Staffordshire Health and Wellbeing Board

Better Care Fund Narrative Plan 2021-22

This plan complements the agreed spending plan and ambitions for BCF national metrics in Staffordshire's BCF Planning Excel Template.

1. Partners involved in preparing the plan

The following partners have been involved in the drafting of this plan:

- Staffordshire County Council (SCC)
- Staffordshire Clinical Commissioning Groups (CCGs)

In addition, the following partners have contributed towards development and/or delivery of individual schemes that form part of the plan:

- Midlands Partnership Foundation NHS Trust (MPFT)
- Acute Hospitals, including:
    - University Hospital of North Midlands NHS Trust (Royal Stoke and County Hospital Sites)
    - University Hospitals of Derby and Burton NHS Foundation Trust (Queens and Derby Royal Hospital Sites
    - Royal Wolverhampton NHS Trust (New Cross Hospital
    - Walsall Healthcare NHS Trust (Walsall Manor Hospital)
    - The Dudley Group NHS Foundation Trust (Russell's Hall Hospital
    - University Hospital of Birmingham NHS Foundation Trust (Good Hope Hospital)
- District councils in relation to Disabled Facilities Grants
- Voluntary sector providers
- Residential Care Home Providers
- Home Care Providers
- Home-First Discharge-to-Assess Reablement Providers

Stakeholders have been involved through a number of different ways, with most BCF projects having their own project groups and governance with various stakeholders involved. As an example, "Together We're Better" is the Integrated Care System (ICES) for Staffordshire and Stoke-on-Trent. The formation of the ICS is a partnership of NHS and local government organisations, alongside independent and voluntary sector groups. The ICS has a Board in place whose role is to agree, oversee and lead on the delivering of the transformational health and care strategies for the population of our local community. The transformational plan has a number of programme workstreams as detailed below; the most pertinent to our BCF plan are

Urgent and Emergency Care (UEC) and Enhanced Primary and Community Care (EPCC).

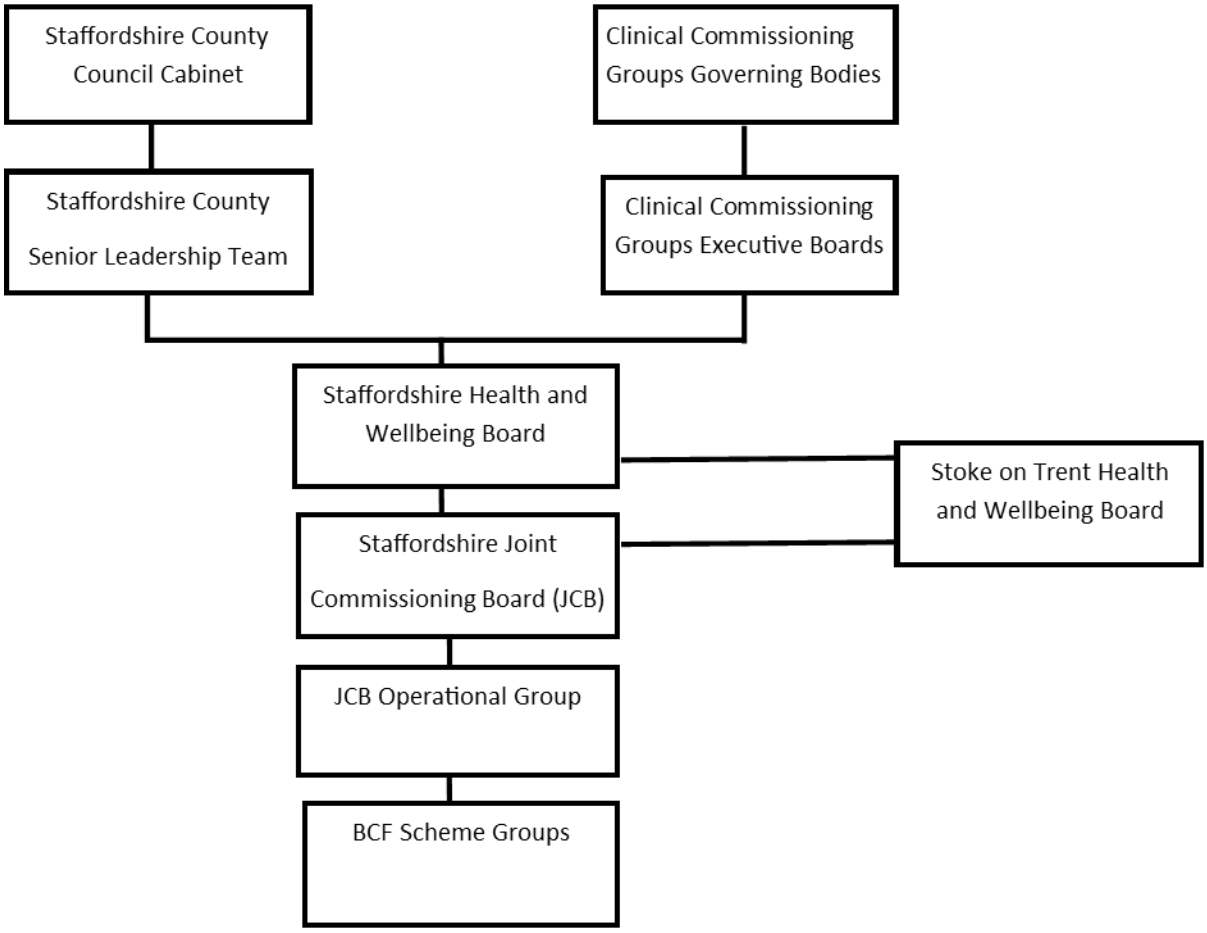
- Urgent and Emergency Care (UEC)
- Enhanced Primary and Community Care (EPCC).
- Planned Care and Cancer;
- Maternity, Children and Young People;
- Prevention;
- Mental Health;
- Workforce;
- Digital;
- Transforming Services;
- Organisational Development and Leadership;
- Estates;
- One Health and Care;
- NHS 111 and;
- Adult Community Mental Health Transformation

