

AGENDA

Health and Wellbeing Board

Date: **Tuesday 20 September 2016**

Time: **2.00 pm**

Place: **Committee Room 1, The Shire Hall, St. Peter's Square,
Hereford, HR1 2HX**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

Ruth Goldwater, Governance Services

Tel: 01432 260635

Email: ruth.goldwater@herefordshire.gov.uk

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Agenda for the Meeting of the Health and Wellbeing Board

Membership

Chairman

Vice-Chairman

Councillor PM Morgan

Dr Dominic Horne

Herefordshire Council

NHS Herefordshire Clinical
Commissioning Group

Simon Hairsnape

NHS Herefordshire Clinical
Commissioning Group

Prof Rod Thomson

Director of Public Health

Diane Jones MBE

NHS Herefordshire Clinical
Commissioning Group

Councillor JG Lester

Herefordshire Council

Jo Davidson

Director for Children's Wellbeing

Paul Deneen

Healthwatch Herefordshire

Jacqui Bremner

Healthwatch Herefordshire

Martin Samuels

Director for Adults and Wellbeing

Jo-anne Alner

NHS England

AGENDA

PUBLIC INFORMATION

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1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

To receive any details of members nominated to attend the meeting in place of a member of the committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest by members in respect of items on the agenda.

4. MINUTES

To approve and sign the minutes of the meeting held on 19 July 2016.

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5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive questions from members of the public relating to matters within the board's terms of reference.

(Questions must be submitted by midday three clear working days before the day of the meeting)

6. BETTER CARE FUND 2016-17 QUARTER ONE PERFORMANCE REPORT

To approve the better care fund quarter one return.

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7. UPDATE ON PRIORITY THREE OF THE HEALTH AND WELLBEING STRATEGY

To review progress in delivering the third priority of the health and wellbeing strategy, covering older people, to include progress plans and challenges.

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HEREFORDSHIRE COUNCIL

SHIRE HALL, ST PETER'S SQUARE, HEREFORD, HR1 2HX.

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MINUTES of the meeting of Health and Wellbeing Board held at Committee Room 1, The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Tuesday 19 July 2016 at 2.00 pm

Present: **PM Morgan (Herefordshire Council) (Chairman)**
 Dr D Horne (NHS Herefordshire Clinical Commissioning Group (Vice Chairman))

Mr S Hairsnape	NHS Herefordshire CCG
Mrs D Jones MBE	NHS Herefordshire CCG
Mrs J Davidson	Director of Children's Wellbeing
Mr P Deneen	Healthwatch Herefordshire
Ms J Bremner	Healthwatch Herefordshire
Mr M Samuels	Director For Adults and Wellbeing
Cllr JA Hyde	Herefordshire Council
Mr A Exell	NHS England
Mrs A Westlake	Consultant in Public Health

In attendance: **G Murray, J Shapiro, A Talbot-Smith**

71. APOLOGIES FOR ABSENCE

Apologies were received from Jo-Anne Alner (NHS England), Cllr JG Lester and Prof Rod Thomson.

72. NAMED SUBSTITUTES (IF ANY)

Cllr JA Hyde attended as a substitute for Cllr JG Lester, Alan Exell attended for Jo-Anne Alner (NHS England) and Andrea Westlake for Prof Rod Thomson.

73. DECLARATIONS OF INTEREST

None.

74. MINUTES

RESOLVED

That the minutes of the meeting held on 23 March 2016 be approved as a correct record and signed by the chairman.

75. QUESTIONS FROM MEMBERS OF THE PUBLIC

None.

76. APPOINTMENT OF CHAIR OF THE HEALTH AND WELLBEING BOARD

Councillor PM Morgan was thanked for her work over the past year.

The board noted the reappointment of Councillor PM Morgan as the chair of the health and wellbeing board.

RESOLVED

That Councillor PM Morgan be appointed as the chairman of the board.

77. APPOINTMENT OF VICE-CHAIR OF THE HEALTH AND WELLBEING BOARD

The chair thanked Mrs Diane Jones MBE for her hard work over the past year. She nominated Dr Dominic Horne as new vice-chairman of the health and wellbeing board. Simon Hairsnape seconded the nomination and Dr Horne was elected unanimously as the vice-chairman.

RESOLVED

That Dr Dominic Horne be appointed as vice-chairman of the health and wellbeing board.

78. INTEGRATION: BETTER CARE FUND (BCF), SUSTAINABILITY AND TRANSFORMATION PLAN AND ONE HEREFORDSHIRE

The director for adults and wellbeing introduced these reports under a new standing agenda item to consider integration. The reports presented today were prepared jointly by the council and the clinical commissioning group.

Better Care Fund

It was a requirement to report to NHS England on the performance of the better care fund at required intervals. Board meetings had been aligned to the submission dates given by NHS England but changes to data templates had not made it possible to seek formal board approval of submissions and meet the timescale for submission. It was recognised that this was not ideal and retrospective approval was sought.

A key issue identified as regards financial implications was that of agreed risk sharing. The total spending pool on residential, nursing and health care was in the region of £20m and had overspent by £1.3m which meant that the risk share was bulk-funded by the council. There would be considerable input to the new better care fund to address this issue.

Board members confirmed that in terms of performance of the fund, they would be guided on significant issues and support would be given to officers in decision-making. In terms of quality of care, the quality monitoring team was working with contracted services, although board members were reminded that 70% of care was self-funded. A new quality framework was in process of implementation with a balanced score-card approach for each home to use. This would enable closer involvement to maintain quality.

It was noted that care was provided for the most vulnerable people who were not always able to speak up about the quality of their care and the intention was to work across adults' and children's care to see the whole picture.

In answer to a question regarding a new integrated framework regarding contracts, the director for adults and wellbeing reported that the focus was on working towards a single contract with all residential and nursing homes. There was close working with the CCG which allowed for streamlining of systems and better engagement with the market. For individuals placed or reviewed since April 2015, there was confidence that they were in right place with the right care package at the right price. The focus was on individuals who had not had a review and were not already on standard rates, to ensure proper and full review and risk sharing.

It was noted that although it was possible to place people at standard rates, sometimes placement was not as close to home as wished. Whilst there was some pressure, this was not due to capacity, although it was noted that domiciliary care was more difficult, particularly for people with complex needs in more rural areas where it was less easy to

establish cost effective visiting routes. To address this, reprocurement was intended, with active public consultation.

The director of children's wellbeing explained that there were also children and young people with complex needs and although numbers were small, a new approach was introduced to support a reduction in reliance on residential care, whilst providing a range of therapeutic provision which was value for money. The director referred to the Narey report on the quality of care in children's residential services which was driving an increase in the quality of care and local provision would need to meet this.

One Herefordshire / sustainability and transformation plan

The director of transformation for One Herefordshire introduced an update on the sustainability and transformation plan (STP) and how One Herefordshire would be realised within it. The report summarised the work so far and how it addressed the triple aims gap.

The director explained that One Herefordshire was a key element as a delivery mechanism for the health and wellbeing strategy and the children and young people's strategy. The STP was submitted in June and NHS England had advised that this would be an interim submission with the final plans submitted for approval in September. A draft plan could be shared after that point. The priorities were to maximise efficiency and effectiveness across clinical pathways, with high value contact, and to reduce inefficiencies in front and back office.

The CCG and the council shared a strong vision of prevention. The NHS definition of prevention was evolving to be more about communities and resilience, and encouraging new ways of working. The development of hospital care was under focus and in terms of local footprint for secondary care provision, this was wider than Herefordshire and Worcestershire. It was also noted that there would be changes to the model which would raise the profile for children and young people through the children and young people's plan. There would be a more place-based approach and a recognition that the workforce went beyond direct employees and this resource needed to be maximised. Healthwatch and voluntary and charity services (VCS) were on the programme board, and VCS were involved in some of the work streams. It was noted that there was a desire to focus more on engagement, although this had to follow the nationally mandated process, and more information would be shared as soon as possible.

Discussion took place around a requirement for greater understanding of the plan in order to understand the next steps and although it was difficult to give people more information on the STP until the plans were made public, it was possible to say more about One Herefordshire.

The director for adults and wellbeing observed that there was high level engagement with the STP within the NHS and indications were that the local footprint was coherent. It was important to identify the best use of the £1.4bn budget that would be available by 2020 by addressing the triple aims gaps and providing high quality services. One Herefordshire would be the focus for local provision in Herefordshire and in ensuring that the county's view is seen in order for people to be able to relate to provision locally.

The director of children's wellbeing reported that there had been good dialogue between Herefordshire and Worcestershire regarding key priorities, which included 0-5 years, healthy child programme and integration of services. The aim was to improve how all agencies worked together for children with special educational needs, unaccompanied asylum seekers, risky behaviour and mental health. For the latter, this included supporting parents with their mental health care needs. The chairman added that the key was to address the health of children as this was fundamental to the future health and wellbeing of the population of the county.

Further discussion took place regarding promotion of knowledge of One Herefordshire and making it clearly understandable for everyone. A communications and engagement group on One Herefordshire and the STP took the view that whilst co-ordinated engagement and formal consultation was essential, until there was more detail arising from the strategic level, there was insufficient information to share that would encourage engagement. The chairman of Healthwatch confirmed an offer to assist with this at the appropriate time, noting that there was a range of forthcoming possibilities that could help to raise awareness. The role of councillors in passing on key messages was also noted.

The board was reminded that plans were still at a high level and guidance on integration was not expected until September at the earliest. Plans for health and social care integration by 2020 would be prepared for signing off by the end of the financial year, and any delays meant that the plan may not materialise in tandem with the council's 2017-18 plans and the NHS 2-year plan.

Responding to a question from the vice-chairman, the director for adults and wellbeing added that there would be no shared budget implications arising from this.

Board members commented that the STP had raised the significance of One Herefordshire and was helping to move it forward. The STP was welcomed as a route to a balanced budget. Work streams were evolving and it was important that the board had ownership of the STP as custodians. Contributions from the board regarding the STP were welcomed by NHS England.

RESOLVED

THAT:

- (a) the better care fund (BCF) quarter four report, attached at appendix 1, as submitted to NHS England on 1 June 2016 be approved;**
- (b) the financial outturn report, attached at appendix 2, be noted;**
- (c) board meeting dates be aligned to submission dates;**
- (d) on such occasions when board meetings do not coincide with submission dates, authority be delegated to the director for adults and wellbeing, following consultation with the accountable officer of the clinical commissioning group, to sign-off that submission and to bring it to the next available board meeting to enable the board to review performance and make recommendations for improvement;**
- (e) that a report on the quality of services and market shaping for adults and children be presented at a future meeting of the health and wellbeing board; and**
- (f) the update on the sustainability and transformation plan and One Herefordshire be noted.**

79. HEALTH AND WELLBEING STRATEGY: EARLY HELP STRATEGY

The director of children's wellbeing introduced the report. Board members were reminded that the children and young people's plan included a refreshed approach to early help and there was a lot of evidence that it was not intervening at an early enough point to reduce the number of children reaching the higher tiers of service provision to get help. The children and young people's partnership recommended the refreshed strategy.

The head of children's commissioning summarised the key features of the strategy, which were:

- family focused, addressing the issues of the whole family

- community focused – drawing on strengths and services in each locality and working with families to build resilience
- targeted – ensuring the right level of support and the right time and integrating with the families first programme
- multi-agency – to reflect the complex issues faced by families
- aimed at building resilience in families – equipping families with skills to self-support in the future and looking at alternative ways to support families.

The changes meant that families would be empowered and equipped to identify their own needs and solutions using local resources in their community. Based on a 'team around the family' approach, this would enable support to be accessed at lower levels of need, and avoid the most intensive intervention as far as possible. Any interventions would be based on appropriate assessments and review.

The refreshed strategy presented challenges around changing cultures and strategic developments in the context of One Herefordshire and the STP, and there would need to be co-ordination with care pathways. Effectiveness would be evidenced by an outcomes scorecard which would be reported to the CYPP.

A pilot had commenced in Leominster in order to test the model, extending to Bromyard, and, by the end of the year, would be county-wide.

Support and commitment was sought from the board for the early help strategy and for board members to provide the leadership to ensure that care pathways between partners were joined up.

It was acknowledged that a commitment to the strategy was required from all partners and a rebalancing of resources would be required in order for there to be a beneficial and sustainable service. The need to for earlier contact with families was noted, and in such a way that was supportive and empowering.

The Leominster pilot used community connections and was an opportunity to test those connections, working with a number of families.

The director of children's wellbeing explained that in some cases the biggest issue for families was around the neglect of children but for whom major intervention would not be necessary if they received the right early help provision. The safeguarding board set out the levels of need to show the appropriate level of intervention for children at significant risk of significant harm. However it was evident that the higher level of intervention at level 4 was sometimes applied in escalation to ensure that a child accessed the provision that was needed. Support for professionals was needed in order to reduce need for access to higher levels of intervention so that families could resolve issues themselves rather than depending on formal systems.

Board members identified a number of examples of good practice and partnership approaches that encouraged cohesion, and which if implemented more widely would encourage agencies to change practice and approach. This was particularly important in providing support in rural areas and it was suggested that for completeness, it would be beneficial for the early help strategy to be piloted in a rural area. It was acknowledged that there were a number of other aspects that would benefit from further exploration such as children in home education and young carers, and although this relied on community intelligence, changes should emphasise empowerment for families rather reliance on social care.

Discussion took place regarding the practical steps that could be taken to encourage cultural change, including contact with GPs, teachers and other professionals who could help to promote new approaches, and developing multi-agency group meetings which could be developed into family network meetings.

The chairman commented that the strategy must gather pace following the Leominster pilot in order for it to be seen across the whole system. Commitment at senior leadership level was therefore encouraged to ensure it happened. Board members were assured that there were plans in place to ensure this and the strategy would extend to Bromyard after Leominster and rural issues were being addressed.

However, support was required to increase engagement with providers in recognition that there were many ways of supporting people in communities.

Assurance was also given regarding the matter of information sharing, which would be supported through a data hub and an overarching data agreement covering major agencies and this would set the scene for other providers to follow. The success of this would be dependent on being open with families about sharing data and to establish their consent.

RESOLVED

THAT:

- (a) the early help strategy be endorsed to deliver the priorities of the health and wellbeing strategy;**
- (b) updates on delivery of the strategy be provided to the board; and**
- (c) a visit be arranged for board members to Leominster to review progress to date.**

80. UNDERSTANDING HEREFORDSHIRE: JOINT STRATEGIC NEEDS ASSESSMENT

The director for adults and wellbeing introduced the report and explained that it was a statutory requirement for a joint strategic needs assessment and locally, this was branded as Understanding Herefordshire as a comprehensive online resource.

