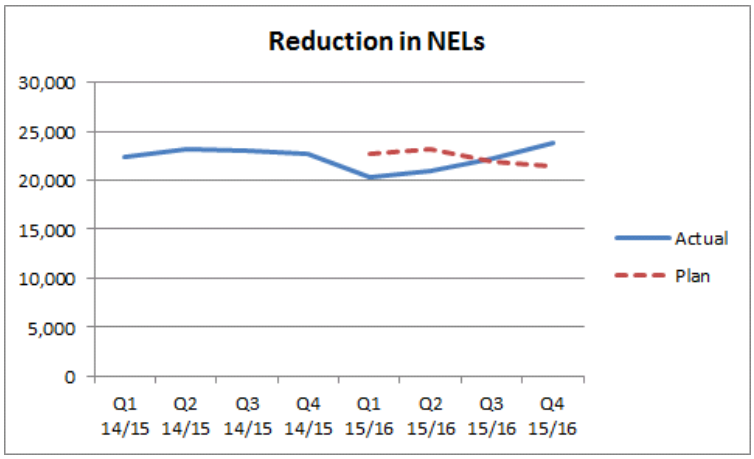
- Growth is applied to the forecast out-turn position for each acute provider reporting NEA activity
- The percentage growth is determined by calculating the difference in 2014/15 actual out-turn against 2015/16 forecast out-turn
- Any reductions against the 2015/16 plan are identified at a HRG level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

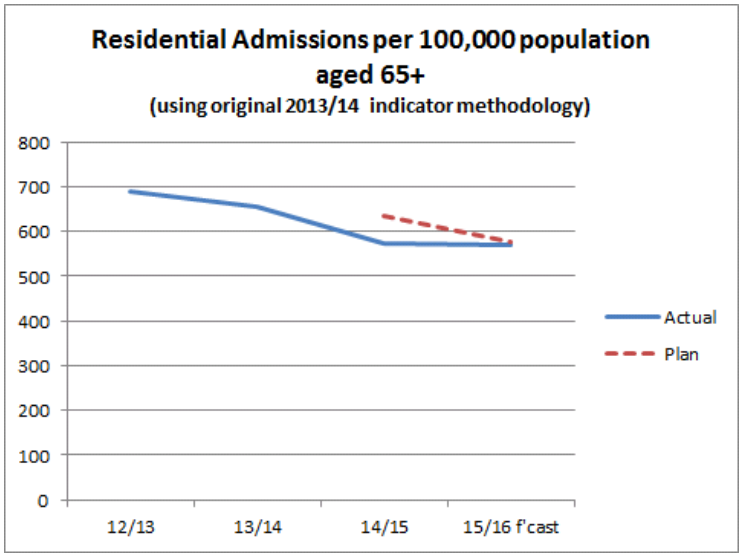
Approach to setting residential admissions metric plan set out (E.2.ii)

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)

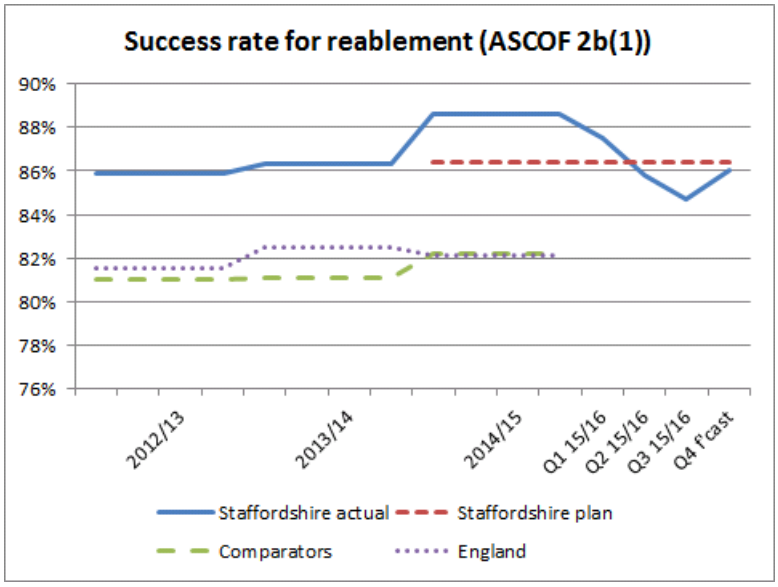
Staffordshire has an excellent track record of successful reablement on hospital discharge, having consistently outperformed the national and comparator averages:

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