2. Governance

The governance for the BCF plan development and its implementation in Staffordshire is shown in the diagram below (figure 1).

Overall strategic oversight of partnership working between Staffordshire CCGs and the Council is vested in the quarterly Health and Wellbeing Board, which make recommendations to the Partners. The Staffordshire CCGs and the Council have also agreed to consult with Stoke CCG as to any actions required to be taken by the Partners where this action will affect Stokes contribution or Services to be provided to cross border service users.

Figure 1 – BCF Governance



3. Summary of Key Priorities for 2021-22:

Key priorities for 2021-22 have included the following:

- Supporting Care Providers throughout the Covid Pandemic:
    - The most significant change and challenge over the last 18 months has been managing the impact of Covid. As has been the case across the country, the pandemic has had an enormous effect both on people with social care needs and on those working within care.
    - We have continued with a very similar approach to supporting the care market in 2021-22 as was the case during 2020-21. This includes:
        - Operating a Provider Incident Management support service 7 days a week
        - Local outbreak management 7 days a week
        - Funding and resources for infection prevention and control and workforce, including underwriting of excess costs for appropriately booked agency staff
        - Training and career development opportunities
        - Increased contact with providers and access to specialist advice and support where necessary
        - Targeted support to maximise vaccination uptake
        - The Enhanced Health in Care Homes programme

        - A range of wellbeing resources to support staff who are working in a highly stressful environment;
        - A joint health and social care Provider Improvement Response Team to support quality assurance and quality improvement in the care home market; and
        - Aupport to care homes through MPFT's Care Home Intensive Support Team which can provide on-site support for the most challenged care homes, as well as links to other community support services.
    - There have also been substantial increases in expenditure, delays in delivering savings programmes, and reductions in income levels, though the emergency Covid-19 funding allocations have helped to ease some of the financial pressures.
    - Despite the vaccination programme and the release of 'lockdown' restrictions, there remains uncertainty about the long-term impact on the market. Providers are facing increased costs due to infection control measures, additional personal protective equipment (PPE) requirements, additional staffing costs and so on. This has been exacerbated by reduced income levels due to lower activity; though the distribution of grants has helped in part to mitigate some of this. There may be a changed pattern in demand for care home placements and home care, as well as further legislation or guidance that affect workforce and/or costs.
    - Our priority has been and continues to be to support our providers to mitigate the impact as much as possible. In order to mitigate future year risks, we endeavour to identify solutions collectively that meet residents assessed needs, deliver good outcomes and provide value for money.