The key points were that:

- Herefordshire had a population of 187,000 people which was not ethnically diverse
- the county had an older population compared with the national average although people were living longer in poor health, which had implications for the wellbeing of the population
- the county contained 12 lower super output areas (geographic areas for the purpose of gathering population data) which were in the top 25% nationally of most deprived areas. This had increased by four, to include Bromyard, since 2010.
- 4500 children lived in deprived households although the level of deprivation was hidden in the county
- mortality was linked to deprivation and there were many examples of the wider determinants of health impacting on life chances. The JSNA looked at wellbeing more broadly so, for example, child sexual exploitation and neglect were considered as being consequential to behaviours.

There was a busy and active public health team and the board was asked to consider how to use the resource to best effect in order to ensure that policies and commissioning were evidence based. Although the JSNA informed planning and commissioning, and the focus on the social and economic aspects of the county was welcomed, it was noted that it could be used more to map services and identify gaps in provision. For example, a specific issue was the poor state of dental health and the need to address this, noting the policy to not provide fluoride in the county's water supply.

On the matter of dental health, steps were being taken with Public Health England to address funding streams supported by additional data and to encourage schools to engage with dentists. It was noted that Herefordshire was not allocated funding for dental health and a solution was sought with NHS England and PH England.

The JSNA would support a refreshed health and wellbeing strategy and inform the annual report of the director of public health. Whilst it was noted that the data was essential, the themes should be prioritised for focused reporting rather than reporting on every aspect each year.

Assurance was given that NHS England was engaged with the process and that involvement would be reviewed to enable better outcomes.

It was noted that there was a wealth of data within Understanding Herefordshire which highlighted issues that needed attention. One Herefordshire would support planning cycles and commissioning to be more cohesive.

Understanding Herefordshire was to be presented to Cabinet next week.

Board members were advised that the annual report of the director of public health would give more information on public health's work around inequalities and outcomes. The report would be presented to the health and wellbeing board in September.

RESOLVED

That Understanding Herefordshire: JSNA 2016 be approved for publication.

The meeting ended at 4.33 pm

CHAIRMAN



Meeting:	Health and wellbeing board
Meeting date:	20 September 2016
Title of report:	Better care fund 2016-17 quarter one performance report
Report by:	Joint commissioning better care fund manager

Classification

Open

Key decision

This is not an executive decision.

Wards affected

Countywide

Purpose

To approve the better care fund quarter one return.

Recommendation(s)

THAT:

- (a) the better care fund (BCF) 2016-17 quarter one return, attached at appendix 1, as approved by the council's director for adults and wellbeing, be reviewed; and
- (b) in light of the information within the return, the board consider whether there are any actions it wishes to recommend to secure improvement in efficiency or outcome.

Alternative options

- 1 It is open to the board to recommend actions to be considered by the partners, which would secure improvement in efficiency or outcome.

Further information on the subject of this report is available from
Amy Pitt – joint commissioning better care fund manager on Tel (01432) 383758

Reasons for recommendations

- 2 To meet national scheme requirements and ensure continuous improvement.

Key considerations

- 3 On 29 July 2016, the health and wellbeing board delegated authority to the director for adults and wellbeing, following consultation with the accountable officer of the Herefordshire Clinical Commissioning Group (CCG), to sign off BCF submissions on such occasions when the board meetings do not coincide with submission dates. The national submission date for this quarter one return was 9 September 2016 and therefore has, following appropriate sign off, been submitted.
- 4 The BCF national policy framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2015-16, with only minor amendments to the definition of individual metrics. The quarter one report at appendix 1 provides an update and monitors Herefordshire's delivery of national metrics, plus other key areas within the BCF plan. In summary, the national BCF metrics for 2016-17 are:
 - a. non-elective admissions (general and acute);
 - b. admissions to residential and care homes;
 - c. effectiveness of reablement; and
 - d. delayed transfers of care.
- 5 The report identifies that partners are on track for an improved performance from last year in relation to non-elective admissions, however not to meet the full target. A number of schemes have been set up, via the BCF programme, to address the increased demand, including rapid assessment, fallers first response service, virtual wards, hospital at home and the rapid access to assessment and care (RAAC) programme.
- 6 Throughout quarter one, partners have been working in close collaboration to redesign the current RAAC scheme in order to achieve a more effective bed based intermediate care offer in Herefordshire. The aim of the scheme is to maximise the independence of patients and residents, reduce avoidable admissions to hospital, nursing homes, long term residential care or care packages and provide an alternative to hospital care, when recovery and reablement are required. Partners are currently liaising with providers and aiming on introducing the revised scheme from 1 October 2016.
- 7 Admissions to residential and care homes during quarter one have shown no improvement, however performance remains very consistent when compared with the same point last year.
- 8 The effectiveness of reablement and a local measure to reduce the number of fall related admissions are currently on track to meet their targets for 2016-17. Performance of the falls first responders scheme continues to help address the gaps in the falls pathways, caring for those fallers who have not received serious injury and continues to be positive in terms of the financial impact of the scheme. Current data in relation to the proportion of older people who were still at home 91 days after discharge from hospital into reablement indicates a small improvement compared

Further information on the subject of this report is available from
Amy Pitt – joint commissioning better care fund manager on Tel (01432) 383758

with 2015-16, and above our target of 80% for 2016-17.

- 9 A local area action plan for delayed transfer of care (DTOC) has been developed and forms a key part of Herefordshire's BCF plan 2016-17. The aim of this action plan is to reduce DTOC ensuring that people are discharged in a timely manner to the most appropriate setting to meet their assessed needs. The quarter one performance data indicates no improvement in performance in relation to DTOC. A number of schemes are being worked through to help address the pressures, including earlier identification of potential discharges, additional RAAC capacity and brokerages and additional support to self-funders and care homes.
- 10 The largest pool within the BCF plan for Herefordshire is for the joint contracting and commissioning of residential and nursing placements. The unified contract, in relation to these placements, has been developed during the last year, involving a detailed engagement process with the market on the contract principles and changes. The content of the unified contract was agreed during quarter one and is currently available to providers via an accreditation process. The advantages of providing this unified contract are consistency in contractual arrangements across partners, a joint quality assurance framework, a movement to gross payments, and a reduction in administrative support requirements. Improvements are expected to be delivered during 2016-17.
- 11 This report demonstrates that the NHS number continues to be used as a primary identifier for health and social care. Furthermore, work continues to progress to pursue open API's (application programming interface - i.e. systems that speak to each other) and ensuring appropriate information governance controls are in place. Further detail can be found within section 6.4 of Herefordshire's BCF plan 2016-17, located at appendix 2.
- 12 The legal framework for the BCF fund derives from the amended NHS Act 2006, which requires that in each area the BCF fund is transferred into one or more pooled budget, established under section 75. During quarter one a small working group has reviewed the existing section 75 arrangements in Herefordshire and a single agreement has been developed. Subject to approval through the partner's governance processes, the single agreement will take effect from 1 October 2016. This arrangement will allow monitoring and reporting to become combined and will ensure that duplication is minimised. It will also enable partners to further improve the quality and efficiency of services and continue to make more effective use of resources for the benefit of residents.
- 13 Following a national assurance process, the Herefordshire BCF plan 2016-17 has been approved. A copy of the final version is located at appendix 2.

Community impact

- 14 The BCF plan is set within the context of the national programme of transformation and integration of health and social care. The council and CCG are working together to deliver on the key priorities within the plan to achieve savings and improve the delivery of services.

Equality duty

- 15 The council and CCG are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance

Further information on the subject of this report is available from
Amy Pitt – joint commissioning better care fund manager on Tel (01432) 383758

equality of opportunity and foster good relations.

- 16 All equality considerations are considered as part of the development and implementation of the plan.

Financial implications

- 17 The Herefordshire BCF plan 2016-17 details a planned full year spend of £42m. This figure includes a pooled budget for residential, nursing, continuing health care (CHC) and funded nursing care (FNC) costs. A late announcement in the increase in FNC fees by 40% was not included within the original budget figures; therefore the quarter 1 return details a forecasted budget of £43.1m to reflect the changes, which is an additional cost to the CCG of £1.1m.
- 18 During quarter 1 a new risk share arrangement, on a restricted client cohort replacing the previous much broader risk share arrangement, has been agreed. A copy of this agreement is located at appendix 3. This arrangement with Herefordshire CCG caps the council's risk share on pool 2 (care home market costs) at 13% of the current cost of a cohort of 27 individuals. Consequently this limits the financial risk to each partner at £180k per annum, on a non recurrent basis.

Legal implications

- 19 There are no legal implications with the report.

Risk management

- 20 The board is required to note the content and therefore the risk is minimal. The data return has already been submitted nationally due to a deadline of 9 September 2016. The report provides an update on the BCF plan and is based on statistical and financial information.
- 21 A risk share arrangement, restricted to a cohort of individuals, has been agreed between the partners, as located at appendix 3.

Consultees

- 22 Public engagement is not required for this return.
- 23 Consultation with the CCG's accountable officer has taken place, as required, in order to complete the sign off process prior to submission.

Appendices

Appendix 1 - better care fund quarter one 2016-17 return

Appendix 2 – BCF plan 2016-17 final version

Appendix 3 – risk share agreement 2016-17

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 9th September 2016.

The BCF Q1 Data Collection

This Excel data collection template for Q1 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell

Pre-populated cells

Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.

1) Cover Sheet - this includes basic details and tracks question completion.

2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.

3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.

4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.

5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, coordinated, and person centred care.

7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board

Who has completed the report, email and contact number in case any queries arise

Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

Have the funds been pooled via a s.75 pooled budget?

If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (<http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Planned income into the pooled fund for each quarter of the 2016-17 financial year

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year

Actual income into the pooled fund in Q1 2016-17

Planned expenditure from the pooled fund for each quarter of the 2016-17 financial year

Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year

Actual expenditure from the pooled fund in Q1 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q1 2016-17

Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 /Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.

For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q1 16/17.

Better Care Fund Template Q1 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Have funds been pooled via a S.75 pooled budget? if no, date provided?
Yes

3. National Conditions

	7 day services			
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	Yes
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	Yes
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
NEA	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
DTOC	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
Local performance metric	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
If no metric, please specify	Yes	Yes
Patient experience metric	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential care	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress
Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes
	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes
	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes
Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes				
Total number of PHBs in place at the end of the quarter	Yes				
Number of new PHBs put in place during the quarter	Yes				
Number of existing PHBs stopped during the quarter	Yes				

Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes
7. Narrative	
Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there 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
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17	
Yes	
Yes	

Yes
Yes

Specialised palliative	
Yes	
Yes	

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q1 2016/17

Health and Well Being Board

Herefordshire, County of

completed by:

Amy Pitt

E-Mail:

apitt@herefordshire.gov.uk

Contact Number:

07792 811 896

Who has signed off the report on behalf of the Health and Well Being Board:

Director for Adults and Wellbeing

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Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	2
3. National Conditions	36
4. I&E	21
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Herefordshire, County of

Have the funds been pooled via a s.75 pooled budget?	Yes
--	-----

If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	
--	--

National Conditions

Selected Health and Well Being Board:

Herefordshire, County of

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.

Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.

Further details on the conditions are specified below.

If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - In Progress	31/03/2017	Please see Herefordshire's BCF plan 2016/17 for details regarding planned developments of 7-day services.
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	31/03/2017	Although not all in place, these are developing as per Herefordshire's BCF plan 2016/17
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	No - In Progress	31/03/2017	These are developing, as per Herefordshire's BCF plan 2016/17
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5) 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	No - In Progress	31/03/2017	Although not all in place, these are developing as per Herefordshire's BCF plan 2016/17
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent 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;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (<https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf>).

By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

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

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (<https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf>; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - <http://systems.hscic.gov.uk/infogov/iga>

5) 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

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

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

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

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

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

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

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

N All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

- Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
- Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
- Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
- Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
- Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
- Demonstrate engagement with the independent and voluntary sector providers.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board:

Herefordshire, County of

Income

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£11,680,600	£10,122,300	£10,122,300	£10,121,968	£42,047,168	£42,047,168
	Forecast	£12,404,300	£10,389,800	£10,388,800	£9,934,268	£43,117,168	
	Actual*	£12,404,300					

Please comment if one of the following applies:

- There is a difference between the planned / forecasted annual totals and the pooled fund
- The Q1 actual differs from the Q1 plan and / or Q1 forecast

Forecast reflects additional cost of FNC placements - included in additional pool.

Expenditure

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£10,511,800	£10,511,800	£10,511,800	£10,511,768	£42,047,168	£42,047,168
	Forecast	£10,605,700	£10,779,300	£10,779,300	£10,953,100	£43,117,400	
	Actual*	£10,605,700					

Please comment if one of the following applies:

- There is a difference between the planned / forecasted annual totals and the pooled fund
- The Q1 actual differs from the Q1 plan and / or Q1 forecast

Forecast reflects the additional cost of FNC placements which are included in the additional BCF pool. Actual figures latest estimate - TBC

Commentary on progress against financial plan:

The Herefordshire BCF plan involves an additional pooled budget for residential, nursing, CHC and FNC costs. The late announcement of the increase in FNC fees by 40% was not reflected in the budget but has been updated in the forecast. I&E assumes even profile with the exception of DFG grant which is received in Q1.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.

Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB and has been rounded to the nearest whole number.

National and locally defined metrics

Selected Health and Well Being Board:

Herefordshire, County of

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	A number of schemes have been set up, via the BCF programme, to address the increased demand. These include rapid assessments, fallers first response, virtual wards, hospital at home and the RAAC scheme.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	A number of schemes are being worked through to hel address the pressures, including earlier identification of potential discharges, additional RAAC capacity and brokerage and additional support to self-funders and care homes.

Local performance metric as described in your approved BCF plan	As in the approved Plan the local measure is Reduction in Fall Related Admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Performance continues to be positive in terms of the financial impact. The falls first responders scheme continues to help address the gaps in the falls pathways, caring for those fallers who have not received serious injury.

Local defined patient experience metric as described in your approved BCF plan	Customer satisfaction / user experience annual survey.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	This data is collected on an annual basis and will be reported in Q4

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	In the year to date there have been 57 new permanent admissions, 28 to residential and 29 in nursing placements. This remains very consistent when compared to the same point last year, however there is often a slight lag in the data which is more evident in the early months of the year.

Additional Measures

Selected Health and Well Being Board:

Herefordshire, County of

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	No

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Hospital	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	01/03/17	01/03/17	01/03/17	01/03/17	01/03/17	01/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped
---	--------------------

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	8
Rate per 100,000 population	4

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	0
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	189,247
-----------------------	---------

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5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	No - nowhere in the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
<http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1>
Q4 15/16 population figures onwards have been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board:

Herefordshire, County of

Remaining Characters

30,280

Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template.