- Supporting hospital discharge:
    - SCC and the CCGs have commissioned a Homefirst D2A service across the county, in order to support safe timely discharges from hospital, improve outcomes for people leaving hospital, and support people to remain at home and maintain their independence. A key priority continues to be ensuring we have the right capacity in place, and that the services are improving outcomes for people who use them.
    - There has been a significant increase in the number of people discharged from hospital requiring our commissioned Homefirst D2A services; if the current trend continues, there will be over delivery of over 163,000 hours across the year. Due to this significant increase in the number of hours delivered, and the national discharge funding not being a permanent funding solution, the system is prioritising further work with each acute trust to ensure that Simple and Timely discharges are as high as possible, and to understand and model forward the flow of admissions, discharges, and requests for complex discharge support, and to ensure that people are being discharged into the most appropriate pathway.
    - SCC is planning to procure additional voluntary sector support for the winter, and will work with MPFT to identify any potential to divert discharge requirements from Home First to the voluntary sector where this is safe to do so. Both the Council and MPFT have also been seeking to identify

people in Home First who could be supported by the voluntary sector instead.

- Improvements to the commissioning of D2A beds in Care Homes
    - Historically, across Staffordshire and Stoke-on-Trent the way in which D2A beds in Care Homes (including wrap around and clinical governance) was commissioned was fragmented with multiple patient handoffs between teams and services which led to increased length of stay within community bed based services and poor patient experience.
    - Lack of wrap around, clinical oversight and day to day management of these pathways specifically in the south of the county led to issues on a day to day operational basis, furthermore as commissioner, any issues that could not be managed within the operational teams were handed to the CCG to raise via the contract which often caused duplication and further delays.
    - To address these concerns/ issues and to improve performance and patient experience, a key priority for the system was to change how D2A beds in Care Homes are commissioned by transferring the procurement, sourcing and contracting of these beds to our community provider; MPFT, with effect from 01 October 2021. This has resulted in one single integrated bed hub across Staffordshire and Stoke-on-Trent who are responsible to support all patients following an acute episode of physical or mental ill health to be discharged to the most appropriate setting based on assessed need. The single integrated bed hub includes a multi-disciplinary complex assessment team compromising of nursing, social care, therapy, mental health, voluntary sector and medical input that wrap around the homes and be involved in the day to day care of the patient and support the care staff in the home to manage D2A patients with a daily physical presence over a 7 day week.

- Home care provision:
    - SCC has a statutory duty to meet the needs of people who are assessed as eligible for care and support under the Care Act 2014. If an eligible person is identified as having care needs that require care and support at home, SCC will commission home care hours from the independent sector home care market, or from our commissioned Provider of Last Resort where there are issues in sourcing.
    - As is the case nationally, in addition to managing the impact of Covid, the market are experiencing difficulties with recruiting and retaining staff and have seen a reduction in the overall availability of the workforce available for care. As a result, since June 2021 there has been a sharp deterioration in the market's ability to meet demand to time.
    - To enable more capacity in the Home Care market, maximise current capacity, and to help providers with issues around recruitment/retention we have developed the following workstreams:

- Series of locality provider forums have been established to work collaboratively with providers to understand the root causes and options for solutions at a locality level.
- Creative options for helping providers with transport, such as parking concessions or “carer permits”
- Linking with DBS regarding staff resigning with no notice and employers not requesting references. Incorporated recruitment practice as part of our approach to quality.
- Working collaboratively with providers to enable them to work together to look at capacity and see if they can make more efficient runs
- Support to locality group processes, with the outcome of enhanced co-design and co-production with providers
- Developing links and working with voluntary sector
- Improved Trusted Assessor process in place, with care plans, social work teams, QA and safeguarding processes aligned
- The use of starter bonuses to enable packages to be sourced
- Working with providers on their contingency planning during school holidays
- Trialling of outcome based commissioning

- Care home provision:
  - If a person is identified as having assessed social care needs that can no longer be safely managed in their own home or another community setting, SCC will meet those needs by commissioning a care home placement. SCC also has a duty to shape the market to ensure that care and support is available when required. In addition to supporting providers to manage the impact of Covid, our overarching strategic priorities for care homes include:
    - Improving the quality of care in Staffordshire - This is primarily measured by the proportion of care homes rated by the Care Quality Commission (CQC) as ‘outstanding’ or ‘good’ with a target to reach the England average within the next 3-5 years. It is supported by targeted quality assurance and quality improvement actions, including from the Provider Improvement Response Team (joint between the Council and the CCGs)
    - Ensuring timely access to care home placements when required - This is measured by the proportion of placements sourced to timescale with a target of 85% overall.
    - Ensuring affordability of care home placements, such that we are paying a fair price, achieving value for money, and that overall expenditure does not exceed the budget - This is measured by the average price of placements with a target that this increases only by the cost of inflation and that variation in price is reduced. A key change since the 2020/21 plan, has been that the Council are increasing the number of block booked beds purchased from the market, which ensures a level of financial stability for providers, an

affordable rate for the council, and guaranteed capacity for commissioners.

- Community Equipment
    - Contracting arrangements for the Integrated Community Equipment Service (ICEs) are due to change, following the novation from SCC to North Staffordshire CCG. The service will remain integrated via a partnership approach/ agreement including both Local Authorities and all six CCGs. The service was due to be re-tendered during 20/21 however this was delayed due to Covid-19 and has now commenced with the tender released to the market in October 2021.
    - An extensive engagement programme has taken place with stakeholders to revise the service specification and product catalogue to improve patient experience and outcomes. The following changes have been made:
      – Implementation of a 7 day delivery service, same day to support hospital discharge, admission avoidance and to meet the needs of patients who are end of life. This is in line with the National Discharge Policy published in August 21.
    - A number of items have been transferred from specials to standard stock following evidence that items are ordered multiple times and leads to delays in discharges. This is largely around bariatric equipment.
      Revised process for the ordering of specials equipment to mitigate the loss of clinical time across acute and community providers.
      it is expected that the tender will conclude in the Spring 2022 and the new contract enact following contract award and mobilisation.

4. Overall approach to integration

Along with other partners in the local area, SCC and the CCGs are collaborating to inform the development of the local ICS system architecture and place based commissioning. The focus for integration during 2021-22 has been to identify and progress service areas and pathways where both SCC and the CCGs, as well as other partners, believe that there are clear opportunities to develop and implement specific, concrete proposals to improve outcomes and/or cost effectiveness. The priorities within this approach to joint/collaborative commissioning linked to BCF funded services for 2021/22 are:

- Urgent and emergency care pathways, including:
    - Discharge to assess pathways – timeliness and effectiveness
    - Improved patient experience and communications
    - Admission avoidance
- Quality improvement in care homes, including
    - Improving the effectiveness of Enhanced Health in Care Homes;
    - Identification of and support to deteriorating patients
    - Technology in care homes;
    - Revised pathways to prevent unnecessary admissions to hospitals from care homes
- Development of the social care workforce, including:

        - Partnership working through the ICS workforce hub
        - Additional funding to support career development for social care staff
        - Additional funding to support retention and recruitment in home care
        - Piloting of a reservists model for social care, and
        - Piloting of a potential hybrid NHS and social care staffing model to support a potential improved approach to a career pathway in home care
    - Development of a Learning Disability and Autism Board to improve the governance of and outcomes from programmes of work which include:
        - Annual Health Checks
        - Transforming Care Programme/subsequent actions for people with a Learning Disability or Autism in hospitals
        - LeDeR - reviews deaths to see where we can find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability.