Risk share

* During quarter 1 a new risk share arrangement, on a restricted client cohort replacing the previous much broader risk share arrangement, has been agreed. A copy of this agreement is located at appendix 3. This arrangement with Herefordshire CCG caps the Council's risk share on pool 2 (care home market costs) at 13% of the current cost of a cohort of 27 individuals.

RAAC review

* As approved by the joint commissioning board, throughout quarter one partners have been working in close collaboration to redesign the current RAAC scheme in order to achieve a more effective bed based intermediate care offer in Herefordshire. The aim of the scheme is to maximise the independence of patients and residents, reduce avoidable admissions to hospital, nursing homes, long term residential care or care packages and provide an alternative to hospital care, when recovery and reablement are required. Partners are currently liaising with providers and aiming on introducing the revised scheme from 1 October 2016.

S75

* The legal framework for the BCF fund derives from the amended NHS Act 2006, which requires that in each area the BCF fund is transferred into one or more pooled budgets, established under section 75. During quarter one a small working group has reviewed the existing section 75 arrangements in Herefordshire and a single agreement has been developed. Subject to approval through the partner's governance processes, the single agreement will take effect from 1 October 2016. This arrangement will allow monitoring and reporting to become combined and will ensure that duplication is minimised. It will also enable partners to further improve the quality and efficiency of services and continue to make more effective use of resources.

Unified Contract

* The largest pool within the BCF plan for Herefordshire is for the joint contracting and commissioning of residential and nursing placements. The unified contract, in relation to these placements, has been developed during the last year, involving a detailed engagement process with the market on the contract principles and changes. The content of the unified contract was agreed during quarter one and is currently available to providers via an accreditation process. The advantages of providing this unified contract are consistency in contractual arrangements across partners, a joint quality assurance framework, a movement to gross payments, and a reduction in administrative support requirements.



Herefordshire Better Care Fund Plan

2016-17

Submission Four

27 June 2016

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1. INTRODUCTION

The Better Care Fund (BCF) programme aims to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. A key principle of the BCF is to use a pooled budget approach in order for health and social care to work more closely together. The need for integrated care to improve people's experience of health and social care, the outcomes achieved and the efficient use of resources has never been greater.

Within Herefordshire a Redesign Management Group has been established to lead and implement a transformational change across all services and to develop a 'One Herefordshire' alliance. The One Herefordshire Plan has been developed through an alliance of all the Herefordshire health partners¹ and the council working in partnership to address the fundamental issues facing the county. It provides the fundamental context and approach that underpins this BCF plan.

Within the overall One Herefordshire approach, the BCF plays a key enabling role in delivering our system wide vision by creating a substantial pooled budget between the council and CCG for the delivery of community based services, residential and nursing provisions and the protection of adult social care that are strongly focused on shared aspirations. This will provide a robust platform for developing more integrated approaches to service delivery and integrated commissioning and governance.

The Herefordshire BCF plan 2016/17 demonstrates the progress made on the 2015/16 intentions, details key milestones for 2016/17 and describes the future vision for the county. This plan is a key component of, and wholly consistent with, the system wide transformation of Herefordshire's health and social care economy. In addition the BCF also supports the delivery of the Sustainability and Transformation Plan (STP) common objective: *Collaboration and joint working on a scale not achieved before to deliver transformational change that closes the triple aim gap and supports a financially sustainable health and social care economy.*

¹ The partners are: Herefordshire Council, Herefordshire CCG, Wye Valley NHS Trust, 2gether NHS Foundation Trust and Taurus Healthcare

2. LOCAL VISION FOR HEALTH AND SOCIAL CARE SERVICES

“The vision for the local health and care system in Herefordshire is one where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people”.

One Herefordshire, January 2016 (B.1.i)

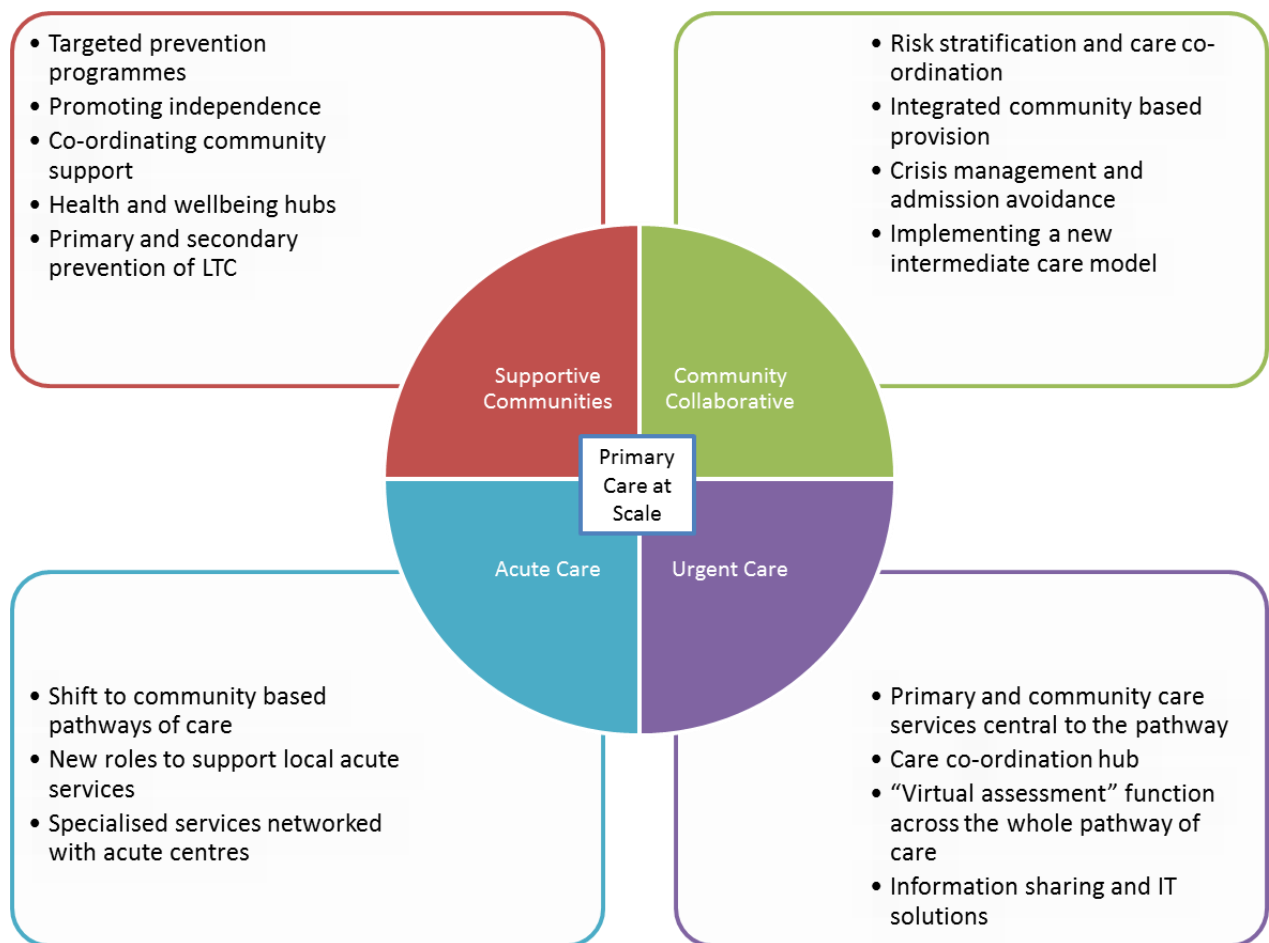
Our shared intent is to redesign services in order to deliver person-centred care, working together to support people to improve their wellbeing, maintain their independence and live longer in good health. By working in partnership across organisational boundaries we will increase support for self-care, maximise the provision of care in community settings, and reduce demand for specialist care in acute hospital settings or in residential and nursing homes.

This plan is based on securing a change in the relationship between the citizen and public services, such that individuals and their communities take on the prime responsibility for maintaining their own wellbeing and independence. The intention is to enable the public to avoid the crises that would otherwise push them into reliance on statutory care services. Under this new approach, the statutory sector will play a vital role as a catalyst for the development and maintenance of the necessary community capacity, supporting a lead taken by our vibrant local voluntary sector partners. Our services will be designed through a philosophy of supporting self-care, cohesive delivery in the community wherever practical, and reduced reliance on specialist care, whether provided in hospital or in residential and nursing homes.

Recent analysis of current spending shows that 48% of budgeted spending is on acute services, with a further 13% on residential, nursing and continuing care. Herefordshire’s new model of care will deliver a significant shift in this position, as:

- Investment in preventative services and self-care will have a medium to long-term benefit in avoiding the need for acute and institutional care services – albeit we are prudent on the scale of financial benefits that can be realised within the five-year timeframe of the STP
- Investment in primary care at scale and community services will have a short- and medium-term impact in redirecting work from acute settings and providing financial benefits.

The diagram below sets out the key deliverable workstreams of the One Herefordshire transformation programme and lists some of the key features of the projects that they are delivering. The BCF plan is a key enabler supporting many areas of that programme.



The arrangement not only includes the commissioners and main providers of care but also closer collaborative working with other key agencies that have an impact on the wider determinants of health and wellbeing within the county. This approach is fully consistent with the Government’s vision for full health and social care integration by 2020.

In line with both with the NHS England ‘Five Year Forward View’ and the existing One Herefordshire programme, we expect to test new models of care delivery, drawing on concepts such as community development and empowerment, integrated primary, community, mental health and acute provision, clinically networked services, and technology-driven delivery solutions. The BCF plan underpins this wider One Herefordshire plan in a number of ways and clearly links into the work-streams of the transformation programme as shown below **(B.1.ii)**:

Supportive Communities

- Development of information and advice services
- Expansion of DFG support
- Redesign of domiciliary care services

Community Collaborative

- Risk stratification
- Improved co-ordination of health & social care teams
- Hospital at home
- New model of intermediate care
- Redesign of reablement service
- Implementation of redesigned social care teams
- Implementation of Joint Carers Strategy
- Rapid Response
- Managing the care home market

Acute Care

- Redesigned and re-commissioned mental health service

Urgent Care

- Enhanced 7 day capacity
- Care co-ordination hub
- Integration with GP out of hours services
- Information and record sharing across providers
- Develop infrastructure to deliver 7 days services
- Better data sharing between health and social care, based on the NHS number
- Joint approach to assessments and care planning
- Locally developed action plan for DTOC

The vision for future service delivery in Herefordshire embraces national thinking on new models of care, and embodies a number of themes, including a commitment to:

- Empower communities to behave differently and reduce demand for services
- Support enhanced provision of primary, community care and mental health care at scale
- Utilise technological innovations to deliver improved care
- Deliver preventative and tailored care to support people keeping well, at home
- Develop proposals for primary care at scale that underpin the delivery of the above
- Support local delivery of acute hospital services
- Consolidate clinical networks across care settings to ensure optimum sharing of expertise to deliver high quality, safe and cost effective services