An example of a successful BCF collaboration between SCC and the CCGs is the commissioning of health tasks:

- SCC and the CCGs have a section 256 agreement in place to enable SCCs brokerage service to source health task calls and packages on behalf of the CCGs. This means that we can ensure that people will receive a seamless service to support both their health and social care needs in Staffordshire, and is an important step forward in our ambition to facilitate integrated care for Staffordshire citizens. This agreement has enabled Home Care Providers to provide health tasks as part of integrated social care and health calls which has avoided people receiving multiple calls from different providers, offered continuity of care, and an overall better experience for Service Users. This has also provided better value for money to commissioners and ease of procurement and contracting, by offering access to the Council's Home Care Framework Contract for the CCGs.
- SCC, Stoke City Council and the CCG have also completed a joint audit of health care tasks procured by SCC on the CCGs behalf. A registered District nurse was employed in Staffordshire, and one in Stoke, to review the packages and ensure that identified assessed health needs are being met in the most effective way for the service user, and that as far as possible people are supported with Assistive technologies to enable them to remain as independent as possible. Whilst this process has identified some challenges it has also brought about many successes, including a joint approach to reviews, exploring more effective pharmacy prescribing, making the best use of already commissioned community health contracts such as District Nursing, ensuring Assistive Technology is offered to promote self care, and helping people to maintain greater resilience to self-manage their own care where possible.

5. Supporting Discharge (national condition four)

SCC and the CCGs are both partners, with others, in the local UEC Board and its workplan. There are five key elements of the overall workplan: three within acute hospitals; one for pre-hospital; and one for post-hospital (supporting discharge). The SROs for the supporting discharge elements of the workplan are Jennie Collier (Chief Operating Officer at MPFT) jointly with Andrew Jepps (Assistant Director at Staffordshire County Council) and Peter Tomlin (Assistant Director at Stoke-on-Trent City Council).

This sets out our agreed approach to the delivery of Discharge to Assess (D2A) and HomeFirst services, as well as building on the High Impact Change model. The incorporation into the UEC system plan ensures the involvement of acute trusts in the county, both in developing the plans and agreeing them through the Board. The aims and objectives of the post-hospital discharge workstreams are:

- To ensure timely discharge from hospital for patients with complex needs, to their own home or original place of residence wherever possible
- To improve the effectiveness of bed based D2A, when this is required, with timely admission to Pathways 2 and 3, and a high proportion of patients in Pathway 2 able to return to their own home or original place of residence
- To improve communication with patients and, where appropriate, their families through the hospital discharge pathway
- To ensure equitable access to good discharge services for people with complex needs across Stoke-on-Trent and Staffordshire, regardless of which hospital they have used

Key initiatives to achieve this in 2021/22 are:

- The review and redesign of Pathway 2 and 3 D2A beds, with a revised model operating by winter 2021/22 (see below)
- Improved and more consistent communications with patients and, where appropriate, their families throughout the pathway, capturing the experience of patients consistently and building on recommendations from a 2019/20 review of D2A by Healthwatch
- Partners at each ICP level are also prioritising and implementing specific actions arising from a renewed self assessment against the High Impact Change model.

In addition to the above, the UEC board are also prioritising initiatives to help prevent avoidable hospital admissions, given the current pressures on the system including increased demand on ambulance services which then impact on response times etc. The UEC Board are progressing actions to raise the profile of current services such as CRIS that can support this. Further communications have been sent out to providers to promote the use of these services in order to prevent avoidable hospital admissions.

Commissioners are aware that Walsall Healthcare NHS Trust has been flagged by the NHS as one of the trusts of focus, and that based on data on emergency

admissions between April and September this year over 10% of Walsall Hospitals emergency admissions were Staffordshire residents. Commissioners and our partners are working with the Trust to understand the challenges and working to support them to make improvements.

Commissioning of Homefirst – D2A

- SCC and the CCGs have commissioned a Homefirst D2A service across the county, in order to support safe timely discharges from hospital, improve outcomes for people leaving hospital. and support people to remain at home and maintain their independence. The Council have a s75 Partnership Agreement with MPFT for the provision of Homefirst reablement in the south, and with Nexxus for reablement in the east of the county. The CCGs contract with MPFT for Homefirst/D2a reablement in the north. Both the CCG and SCC have agreed for the commissioned capacity across both contracts to be flexed across the county to suit demand.