The Future Vision

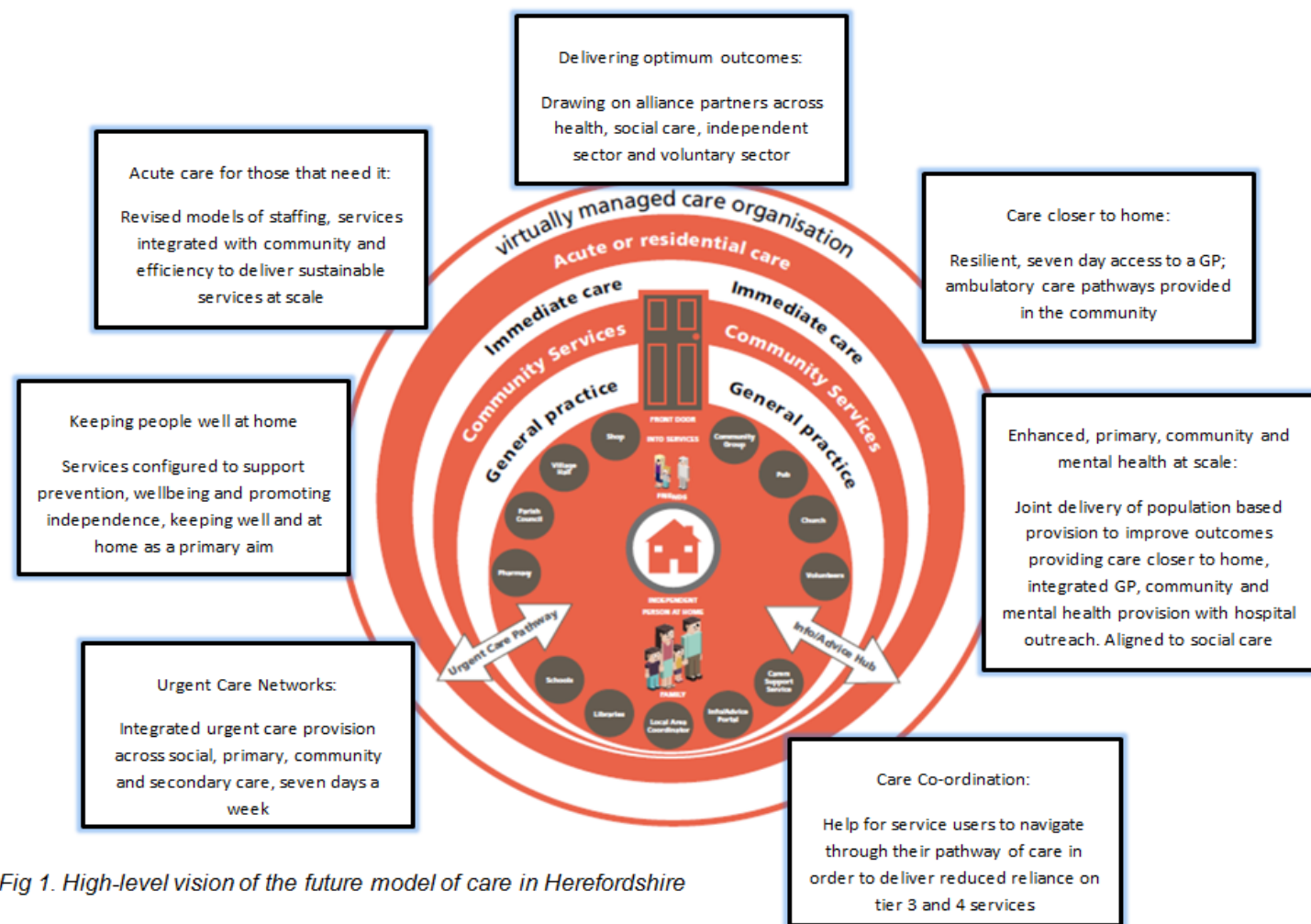


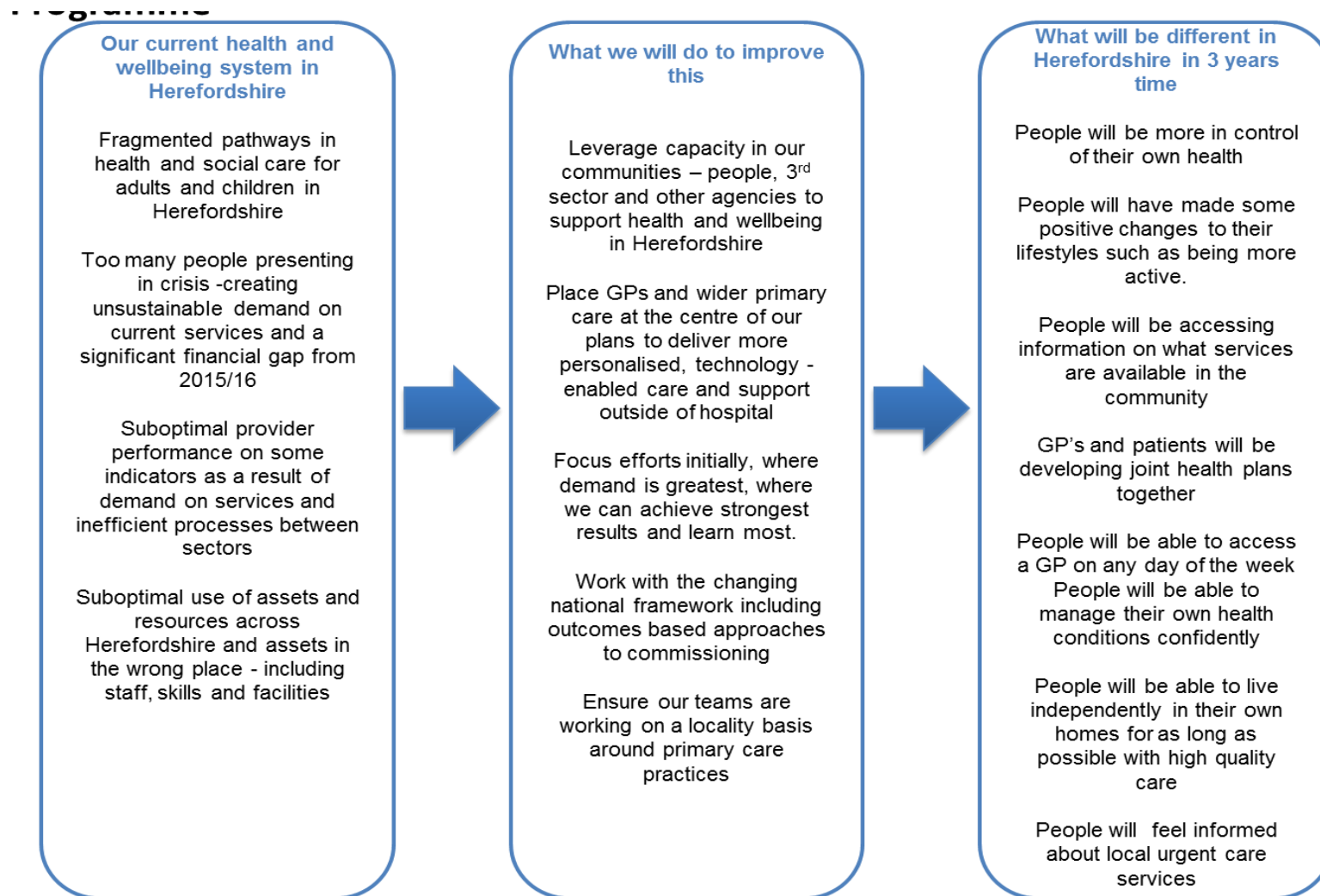
Fig 1. High-level vision of the future model of care in Herefordshire

At a strategic level the BCF intends to support the One Herefordshire alliance in achieving the following **aims (B.2.iii)**:

- to improve the health and wellbeing of everyone in Herefordshire by enabling people to take greater control over their own health and the health of their families and helping people to remain independent within their own homes and communities
- to reduce inequalities in health (both physical and mental) across and within communities in Herefordshire, resulting in additional years of life for citizens with treatable mental and physical health conditions
- to improve the quality and safety of health and care services, thereby improving their positive contribution to improved wellbeing and enhancing the experience of service users
- to achieve greater efficiency, making better use of resources
- to take out avoidable cost thereby reducing financial pressures and ensuring a better alignment between funding and cost
- to ensure that we have sufficient workforce is that is appropriately trained to provide the services our population require in the future.

3. EVIDENCE BASE FOR CHANGE

The vision for Herefordshire is illustrated below. This provides a **clear comparison between current state and planned state post-plan delivery and is described in terms of changes to patient and service user experience and outcomes (B.1.iii):**



Further details in relation to the changes and developments to be delivered through the BCF plan 2016/17 are contained within the Integrated Action Plan (section 4) and within section 3.2 – The Challenges in Herefordshire.

3.1 SUPPORTING THE CASE FOR CHANGE

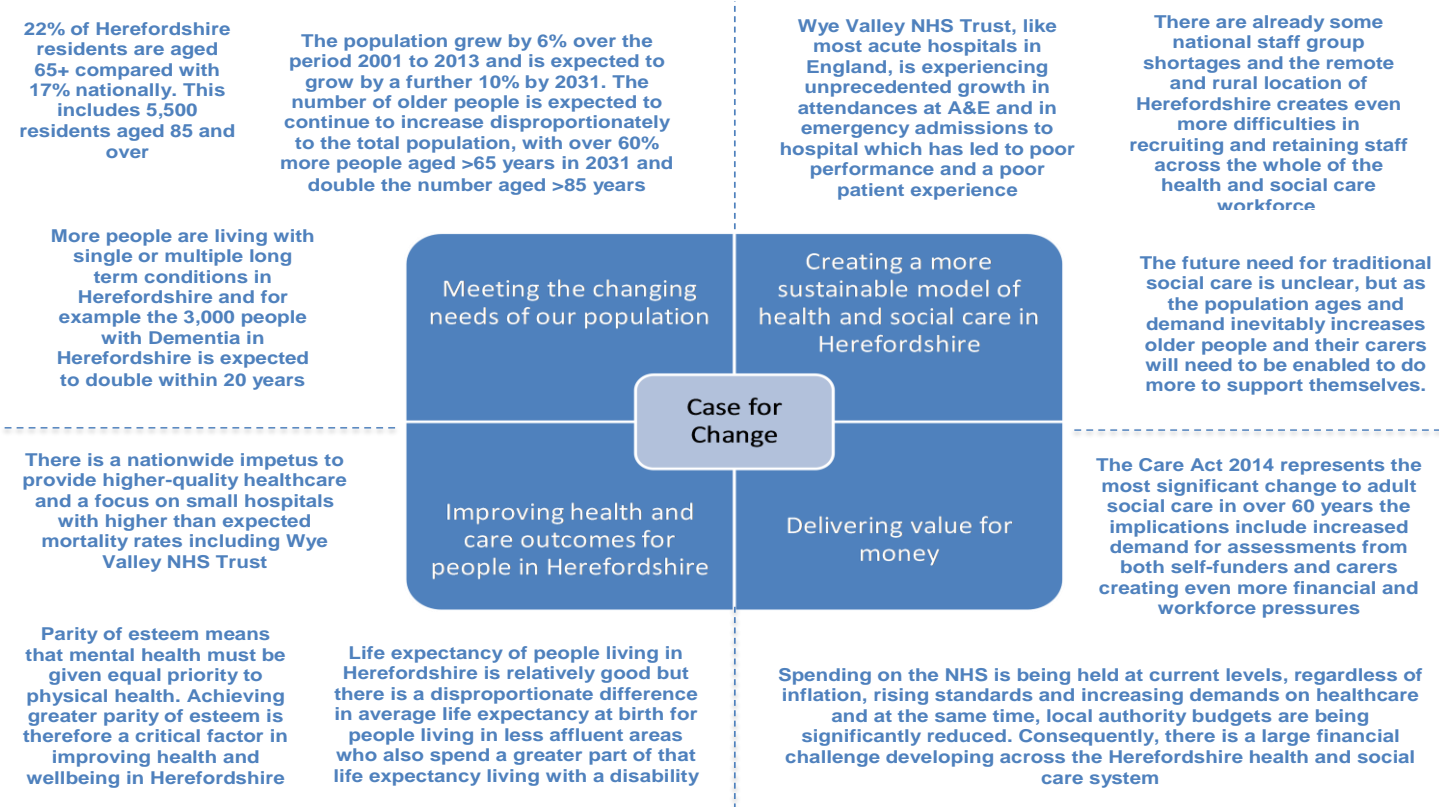
There are a number of local challenges in Herefordshire that we must address if we are to ensure sustainable services:

- **Our population is small and its rural nature means that it is widely dispersed** – the population in 2013 was 186,100 and has grown by six percent since 2001 through migration only. Almost all of Herefordshire's land area falls in the 25% most deprived in England in relation to geographical barriers to services. Transport is severely limited, with limited railway and road networks. There are few public transport routes that are commercially viable, which further restricts mobility. Access to health services in rural areas is limited with 21% of rural households having to travel 2.5 miles or more to visit their GP or other health services.
- **Herefordshire has a much older population than nationally and this will grow** - 23% of Herefordshire residents are aged 65+ compared with 17% nationally. This includes 5,500 residents aged 85 and over. The number of older people is expected to continue to increase disproportionately to the total population, with over 60% more people aged 65+ in 2031 and double the number aged 85 and over.
- **People living longer will experience more health and wellbeing issues** - more people are living with single or multiple long term conditions in Herefordshire, for example, the number of people with Dementia in the county is expected to double within 20 years, from 3,000 to 6,000. Linked to this, Wye Valley NHS Trust, like most acute hospitals in England, has experienced significant growth in attendances at A&E and in emergency admissions to hospital and this has had an impact on performance and patient experience.
- **All of our provider and commissioner organisations are facing challenges to their finances, service delivery and sustainability** - this was dramatically highlighted in the recent report produced by Ernst and Young (partly funded by NHS England). This showed that even with significant changes in behaviour, and unprecedented efficiency savings, our local economy would still be facing a gap of £30m-£38m by the end of the decade.
- **Our services lack the scale and efficiency to meet the needs of the future** - As one of the smallest Trusts in England; WVT faces significant diseconomies of scale when providing a range

of general hospital services for such a small population. The diseconomies of scale cannot solely be resolved by reducing the range of services through providing them at another hospital, as the distances are such that a range of services have to be available within the county, not least to serve the population of Powys. In contrast, some services that are provided at scale, such as mental health, are more resilient as a result.

- National issues with recruitment and retention are felt more acutely in Herefordshire** - there are already some national staff group shortages and the remote and rural location of Herefordshire creates even more difficulties in recruiting and retaining staff across the whole of the health and social care workforce.
- We have significant infrastructure challenges** - many of our buildings are outdated and our services have outgrown them. At the same time, changes in the model of delivery mean we have a number of sites that could be rationalised without impacting the quality of care. However improvements in the physical infrastructure would need to be made. There is a need to review the health and social care estate to assess the possibility of greater efficiencies. Our IT infrastructure is also limited but there are many opportunities; the secondary care services have extremely low digital maturity and are largely paper-based but our primary care services are extremely well integrated across one system.

The illustration below details Herefordshire’s case for change:



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

In developing this BCF plan, insights from the Herefordshire Joint Strategic Needs Assessment (JSNA) have been used to understand the current and future population trends as well as the real and predicted changes in use of unplanned care and those being supported through primary care and social care services. The following **data supports the case for change and illustrates a clear and quantified understanding of the precise issues that the BCF will be used to address in Herefordshire (B.2.i), (B.2.iv).**

Herefordshire's population grew by 6% over the period 2001 to 2013, largely as a result of inward migration and is expected to grow to approximately 205,300 by 2031. However the number of older people is expected to continue to increase disproportionately to the total population, with over 60% more people aged >65 years in 2031 and double the number aged >85 years. Although the life expectancy of people living in Herefordshire is relatively good, there is a disproportionate difference in health outcomes for people in less affluent areas who generally have a shorter average life expectancy at birth, (6.2 years for males and 5.9 years for females) and spend a greater part of that life expectancy with a disability compared with residents in less deprived areas.

Primary care

Whilst overall primary care is of a high quality there is some variation in performance and in Herefordshire in 2011-13, across the GP-registered population, there were 567 premature deaths amounting to 12,695 potential 'years of life lost' from conditions that are usually treatable.

Similarly, over the past 5 years, the number of unplanned hospital admissions in Herefordshire from chronic conditions that should normally be managed in a primary or community care setting (often referred to as 'ambulatory care sensitive conditions') has been increasing.

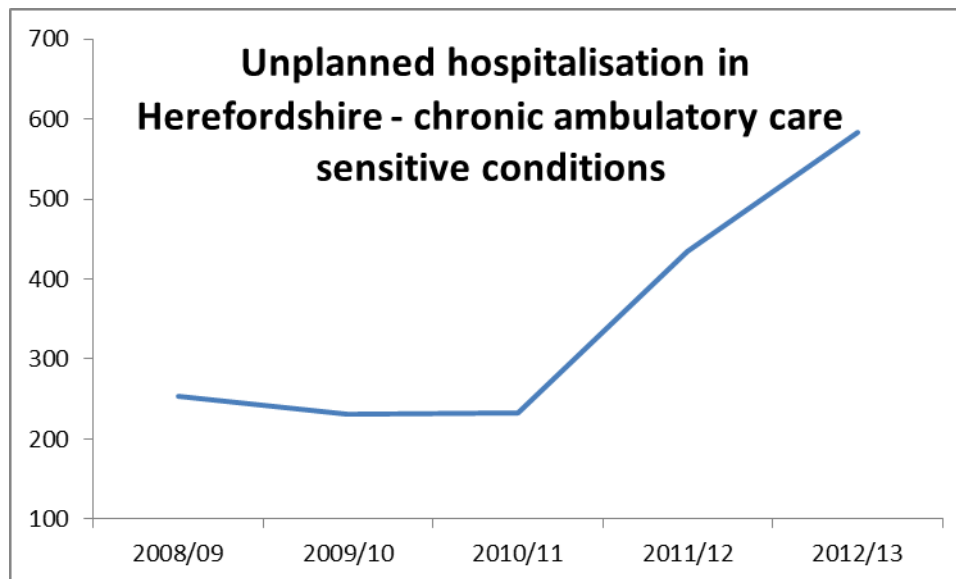


Figure: Unplanned hospitalisation for chronic ambulatory care –sensitive conditions (Indirectly age/sex standardised rate per 100,000 population) Source: The Health and Social Care Information Centre (<http://www.hscic.gov.uk>)

Community-based services

Community-based services involve a range of service types and providers, including social care, district nursing, health visiting and community mental health care. Providers have reported that services have struggled in recent years to cope with an increase in workload and referrals, and the trend is set to continue due to the increase in our elderly population.

This extra burden has adversely affected their ability to respond as swiftly and effectively as we would like, and to be more effective, they need to be better integrated with primary care and with hospital – based specialised care in Herefordshire. In the 2011/12 National GP Survey, 55% of respondents in Herefordshire said that they had a long standing health condition and although 70% of people said that they felt they had sufficient support from relevant services and organisations to manage their condition, more often than not this care and support is not well joined-up and may result in duplication of effort without improvement in the outcomes of care.

Adult Social Care

Adult social care and support in Herefordshire is provided by Herefordshire Council working with private care homes, home care agencies and other organisations to deliver services on its behalf. In 2013-14 the local authority funded adult social care for 4,200 people aged 18 and over. Seventy two per cent received this care mainly because of a physical disability, frailty or sensory impairment. Nearly three quarters of adult social care clients are aged 65 and over. Social care providers have

struggled in recent years because of severe downward pressure on fee rates due to cuts in social care budgets and because they are finding it increasingly difficult to compete with other employers in attracting workers into a career in social care.

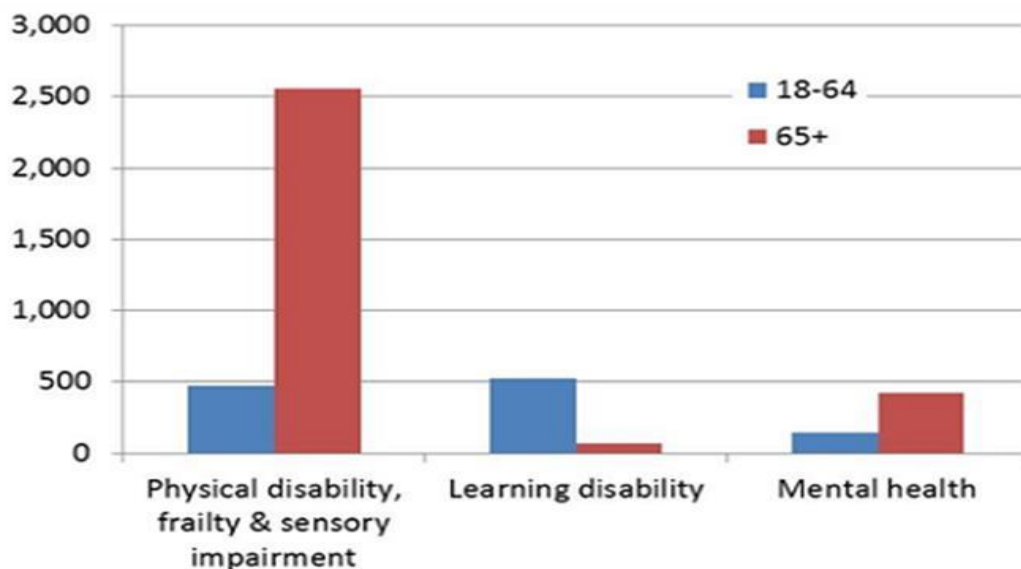


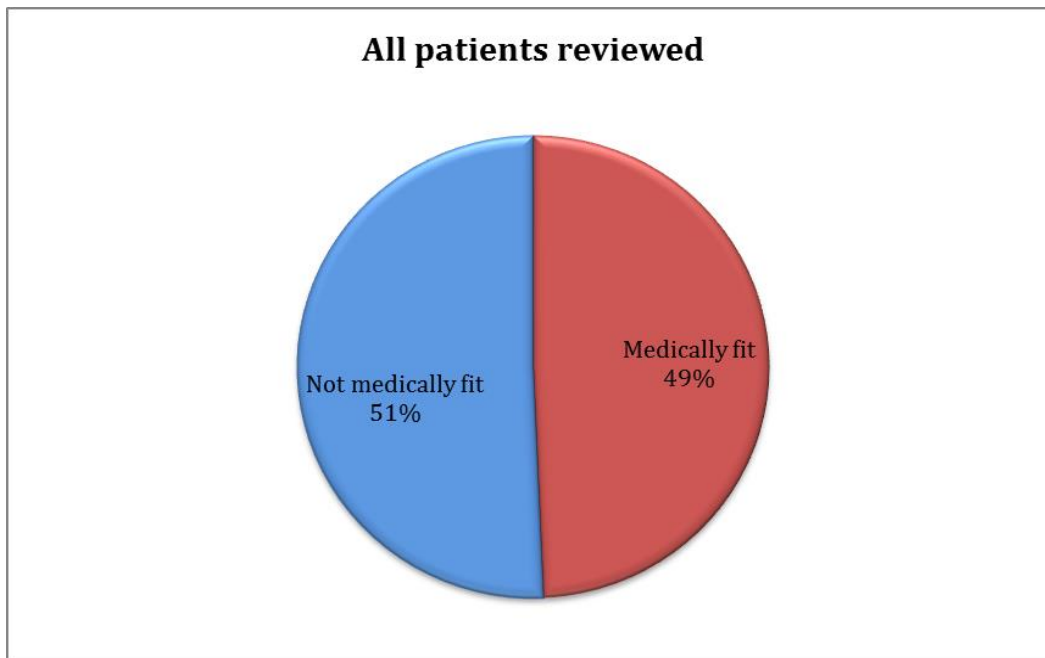
Figure: Adult social care clients (persons) in Herefordshire 2013/14

Source Understanding Herefordshire 2014, Herefordshire County Council

Herefordshire supports a smaller proportion of older people in social care than the national average, due in part to residents being on average healthier and more able to self-fund than elsewhere. The future need for social care is unclear, but as the population ages and demand inevitably increases (for example, an estimated 3,000 people with dementia could almost double in 20 years) older people and their carers will need to be enabled to do more to support themselves.

In addition to the data taken from the JSNA, a recent Length of Stay review, conducted during January 2016, has provided a clear evidence base for the development of Herefordshire's DTOC plan. This review was carried out using a tried and tested methodology developed by the Emergency Care Intensive Support Team ECIST which has been used in many acute and community hospitals across England. Four multi-disciplinary teams were formed and visited a number of community hospitals and wards, where a total of 144 patients were reviewed.

Of the 144 patients reviewed 49% (71) were found to be medically fit for discharge from their current bed but waiting for some form of onward care, intervention or equipment. The average LOS of those found to be medically fit is 23 days and on the day of the review the 71 patients had occupied 1669 bed days.



Data analysis of the review concludes the following:

- There are a high proportion of patients across the hospital wards reviewed who are medically fit for discharge but waiting for intervention.
- The majority of patients are waiting for some form of external assessment/input to allow them to move on.
- Patients are deteriorating whilst waiting for discharge and alternating between being fit and unfit.
- Length of stay for patients who are medically fit is high at 23 days.

3.2 THE CHALLENGES IN HEREFORDSHIRE

The table below summarises the key challenges facing Herefordshire (source One Herefordshire Plan) and identifies the activities of the BCF plan which will support their resolution. This clearly identifies **the precise aspects of the change that the local area is intending to deliver using the BCF (B.1.iv).** This table details the changes which will be delivered through the BCF plan, within consideration to impact and provides clear links to its contribution to the delivery of the One Herefordshire Plan **(B.1.iii) (B2.i)**

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
Lack of capacity across statutory services against a backdrop of increasing demand	Leverage capacity in the community, including the public, third sector and other agencies to promote independence	Development of community links model (April 16) to develop local solutions and support.
Abundance of voluntary assets, poorly co-ordinated and poorly understood	Co-ordinated voluntary support, linked to health and wellbeing hubs and care co-ordination service	Development of information and advice services, community and web based (Feb 16), Further enhancements / developments of web system in 2016/17
Disparate community services, little co-ordination	Community and mental health locality teams, integrated with primary care and social care Development and implementation of joint service specification for community health, mental health and social care services	Social care teams redesigned, locality and complex teams to promote closer working with community health and mental health Single model agreed through One Herefordshire programme.

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
Fragmented urgent care pathways in health and social care	<p>Development and implementation of joint service models and specifications.</p> <p>Care co-ordination centre acts as a hub, allowing healthcare professionals to navigate care pathways</p> <p>Review of RAAC (Rapid Access to Assessment and Care) provision to align with community services redesign.</p> <p>Increased focus on Delayed Transfers of Care from community settings to support improved pathways for individuals to the most effective setting to meet their needs.</p>	<p>Joint Service Specification for community health, mental health and social care services agreed as part of One Herefordshire Community Collaborative project. Implemented in health contracts from 1st April 2016.</p>
Too many people presenting in crisis creating unsustainable demand	<p>Focus on prevention, case finding and proactive case management of high risk clients – optimal management of long term conditions, frailty and the implementation of an agreed urgent care strategy</p>	<p>Expansion of DFG</p> <p>Redesign housing support</p> <p>Intermediate care redesign to support step up provision</p> <p>Role out of Risk Stratification and “Virtual Ward” model across the county.</p>
Bed occupancy of acute and some community hospital beds routinely 98%	<p>Reduce to best practice occupancy levels of 92% through reducing demand and increasing capacity</p> <p>ECIP review commissioned in early 2016 and demonstrates that around 50% of</p>	<p>Redesign domiciliary care model (2016-2017), rapid response service. Step up / step down beds</p> <p>Intermediate care redesign</p> <p>Providing an option for self-funders</p>

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
	current occupancy of acute and community beds assessed as “medically fit”. Alternative models of provision, assessment and transfer required to support improved flow.	Joint Service Specification for community health, mental health and social care services
Lack of information sharing between providers means that service users receive inefficient sub-optimal care	Protocols for sharing information agreed and IT systems linked	Social care system upgrade, potential for web based data sharing? IM&T Programme Board in place and working collectively on Digital Roadmap, linking in with STP, to support long term improvement across all systems.
Services commissioned in silos and not aligned	Community commissioning would be aligned between HCCG and HC, and through the STP, wider opportunities are being explored for commissioning to be aligned at a strategic level, where this is appropriate and able to deliver demonstrable benefits, with Worcestershire and other neighbouring areas.	BCF key enabler to support the development of integrated commissioning. Joint Service Specification for community health, mental health and social care services.

Workforce Challenges

In Herefordshire we have specific challenges around recruitment and retention of staff and the system change we are planning to implement will need to take account of these. Any system change requires the full engagement and support from the workforce and effective service delivery across a system will only be possible when the clinicians and practitioners are fully engaged in the process.

Herefordshire's model proposes system change that moves from the acute to the community, to a team working approach across disciplines based around the GP practice to one that promotes self-help and enables people to manage their own conditions through peer support groups.

To achieve this will require significant cultural, relational and behavioural change; not just changes in organisational structures or processes but in the ways in which staff work alongside patients and residents. We have already started to identify some merging good practice and a genuine willingness to change. We propose to progress this by identifying our current workforce capacity, **assessing future capacity and workforce requirements across the system** and creating some early implementer change projects **(C.1.iv)**.

Risk Stratification

Identifying those most at risk within our communities and supporting them to self-care and reduce their reliance on care services is key. As detailed within the BCF plan 2015/16, within Herefordshire 5.5% of adult population is deemed to be at risk of sudden deterioration and hospital admission. This figure was derived from work by the former PCT in collaboration with the BUPA risk stratification tool.

Herefordshire CCG is currently working through IG compliance issues and is implementing the Aristotle risk stratification tool across the county. Currently each GP practice determines a patient's risk of hospital admission via clinical search of the primary care patient data base. Currently each GP practice in Herefordshire has identified 2% of their patients who are most vulnerable to sudden deterioration and hospital admission and are ensuring personalised care plans are developed with a named accountable GP for each patient. Within the adult patient population of Hereford City the risk stratification (virtual ward) pilot supported the most vulnerable 3% of the practice population with development of a jointly produced personalised care plan. The intention with implementation of the HiHub risk stratification tool is to increase identification over the coming months. The roll out of risk stratification across Herefordshire, supported by the extension of the Virtual Ward and Hospital at Home programme is well advanced and the project aims to achieve significant reductions in emergency admissions and improvements in the safety and quality of care for some of the most vulnerable individuals being managed in community settings. **(B.2.ii)**

The risk stratification tool is in place within Herefordshire and is used to inform monthly multi-disciplinary meetings, where a range of organisations are present including GPs, mental health, adult social care, occupational therapy, physio therapy, ambulance service and integrated care practitioners. However, due to the often limited implementation of the tool and its sparse data set, it is often supplemented by patient information provided by professionals at a locality level. In order to encourage GP participation in risk stratification case management, Herefordshire CCG are currently implementing a local incentive scheme with each GP practice in the county. Practices are to be incentivised for identifying, through the use of an approved computerised risk stratification tool nominated by the CCG, patients who will benefit from proactive case management. Once the consistency and quality of the information collated by the risk stratification tool is improved Herefordshire will then be in a stronger position to use this data more effectively to improve quality and reduce costs based upon a segmented risk stratification approach (B.2.ii). The following high level timescales apply to the implementation of risk stratification in Herefordshire:

Action	Deadline
GP Local Incentive Scheme agreed with Practices	April 2016
Display of patient facing advice and posters including individual patient opt out opportunities	April-July 2016
Data sharing agreements with Practices	April – May 2016
Full testing of the GP extract in first GP Practice	May 2016
Risk Strat tool with Secondary Care data accessible in all GP Practices	June 2016
Monthly GP MDT meetings inc use of risk stratification to case find patients – incremental approach	May –October 2016
Additional 5 GP Practices agreement to GP data extraction	June-July 2016
Remaining GP Practices agreement to GP data extraction	July – September 2016
Monitoring report of risk stratification usage to inform case finding	end Q3 2016

4. INTEGRATED ACTION PLAN

The following section details the strategic objectives of the principal schemes in the BCF plan, provides an update on the changes delivered during 2015/16, and gives a high level perspective on the additional developments planned for 2016/17 and longer term aims for delivery by 2020. (B.1.iii)