- There has been a significant increase in the demand for Home First hours this year, resulting in an over delivery across the county of over 81,000 so far. During this period there has also been an increase in bed-based demand in the D2A process. Work continues with each acute trust to ensure that Simple and Timely discharges are as high as possible, and to understand and model forward the flow of admissions, discharges, and requests for complex discharge support. SCC is planning to procure additional voluntary sector support for the winter, and will work with MPFT to identify any potential to divert discharge requirements from Home First to the voluntary sector where this is safe to do so. Both SCC and MPFT have also been seeking to identify people in Home First who could be supported by the voluntary sector instead.

- As part of the contract management process, SCC and the CCGs monitor the services KPIs to ensure that the services are effective and improving outcomes for people who use them. Waiting times for reablement, from the time of referral to commencement of the reablement service remain low; at around half a day during this period. This means that patients are being discharged from hospital in a timely manner and getting support provided to them at home. The average length of time spent in in the service to re-able people to their optimum level is around 20 days. The KPI for the % of people receiving reablement where the immediate outcome was no support is currently reported at around 88%.

6. Disabled Facilities Grant (DFG)

As a two tier area, decisions around the use of the DFG funding, allocated through the BCF has the direct involvement of both tiers working jointly to support integration between health, care and housing. The total allocated DFG funding of £10,005,367 has been passported to the eight District Councils in Staffordshire, as detailed in table 1 below:

Table 1 – DFG allocation per district

District	Amount
Cannock Chase	£1,051,224
East Staffordshire	£1,160,392
Lichfield	£1,109,194
Newcastle-under-Lyme	£1,715,114
South Staffordshire	£1,126,662
Stafford	£1,522,033
Staffordshire Moorlands	£1,773,856
Tamworth	£546,890
Total	£10,005,367

Work is ongoing between the CCGs, district and borough councils and the local authority across Staffordshire, to consider how services, including DFG funded home adaptations, and use of technologies can be delivered to ensure a seamless and joined up approach to assessment of need and access to those services. This work is on-going to deliver benefits through:

- Our commissioned community equipment service, on behalf of various health and care partners in Staffordshire and Stoke on Trent. This enables people to live in their own homes more easily by providing a range of equipment to assist in their daily lives. Equipment is loaned to people with an assessed health or social care need, and then collected and recycled when no longer needed. The equipment ranges from small aids to help with daily living, up to large items such as lifting hoists and specialist beds and may be provided to a range of eligible individuals aged 18+.
- Support people to maintain their home environments to enable them to remain independent in their own homes
- Improved customer experience (flexibility; ease and choice) and reduced end to end times
- Reduction in costs – getting it right first time for the customer; avoiding rework; designing out the waste in system
- Improved discharge pathways from hospital – more flexible use of DFG
- Improved partnership and collaborative working
- Implementation of appropriate measures to demonstrate impacts and benefits
- Some districts have developed Housing Assistance policies and are looking at innovative ways to use DFG monies and benefit and enable people to remain at home. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital.

7. Equality and health inequalities.

A key contribution made by BCF services in 2021/22 in reducing health inequalities has been in the delivery and refinement of a full Discharge to Assess model in the south and the east of the county. Prior to the pandemic, there was a much higher probability of discharge home (where complex discharge support was required) for residents living in the northern part of Staffordshire, and limited ability to be supported home with HomeFirst. Through the development of both increased HomeFirst services in MPFT and the continuation of Nexxus Care reablement services, this inequity has been addressed, and this inequality has been overcome, improving hospital discharge performance for residents in these parts of the county.

During the pandemic, local partners have supported the rollout of the vaccination programme, including into adult social care settings and for adult social care groups. Clear data has enabled additional focus and support for those settings and groups who have been less likely to take up the vaccination offer, including specific clinically led support or encouragement from community leaders as appropriate to reduce differential levels of uptake and reduce inequalities. The use of data to drive specific additional interventions has created local learning which is being built on in other programmes (such as those reporting to the Learning Disability and Autism Board).