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE

Strategic objective of the scheme	To maintain the existing levels of NHS (section 256) investment in social care in order to enable the local authority to support services which meet the wider strategic objectives of the BCF.
Planned Change 2015/16	<p>Investment in a community based model of care across a range of services which addresses one or more of the following key criteria:</p> <ul style="list-style-type: none"> • Prevention • Managing demand • Early intervention / Rapid Response • Intermediate care • Managing long term conditions
Change Delivered 2015/16	<p>The Protection of social care funding was invested in the following areas:</p> <ul style="list-style-type: none"> • Urgent care and rapid response • Community equipment • Reablement • Intermediate care • Carers, including reprocured carer's services • Mental/LD health • Demand management <p>Key outcomes achieved:</p> <ul style="list-style-type: none"> ✓ The reprocurement of carer's services ✓ The implementation of an information advice and guidance service (to divert demand). ✓ Improvements in community equipment service delivering savings for both council and CCG ✓ Implementation of rapid access to discharge bed provider framework ✓ Realignment of the care management teams with additional focus on hospital discharge and the advice and referral team
Planned Developments 2016/17	<p>This funding will enable the ongoing delivery of services.</p> <p>The investment will support the delivery of the strategic aims and objectives outlined within this plan.</p> <p>Specific developments within these service areas for 2016/17 include:</p> <ul style="list-style-type: none"> • Implementation of redesigned social care teams into locality / complex care teams • Review and redesign of reablement services to align with the wider development of community health, mental health and social care services. • Redesign of the RAAC provision to enable a community based support service offering both "step up" and "step down" provision

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE

	<ul style="list-style-type: none"> • Implementation of the Joint Carers Strategy • Reduced delays in transfer of care from community settings to the most appropriate setting to support individual needs
Further Developments to 2020	<ul style="list-style-type: none"> • Further development of aligned working arrangements • Implementation of an outcomes focused home care provision • Further development of preventative services

SCHEME: CARE ACT IMPLEMENTATION

Strategic objective of the scheme	To ensure that all duties under The Care Act 2014 are met.
Planned Change 2015/16	<p>For the BCF to be utilised to meet the requirements of the new duties, including:</p> <ul style="list-style-type: none"> • Setting national eligibility criteria • Implementing statutory safeguarding adults boards • New duties for self-funders • Duties for self-funders • Provision of advocacy • Provision of information and advice
Change Delivered 2015/16	<ul style="list-style-type: none"> • New information and advice website launched • City centre IAS service open • Pop up hubs will be implemented across the county
Planned Developments 2016/17	<ul style="list-style-type: none"> • Enhance content of IAS • Re-procure advocacy service • Initial local area development of community links model
Further Developments to 2020	<ul style="list-style-type: none"> • Rollout community links model countywide • Develop / expand preventative / self help services • Preparation for delivery of phase 2 of Care Act – details TBC

SCHEME: COMMUNITY HEALTH AND SOCIAL CARE SERVICES REDESIGN

Strategic objective of the scheme	To deliver the right Community Health and Social Care services in the most appropriate way by reviewing the current menu and method or models of provision and implementing the changes required to achieve the transformation aims and objectives.
Planned Change	<ul style="list-style-type: none"> • Improved patient care, safety and experience • Improved Urgent Care

SCHEME: CARE ACT IMPLEMENTATION	
2015/16	<ul style="list-style-type: none"> • System benefit • Improved systems efficiency, cost effectiveness • Improved outcomes <p>A short description of the existing initiatives and service areas within this scheme is set out in the appendices.</p>
Change Delivered 2015/16	<ul style="list-style-type: none"> • Roll out of Virtual Ward and Hospital at Home provision across the county • Implementation of a highly effective falls rapid response service • Review of the short break provision for children and families • Re-procured the carers information and advice centre • Rapid response service was enhanced to provide additional support for community and hospital discharge
Planned Developments 2016/17	<ul style="list-style-type: none"> • Full implementation of the joint service model for community health, mental health and social care services • County wide roll out of the Virtual Ward and risk stratification model, identifying and supporting more individuals in community settings. • Reduction in delayed transfer of care from community settings through an increased focus and development of risk sharing arrangements across health and social care to support and incentivise improvement • Continuation of the short break provision for children and families • Rapid response service will continue at an enhanced level • Intermediate care strategy to be implemented with a focus on step up/step down provisions • Commencement of engagement on redesign of the community hospital and intermediate bedded provision
Further Developments to 2020	<ul style="list-style-type: none"> • Review of all carer services • Full implementation of intermediate care provision • Step change from community hospital and intermediate care bedded provision and focus on community provision • Improved pathways and alignment across acute, community, mental health and social care provision reducing complexity and improving

SCHEME: CARE ACT IMPLEMENTATION

	efficiency and effectiveness of care
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SCHEME: DISABLED FACILITIES GRANT

Strategic objective of the scheme	The purpose of the disabled facilities grant is the delivery of essential structural changes to enable people to remain in their own homes and avoid the need for admission to residential care
Planned Change 2015/16	<ul style="list-style-type: none"> Using the CSR assumptions approximately 10% of adaptations result in avoiding the need for admission to a care home. The average cost of an adaptation in Herefordshire is £4.8k. The grant for 2015/16 is £0.866m which enables circa 180 adaptations per annum, resulting in a possible 18 avoided care home admissions
Change Delivered 2015/16	✓ Currently forecasting to spend full grant allocation in line with plans
Planned Developments 2016/17	<p>Grant increases to £1.558m enabling an additional 144 adaptations to be undertaken, circa 325 in total, subject to OT capacity.</p> <p>This gives the potential to avoid circa 32 admissions based on CSR assumptions.</p> <ul style="list-style-type: none"> Establish a working group to review the DFG scheme Continue to work with Housing colleagues to ensure a joined up approach to improving outcomes across health, social care and housing.
Further Developments to 2020	Extrapolating DFG funding forward to 2020 would result in circa 400 adaptations per annum, 40 care home admissions avoided.

SCHEME: SOCIAL CARE CAPITAL

Strategic objective of the scheme	To enhance community capacity, support system changes required to meet the information technology changes required arising from the Care Act and BCF national condition relating to the NHS identifier
Planned Change 2015/16	<ul style="list-style-type: none"> Complete systems updates for use of NHS identifier Complete system upgrades for Care Act compliance Upgrade social care system for enhanced capabilities / better integrated working
Change Delivered	✓ NHS identifier embedded in social care systems – used for additional pool reporting

2015/16	<ul style="list-style-type: none"> ✓ Upgrades complete ✓ Mosaic upgrade phase 1 go live April 16
Planned Developments 2016/17	No funding for social care capital after 1 April 2016. Scheme ceases to exist
Further Developments to 2020	Not Applicable

SCHEME: CARE HOME MARKET MANAGEMENT	
Strategic objective of the scheme	To deliver more effective market management across Herefordshire to enable the more cost effective purchasing of Residential and Nursing placements through both the council and Continuing Health Care (CHC).
Planned Change 2015/16	<p>Savings released through this scheme to be utilised to provide additional funding for the protection of social care above the minimum funding level.</p> <p>Scheme expected to deliver:</p> <ul style="list-style-type: none"> • Better care outcomes for people • Better functioning system • Better value for money • Financial savings
Change Delivered 2015/16	<ul style="list-style-type: none"> ✓ Unified contract currently in negotiation and under development. Liaising closely with providers with regards to contractual proposals and implementation milestones. ✓ Care home market strategy developed encompassing both council and CCG information
Planned Developments 2016/17	<ul style="list-style-type: none"> • Agree and implement unified contract in relation to residential, nursing and CHC placements.
Further Developments to 2020	<p>Alignment of internal processes including payment processes.</p> <p>Development of market capacity aligned to health and social care needs.</p> <p>Outcomes based commissioning to be developed and to consider incentivized support for addressing DTOC issues in the county.</p>

5. NATIONAL AND LOCAL METRICS 2016/17

The following section provides an overview of 2015/16 performance and an update in relation to the following national and local metrics:

- Non-elective admissions
- Permanent Admissions to Residential and Nursing Homes (Age 65+)
- Older people at home 91 days after Reablement
- Delayed Transfers of Care
- Reduction in Fall Related Admissions
- Patient experience

Metric: Non-elective admissions (E.1.i, E.1.ii, E.1.iii)								
2015/16 target	14,786							
2015/16 performance and update	Description: Total non-elective admissions to hospital (general & acute), all ages, per 100,000 A number of schemes have been set up during 2015/16, including via the SRG programme, to address the increased demand. These include rapid assessments, fallers first response, virtual wards and hospital at home.							
	Plan					Actual		
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16
	4,311	4,182	4,178	4,462	4,527	4,108	4,072	4,204
						Q3 15/16	4,473	
2016/17 target	Partners have developed a range of schemes that will impact on NEA in 2016/17. This work has built on success of schemes in 2015/16 and subsequent evaluation. This modelling has also been undertaken to assess the impact of the CCGs QIPP schemes and is linked to the Contract Negotiations. For example this includes: <ul style="list-style-type: none"> • The plan is based on the QIPP planning submission which includes all expected NEA reductions therefore no 							

additional quarterly reductions are expected within the BCF plan; please note this is a change from the first submission.

- This assumption will be tested before the next submission.
- Impact of Virtual wards schemes during 15/16, subsequent analysis and modelled as lead to projected impact of county-wide roll-out for 16/17
- Continued impact of Falls scheme during 16/17 on NEA, building on successful roll-out in 15/16,
- Continued use of RAAC beds, as an alternative to hospital admissions
- Development of Care co-ordination Hub, and proactive signposting and management in community settings
- Projected impact of Hospice at home and anticipatory care planning developments in 16/17 based on pilots and experiences elsewhere
- CHC – management of market to ensure improved care planning and avoidable admissions; and development of personal budgets, to improve self-care and self-management, and to enable choice to minimise avoidable admissions
- Enhanced Re-ablement schemes to reduce readmissions

Metric: Permanent Admissions to Residential and Nursing Homes (Age 65+) (E.2.i, E.2.ii, E.2.iii)

2015/16 target	680.4
2015/16 performance and update	<p>Description: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population.</p> <p>Permanent admissions to residential and nursing care experienced a 16% surge in admissions during 2014/15 which provided a higher baseline figure for 2015/16. During the past year there has been a steady state of admissions and this is expected to continue in 2016/17. The implementation of a culture change through the care management team is in development to review the cases being referred into residential and nursing homes with a view to source alternative provisions of care.</p>

	Permanent Admissions to Residential and Nursing Care																																	
	65+ Rate (YTD)		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar																				
		2013/14	53.9	120.0	171.5	232.7	296.4	338.1	436.1	477.7	512.0	558.5	595.3	607.5																				
		2014/15	71.6	149.9	219.3	290.9	313.3	349.1	398.4	434.2	478.9	530.4	584.1	655.3																				
		2015/16	50.9	101.9	132.0	180.6	196.8	238.5	266.3	296.4	324.1	345.0																						
2016/17 target	<table><tr><td></td><td>Actual 14/15</td><td>Planned 15/16</td><td>Forecast 15/16</td><td>Planned 16/17</td></tr><tr><td>Annual rate</td><td>653.2</td><td>680.4</td><td>484.4</td><td>487.0</td></tr><tr><td>Numerator</td><td>283</td><td>302</td><td>215</td><td>221</td></tr><tr><td>Denominator</td><td>43,326</td><td>44,387</td><td>44,387</td><td>45,382</td></tr></table>															Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17	Annual rate	653.2	680.4	484.4	487.0	Numerator	283	302	215	221	Denominator	43,326	44,387	44,387	45,382
	Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17																														
Annual rate	653.2	680.4	484.4	487.0																														
Numerator	283	302	215	221																														
Denominator	43,326	44,387	44,387	45,382																														

Metric: Older people at home 91 days after Reablement (<i>E.3.i, E.3.ii, E.3.iii</i>)	
2015/16 target	85.0
2015/16 performance and update	<p>Description: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</p> <p>The community reablement provision has experienced a consistent performance for the last two reporting quarters. The target of 85% has been revisited with a view to reduce this to 80% which is consistent across the country. The reablement provision in Herefordshire is a small, targeted provision therefore a slight change in the reporting would show a large outturn in the performance of the service.</p>

	Location of clients at 91 days following completion of Reablement Intervention												
	Percentage at home 91 days (YTD)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		50.0%	86.0%	86.5%	82.5%	78.5%	78.6%	78.9%	79.1%	79.0%	77.9%		
2016/17 target			Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17							
		Annual %	73.3%	85.0%	79.0%	80.0%							
		Numerator	55	544	79	80							
		Denominator	75	640	100	100							

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Metric: Delayed Transfers of Care (E.4.i, E.4.ii, E.4.iii)	
2015/16 target	516.3
2015/16 performance and update	<p>Description: Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)</p> <p>A number of schemes have been delivered during 2015/16 which are being worked through to help address the pressures of delayed transfers of care, including earlier identification of potential discharges, additional RAAC capacity and brokerage and additional support to self-funders and care homes. To date, the number of delayed cases continues to rise with forecast to continue. Quarterly figures are therefore likely to be further above the target. Data is taken as a snapshot at month end and therefore can appear volatile.</p>

	Delayed Transfers of Care (delayed days) from hospital per 100,000 population								
	2014/15	2014/15	2014/15	2014/15	2015/16	2015/16	2015/16	2015/16	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
	Target Rate	539	527	477	527	448	461	474	516
	Actual Rate	539	712	559	602	614	611	750	693
2016/17 target									

Metric: Reduction in Fall Related Admissions	
2015/16 target	
2015/16 performance and update	<p>The Falls Responder Service provides a 24/7 mobile response to adults who have fallen in their home environment and are uninjured. The team are trained to safely move an individual who articulates that they are uninjured, provide a welfare check, provide signposting to sources of support, notify the GP and refer (with consent) to the Falls Prevention Team for follow up clinical assessment and intervention. A follow up telephone call is made to each individual 24 hrs after the responder visit to clarify impact post fall.</p> <p>Since the introduction of the Falls responder service monthly analysis of WMAS conveyances to Hereford County</p>

	Hospital which are coded as 'Fall' (as a percentage of all WMAS conveyances) are measured as a 12 month rolling average, this indicates a reducing trend for falls conveyances. The falls responder data also indicates that the number of WVT admissions per month with a falls diagnosis measured as a 12 month rolling average indicates an overall decline in the number of admissions. Monthly data analysis indicates that the responder service is delivering the projected system benefits alongside positive patient feedback.												
2016/17 target	<table><tr><td></td><td>Planned 15/16</td><td>Planned 16/17</td></tr><tr><td>Metric Value</td><td>16.0</td><td>0.0</td></tr><tr><td>Numerator</td><td>732.0</td><td>0.0</td></tr><tr><td>Denominator</td><td>4561.0</td><td>0.0</td></tr></table> <p>The metric for 15/16 was to reduce admissions which is forecast to achieve. The identified metric for 16/17 for the falls responders service will be expected to reduce the ambulance conveyance and A&E attendances.</p>		Planned 15/16	Planned 16/17	Metric Value	16.0	0.0	Numerator	732.0	0.0	Denominator	4561.0	0.0
	Planned 15/16	Planned 16/17											
Metric Value	16.0	0.0											
Numerator	732.0	0.0											
Denominator	4561.0	0.0											

Metric: Patient experience	
2015/16 target	User experience (ASCOF) 83.0
2015/16 performance and update	<p>The performance of this metric is based upon survey outputs, taken from an annual data collection. Surveys were distributed during January 2016 to approximately 880 service users. To date (17 March 2016) around half of these have been returned. Strata response rates will be calculated at the end of the survey period in order to establish confidence level.</p> <p>Returns are currently being manually uploaded in order to collate results.</p>
2016/17 target	<p>The target has been set on the basis of continuous improvement, and in line with our previous year's performance of 67% and trends of comparators.</p> <p>Improvements in this measure will not be specific to BCF initiatives as the survey is based on a random sample of</p>

service users. Evidencing the cause-effect of any one initiative in an overall population satisfaction measure will be difficult. However any improvements made in the result will indicate general improvements made within the system.

Please be aware that we are proposing a change to the measure for this year and as such comparison with last year's performance is not possible.

	Planned 15/16	Planned 16/17
Metric Value	83.0	70.0
Numerator	265.0	182.0
Denominator	320.0	260.0

Used ASCOF 4b measure in 15/16 which references feeling safe. Changed to ASCOF 3a for 16/17 customer satisfaction as this is a more meaningful measure.

6. MEETING THE NATIONAL CONDITIONS 2016/17

The following section details how the Herefordshire BCF plan meets the following national conditions:

- Jointly Agreed BCF Plan
- Maintain provision of social care services in 2016/17
- Supporting progress on meeting the 2020 standards for seven day services
- Better data sharing between health and social care, based on the NHS number
- 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
- Agreement on the consequential impact on the providers that are predicted to be substantially affected by the plans
- Agreement that a proportion of the allocation is invested in NHS commissioned out-of-hospital services
- Agreement on a local action plan to reduce delayed transfers of care

6.1 JOINTLY AGREED BCF PLAN

Herefordshire's BCF Plan for 2016/17 was signed off by The Health and Wellbeing Board (HWB) on 21st April 2016. This final submission (27th June 2016) has been approved on behalf of the council by the Director for Adults and Wellbeing, the Director of Operations for the CCG and the chair of the HWB prior to submission. **(C.1.i)**

In agreeing the plan, the CCG and council commissioners have engaged with health and social care providers in both the acute and private sectors. This has been done to ensure that they understand the implications of the proposals contained within this BCF plan insofar as they relate specifically to services they provide to the BCF partners and **to achieve the best outcomes for local people (C.1.ii)**. **There is joint agreement across commissioners and providers as to how the BCF in Herefordshire will contribute to a longer strategic plan.** The CCG and council, as commissioners, and Wye Valley NHS Trust and 2gether NHS Foundation Trust, as providers, are all fully engaged in the alliance to deliver the One Herefordshire Plan and all are sighted on the role of the BCF within the wider transformation programme.

The Disabled Facilities Grant (DFG) has again been allocated through the BCF fund and therefore **local housing authority representatives have been involved in developing and agreeing the plan (C.1.vi)**. Herefordshire is a unitary authority which does not devolve DFG to a second tier

authority. The management of the DFG sits within the local authority housing team in the adults and wellbeing directorate of the council, and is overseen by the head of prevention. ***This assists in ensuring that a joint up approach to improving outcomes across health, social care and housing are achieved.*** Many DFG referrals are received via social care staff and assessment of eligibility for DFG is consistent with delivering wider health and social care benefits, and keeping people safe in their own homes.

6.2 MAINTAIN PROVISION OF SOCIAL CARE SERVICES IN 2016/17

Adult social care services in Herefordshire will continue to be supported within the BCF plan 2016/17 in a manner consistent with 2015/16 (C.2.v). Broadly, funding is assigned to the same service areas although some areas have seen increases (due to in year pressures such as DOLS) or decreases following successful recommissioning of external services (e.g. carers) which have delivered the same level of service, or improved service outcomes for less. Funding is reallocated to make best use of the available funds to services which are aligned to supporting health outcomes.

Protection of adult social care (PASC) has not been protected in real terms as the overall increase in the BCF minimum fund allocation for Herefordshire has been capped at £55k or £0.5%. A real terms uplift of 1.9% would equate to £86k on the 2015/16 figure of £4,520k, more than the total uplift for the fund. We have therefore determined that the most pragmatic solution is to pro rate the uplift in line with the 2015/16 allocations across social care and community health schemes. This means that funding for PASC has increased by £21k only, £65k less than a real terms uplift. **(C.2.vi)**

As stated above, due to the adjustments to the NHS funding formula Herefordshire CCG has not received the full inflationary uplift as it is deemed under the new formula to be funded above the target. To have awarded a full inflationary increase to the PASC funds would have created an additional pressure on the already financially challenged CCG. The partners have therefore agreed that applying the minimal uplift awarded for the CCG minimum BCF allocation pro rata to the 2015/16 allocations was the most appropriate action.

The LGA Care Act indicative funding allocation model would assign funding of £506k for Care Act implementation in Herefordshire, an increase of £48k, whereas the current assumption is an uplift of only £2k.

Overall social care is therefore underfunded by £111k for 2016/17. **In setting the level of protection for social care the local area has ensured that any change does not destabilise the local social and health care system as a whole (C.2.vii).** As the funding for PASC shows a marginal uplift

compared to 2015/16 this has reduced the risk of destabilisation of social care services, but will slow down the pace of change.

The Joint Spending Plan section of this document (section 7) provides **a comparison to the approach and figures set out in the 2015/16 plan (C.2.viii)**. Herefordshire is not planning any significant changes from the schemes included in 2015/16. It should be noted that the approved BCF plan for 2015/16 included indicative figures for the additional pooled resource. When partners finalised the figures these were adjusted down to the level shown in the table in section 7 below and have been used for in year reporting. A high level comparison to the original BCF will show an overall reduction year on year of circa 12% but in reality funding is above the amended 2015/16 budget.

Funding is reallocated to make best use of the available protection of adult social care (PASC) funds to services which are aligned to supporting health outcomes. In agreeing the PASC funding for 2015/16 significant discussions between council and CCG over a considerable period were necessary to agree the allocation of the PASC funds to ensure that the CCG was satisfied that the services invested in were providing health benefits. The overall approach for allocating PASC is consistent with 2015/16 and therefore meets the requirements of the 2012 DH guidance **(C.2.viii)**.

6.3 SUPPORTING PROGRESS ON MEETING THE 2020 STANDARDS FOR SEVEN-DAY SERVICES

This approach will prevent 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 **(C.3.ii)** and improve discharge planning.

Plans are in place to provide 7 days services (throughout the week, including weekends) across community, primary, mental health and social care **(C.3.i)** and the approach will support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care **(C.3.iii)**.

The One Herefordshire Programme, via its Urgent Care and Community Collaborative workstreams, and the schemes within the BCF, have a central focus on ensuring coherence across primary, community and secondary care, seven days a week. This will be achieved through:

- Professional Facing Care Co-ordination Hub which delivers multi-disciplinary clinical input to support decision making and co-ordinating and simplifying:
- Access to most appropriate care that can prevent emergency admissions e.g. diagnostics, community services, social care

- emergency admissions and discharges
- access to specialist opinion and advice (through regional procurement)
- Integration with GP out of hours services to achieve better of continuity care for users, patients carers.
- Improved access to records, including information and record sharing across providers, enabling front line staff to access records to improve the continuity of care and work toward an integrated approach to access of records to effective care across Herefordshire
- Developing IT interoperability enabling direct booking of appointments across service providers first phase NHS 111 direct booking of extended hours primary care appointments
- Building on learning from the Prime Ministers Access Fund (2015) pilot, which makes available primary care extended hours 6-8pm Monday to Friday in three locations across the county and 10am to 2pm on Saturday and Sundays in Ross on Wye and Leominster and 8am to 8pm in Hereford. Core to the success of this work has been full access to patient's primary care record with consent sought at time of clinical consultation.
- To work with primary care at scale to further develop locality based 7 day access to primary care, the PMAG extended hours approach will be marinated in 16/17, primary care at scale evolving model April 2017.
- Wye Valley NHS Trust and 2gether Foundation Trust are working to develop integrated multidisciplinary place based care formulated around GP practice population; a newly appointed joint director of community services is taking this forward in 16/17, with the evolving model being in place by April 2017. This work will improve continuity of information, care co-ordination, transition planning, discharge planning and hospital avoidance, and community based care as an alternative to hospital based care
- As part of the Community Collaborative work focus on virtual community team model drawing together community functions delivered through a multi-disciplinary team identifying the vulnerable through a risk stratification approach and taking a case management approach to establish individual care plans and person centred –outcomes – with focus on education, self-management and reducing hospital admissions, attendances and outpatient appointments. Aligned to this is a quality initiative across both 2g, WVT and West Midlands designed to reduce frequent attendees across several pathways.

- The principle of seven day working is embedded within One Herefordshire and our service redesign plans. **(C3.iv)**
- Our Delayed Transfer of Care action plan (see attachment) describes in more detail several areas of focus that is aimed to support the timely discharge of patients
- Primary care and community services central to the urgent care pathway – with increased capacity and capability over 7 days at locality level
- Potential realignment of resources within Minor Injuries Units and the Walk-In Centre, to simplify access routes for the public, reduce service duplication, and realign workforce and skill sets to primary care and A and E. The Walk-In Centre and Minor Injury Units are to remain open with no immediate changes while proposals for urgent care and for seven-day GP services are being developed, but we are reviewing these services to determine whether care is being provided in the best place at the best time for patients. The outcome of the review is not yet known and no decisions have been made. We will be undertaking a comprehensive and robust consultation with the residents of Herefordshire as part of our work.
- An Integrated NHS111/GP Out of Hours service is currently being commissioned across the West Midlands, on behalf of 16 CCGs which includes Herefordshire. Each CCG in the West Midlands has an opportunity to influence how the NHS 111 service works in their area and we will be ensuring that NHS 111 will be integrated with Herefordshire's urgent care services. Local schedules attached the NHS 111 and Out of hours to ensure appropriate local delivery.
- A public facing “virtual assessment” function across the whole pathway of care, to move towards “talk before you walk”, across primary care, NHS 111, WMAS and the “front door” of A and E. Consistently assessing and directing people to the most appropriate service, with redirection to primary care whenever appropriate.
- The brokerage function within the Adults Wellbeing directorate for the local authority provides 7 days a week support to enable hospital discharges
- Enhanced capacity has been provided to hospital social care management function 7 days a week
- The approach to delivering seven day services will be underpinned by the integrated urgent care pathway and health hubs.
- Plans for 2016/17 are in place for the developments outlined above as part of the One Herefordshire plan but are subject to further development and refinement.

- Hospice at home to support quality and effective EoLc 24/7 hospice at home service was commissioned and started in February 2016 to enable people to die in their preferred place of care outside of hospital.

6.4 BETTER DATA SHARING BETWEEN HEALTH AND SOCIAL CARE, BASED ON THE NHS NUMBER

One of the major cross-cutting themes within the One Herefordshire transformation programme is the need to share information about patients and service users. It is clear that our patients and service users expect that when they interact with a public-sector body regarding their wellbeing, that the care should be “joined-up”. Technology is a vital component in enabling that care.

By April 2016, every local area is now required to deliver, co-ordinated by the CCG,

- A Footprint detailing the partners and the governance arrangements to drive the local health and care system to become paper-free at the point of care.
- A baselined and benchmarked process towards becoming paper-free at the point of care using a new Digital Maturity Self-Assessment Tool.
- A digital roadmap outlining the steps (operational and strategic) to be taken towards being paper-free at the point of care.

The major recommendation from the workstream to date is that Herefordshire should implement a shared care record, with data being supplied from providers once appropriate systems are in place. This would provide a platform that improves the quality of care, the information available to professionals and clinicians and should, with appropriate business change, reduce time in hospital, support living at home longer, improve outcomes for patients and reduce costs.

As yet, the financial evidence about the level of saving that might be achieved is not extensive. There is more evidence of improved outcomes for service users and patients. Additionally, there are a set of smaller activities that would support working within the county. These “quick wins” leverage existing investments and would improve efficiency. This set of activities should be progressed to be in place by Mid-2016.

A service re-design management sub-group has been established called the Transformation Through Technology Group (TTTG), to support the delivery of the Digital Road map in Herefordshire. Initial membership of the group includes representation from the CCG, local authority and key providers including WVT, 2G, St Michaels Hospice and Taurus Healthcare. The digital roadmap is the key

deliverable for the TTTG to ensure that Herefordshire have interoperability of systems by 2020 at patient points of care across both health and social care. The digital footprint was agreed as 'Herefordshire' and submitted to NHS England in October 2015. The TTTG have submitted their Digital maturity Index returns on schedule in January as required by NHS England.

Within Herefordshire, **the right cultures, behaviours and leadership are demonstrated locally by all partners, fostering a culture of secure, lawful and appropriate sharing of data to support better care. (C.4.i).** The NHS number is being used as the consistent identifier for health and care services **(C.4.ii)**. For example, the NHS identifier is being used for reconciliation and reporting purposes within the Care Home Market Management BCF pool and is available for reporting within social care systems. All systems being developed or investigated have an API interface **(C.4.iii)**.

The cultures, behaviours and local leadership are demonstrated through the collaborative approach taken within the four key workstreams of the One Herefordshire transformation programme in which all partners actively participate to develop local solutions.

It is recognised that there is a requirement for **appropriate Information Governance controls to be in place for information sharing in line with the revised Caldicott principles and guidance** (available by the IGA). To date, the council has achieved 74% of the current IG toolkit submission and is at least level 2 in all areas **(C.4.iv)**. A Herefordshire memorandum of understanding on information sharing is in place and local data sharing agreements amongst partners are in the process of being developed. All staff receive mandatory training in information governance and specific multi-agency face-to-face training is in the planning stages for roll-out in the coming months.

Local people of Herefordshire have clarity about how data about them is used, who may have access and how they can exercise their legal rights (in line with the recommendations from the National Data Guardian review). A general privacy notice for Adult Social Care is in place and further privacy notices and consent forms are being reviewed and added as part of the work on implementing privacy notices. Consent forms were also reviewed as part of the work for the changes brought about by the recent Care Act **(C.4.v)**.

These changes highlighted will be an enabler for integration of services in the future and will provide the foundation of successful partnerships. All stakeholders are committed to the delivery of better data sharing to improve and enhance the journey through health and social care. **(C.4.vi)**

6.5 A JOINT APPROACH TO ASSESSMENTS AND CARE PLANNING

The proportion of our local population which has been identified (using our virtual wards scheme) and through the risk stratification tool is 2% **(C.5.i)**. The electronic risk stratification tool draws together primary and secondary care data to identify those individuals likely to experience significant deterioration and hospital admission. These vulnerable individuals are offered targeted support, an individual care plan and proactive case management from a member of the multi-disciplinary community team.

Herefordshire Council and CCG have developed and implemented an aligned assessment for continuing healthcare (CHC) and have also fully implemented the joint support planning process, with an accountable professional assigned to each case.

There is a joint approach to dementia care and living well with dementia in Herefordshire – with a clear shared vision across our system to increase the availability of early diagnosis of dementia, and to support people with dementia, their carers and families to live well with dementia. The model of dementia care is based on a primary facing pre and post diagnosis support. This includes efficient access to assessment (within 4 weeks); a partnership between mental health services and voluntary sector to offer tailored person-centred care that recognizes the different stages of the illness, e.g. carers support, information and advice, maximizing independence, advance care planning; and care coordination. Health and social care are working together to ensure that multi-agency and multi-disciplinary input is coordinated and provided for people with dementia within the community. The coordination extends to ensuring support is provided during times of ill health, e.g. hospital stays, and in different settings, e.g. Care Homes **(C.5.ii)**

We currently have an Integrated Urgent Care Pathway project in place, which is a joint project between the Local Authority and Wye Valley NHS Trust to further develop an integrated Urgent Care Pathway, utilising the existing community health and locality social care teams to maximise opportunities to avoid admissions into the acute hospital, support earlier discharge and facilitate discharge to assess where there is further recovery or rehabilitation required to enable longer term planning to take place. This project develops the footprint for multidisciplinary working building on, lead professional (Key Worker), Trusted Referrer and Trusted Assessor roles across multiple Health and Social Care teams.

The strategic objective is to enable individuals to remain as independent and healthy as possible in their usual place of residence, to minimise admissions and subsequent spend within the acute

hospital environment thereby facilitating investment in community health and social care services to meet our shared objectives of safely and effective care which maintains independence within the community for vulnerable adults.

The pathway prompts rapid responses to urgent care requirements, establishing the principles of right care, in the right place and at the right time, maintaining the person's independence within their usual community setting by deploying the optimal skill mix to ensure the response provided is appropriate and proportionate to the assessed needs. As a health and care system we are working towards the default position where individuals are supported to remain at, or return to their home.

The delivery plan detailed below provides key milestones for Herefordshire's joint approach to assessments and care planning **(C.5.iii-iv).**

Delivery	By when?	By who?
Commitment and scoping of a plan to develop joint or aligned assessments, with the aim to shift to prevention and reduce the number of high cost service users/patients.	Q1 2016/17	CCG and LA
Agree proposal for a functional delivery model for health and social care.	Q1 2016/17	CCG and LA
Full governance agreement to the functional model to include the JCB, System Redesign group, One Herefordshire working groups – <ul style="list-style-type: none"> • Urgent Care • Community Collaborative • Supportive Communities 	Q1 2016/17	CCG and LA
Share the proposal and develop further with key providers. To include: <ul style="list-style-type: none"> • WVT • 2gether Foundation Trust • Shaw Healthcare • Blanchworth • Key LA providers. 	Q1 2016/17	CCG and LA

Delivery	By when?	By who?
Develop further joint working across agencies and community (provider input required). To include the following: <ul style="list-style-type: none"> ➤ Risk stratification ➤ Virtual wards/hospital at home ➤ Rapid response ➤ Voluntary sector ➤ Mental Health 	Q1 and ongoing	CCG and LA
Risk stratification tool to be developed through the community teams to identify people 'at risk' of entering the system.	Q1 2016/17	Community collaborative
Establish joint approach to care planning in line with the delivery model (self-assessment and appropriate professional assessments) and agree milestone plan.	Q1 2016/17	CCG and LA
Identify and establish key processes in relation to key priority populations (e.g. frail/elderly)	Q2 2016/17	CCG and LA
Providers and commissioners to agree pathway and process implementation	Q2 2016/17	CCG and LA
Identification of potential Trusted Assessors, to achieve focus on functions not roles and to enable workforce efficiencies across providers.	Q2-3 2016/17	CCG and LA
Plan for rollout of training programme for Trusted Assessors	Q4 2016/17	CCG and LA
Care Home Inreach Team to review care home residents to identify those without a diagnosis of dementia but who might have dementia, assess them and request that their usual GP adds them to the dementia QOF register if dementia is diagnosed.	Q4 2016/17	CCG
Community dementia team to make effective links with community hospitals to develop process for identification of patients requiring dementia assessment	Q1 2016/17	CCG

Delivery	By when?	By who?
Targeted case finding for key groups with GP surgeries and Mental Health Liaison Service, e.g. frail elderly people, older carers, people with LTCs, patients in care homes, and people with learning disabilities.	Q4 2016/17	CCG
Multi-agency dementia training to aid joint working	Q1 2016/17	CCG

Through implementing the above delivery plan health and social care teams will use a joint process to achieve effective joint working which benefits patients/service users through promoting independence, preventing hospital admission reducing people entering into the care system and ensuring people are in the right part of the system as quickly as possible.

6.6 AGREEMENT ON THE CONSEQUENTIAL IMPACT OF THE CHANGES ON THE PROVIDERS

Herefordshire have reviewed this section following the submission two assurance process and believe the narrative below meets the KLOE requirements. Please note the assurance process was rag rated fully met by one reviewer and not met by the other.

Providers are fully briefed on the projects included within the BCF that impact on them. We are working with our providers to support delivery of the key elements of the One Herefordshire projects and where appropriate, changes are reflected in our contractual relationship with providers.

Key providers are full members of the One Herefordshire programme of work, to which the BCF plans are integral. This ensures that providers are engaged with, and co-produce, transformation and service redesign plans at an early stage (though if re-procurement of a service is required, appropriate conflicts of interest safeguards are in place). **Implications for local providers are set out clearly within this process and allow recognition of service change consequences (C.1.v).**

BCF is an enabler in Herefordshire for the delivery of our system wide plans. For example, the CCG and Herefordshire Council have developed a joint specification for community services which is being included in contractual relationships with key providers. This includes KPIs relating to increasing the amount of care that is provided in a community and primary care setting as opposed to acute setting; improving outcomes for patients receiving care in community settings.

All key service changes are subject to quality and equality impact assessment to ensure any adverse consequences are identified and mitigated against if appropriate. Significant service changes will be subject to wider consultation and engagement of stakeholders, users and patients.

The impact of local plans has been agreed with relevant health and social care providers

(C.6.i). The CCG's contract with its main acute provider (WVT) includes QIPPs and contractual changes that reflect the implementation and extension of schemes that are supported through the BCF – e.g. extension of the Virtual Wards across the whole county. Activity and performance trajectories are modelled, alongside financial impact and these are taken into account through contract negotiations. A clear provider engagement plan will be developed within the BCF 2016/17.

The largest pool within the BCF plan for Herefordshire is for the joint contracting and commissioning of residential and nursing placements. The unified contract has been developed during the last year and the consequential impact on the implementation and delivery of the contract has been monitored and reported on a regular basis. A large engagement process has been undertaken with the market of the contract principles and changes which has been considered throughout the process.

There is ongoing public, patient and service user engagement in the planning process by partners, through our usual activities. A significant engagement programme was undertaken in summer 2015 to support the development of the Health and Wellbeing Strategy which underpins the transformation programme and informed the setting of our local objectives. CCG and council provide regular updates to governing body, Cabinet and members as part of the routine governance and assurance processes. **(C.6.ii)**

These align to provider plans and the longer term vision for sustainable services **(C.6.iii)** through the One Herefordshire Plan

The **importance of mental health as well as physical health** was demonstrated as it was the number one priority arising from the consultation on the health and wellbeing strategy. A joint work programme on the redesign of mental health services is currently underway. **(C.6.iv)**

A demonstration of clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans is shown in the One Herefordshire Plan. **(C.6.v)**

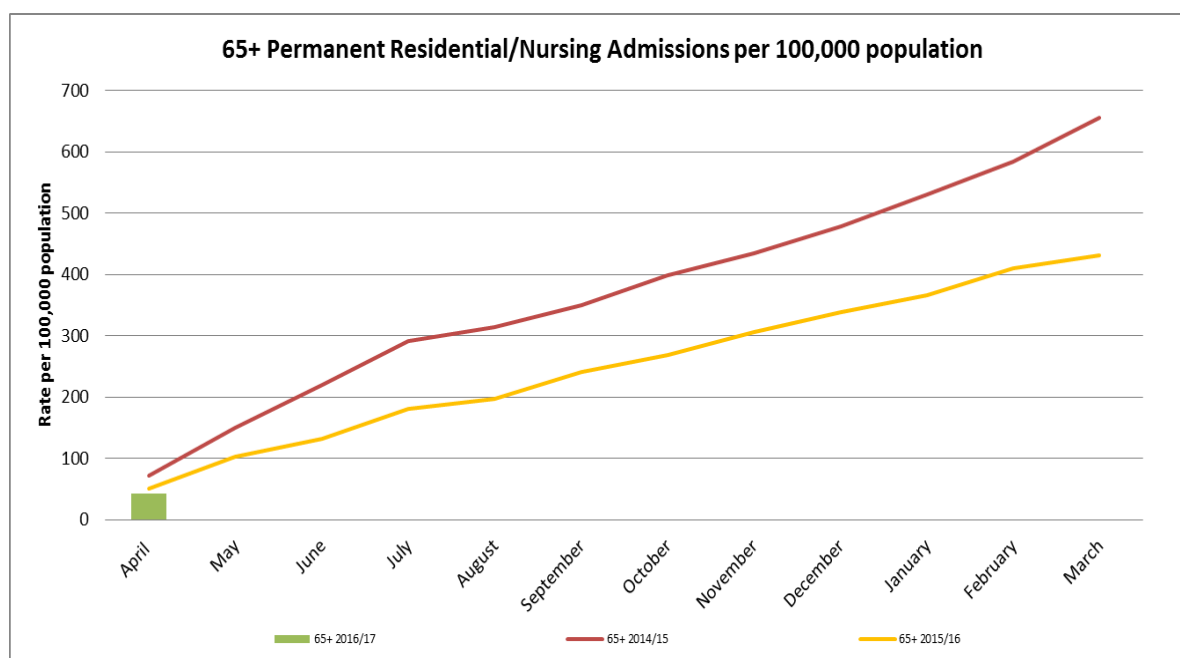
6.7 AGREEMENT THAT A PROPORTION OF THE ALLOCATION IS INVESTED IN NHS COMMISSIONED OUT-OF-HOSPITAL SERVICES

Within Herefordshire there is agreement that NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-

elective admission, continue in a manner consistent with those agreed in 2015/16 (C.7.vi). The community health scheme meets the requirement for allocation of at least £3,339k to be invested in NHS commissioned out of hospital services. The funding has been allocated in full and not retained as part of a local risk sharing agreement. This funding is allocated to district nursing and other community based nursing (C.7.i). The specific detail is clearly set out within the summary and expenditure plan tabs on the BCF planning return template (C.7.ii).

In developing and forming an agreement in relation to the allocation invested in NHS commissioning out-of-hospital services a range of data analysis has been completed which considered the long term trend in admissions and the success of the schemes implemented to date. The information provided below is a sample of the data monitoring and analysis which is completed on a regular basis by Herefordshire's Joint Commissioning Board (C.7.iv).

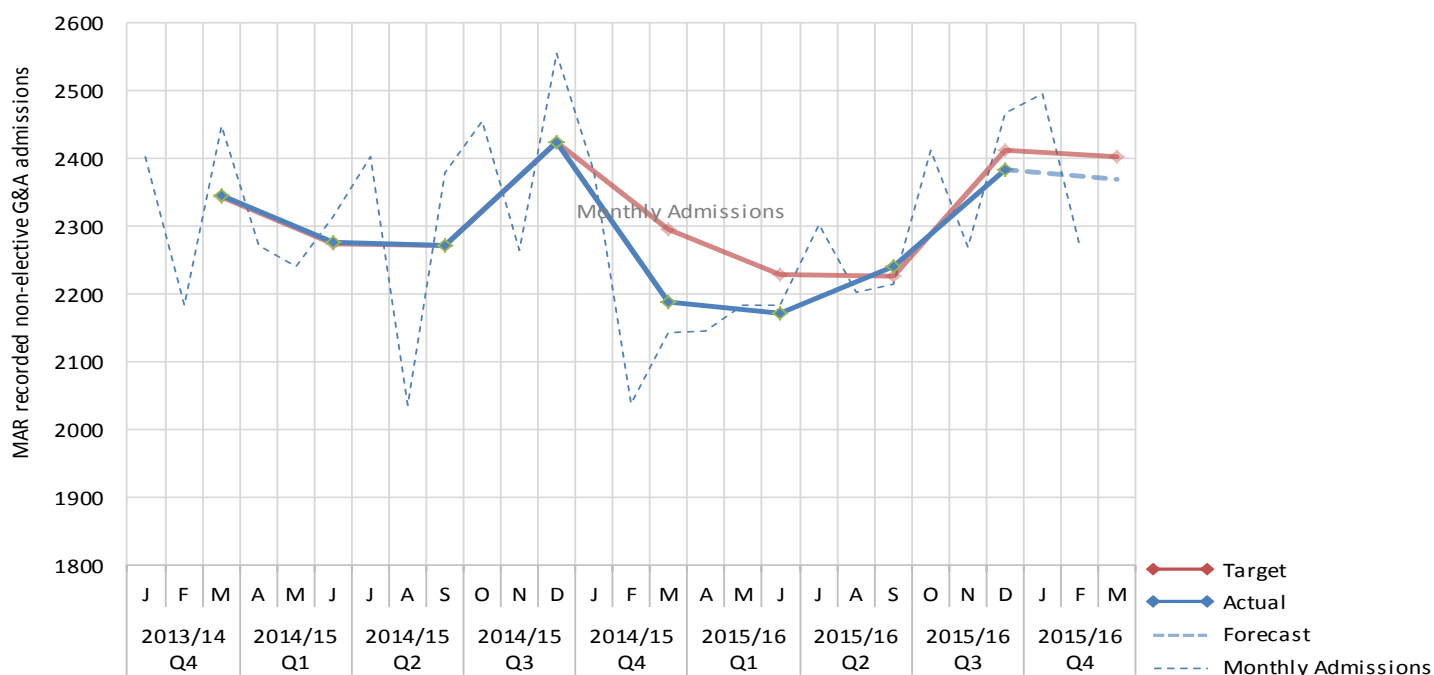
Admissions to Residential & Nursing Homes (Age 65+)



2015/16 data, whilst still in draft, presents a significant improvement in the previous year's results. This is in part due to the more rigorous process of the quality assurance panel, challenging the appropriateness of all residential placements. The target for 2016/17 admissions is to maintain at those levels recorded in 2015/16, therefore the target this year is 2015/16 actual line.

Non-elective Admissions

A number of schemes have been set up via the BCF programme, to address the demand in non-elective admissions with a view to reduce these further. These include rapid assessments, falls first response, virtual wards, and hospital at home.

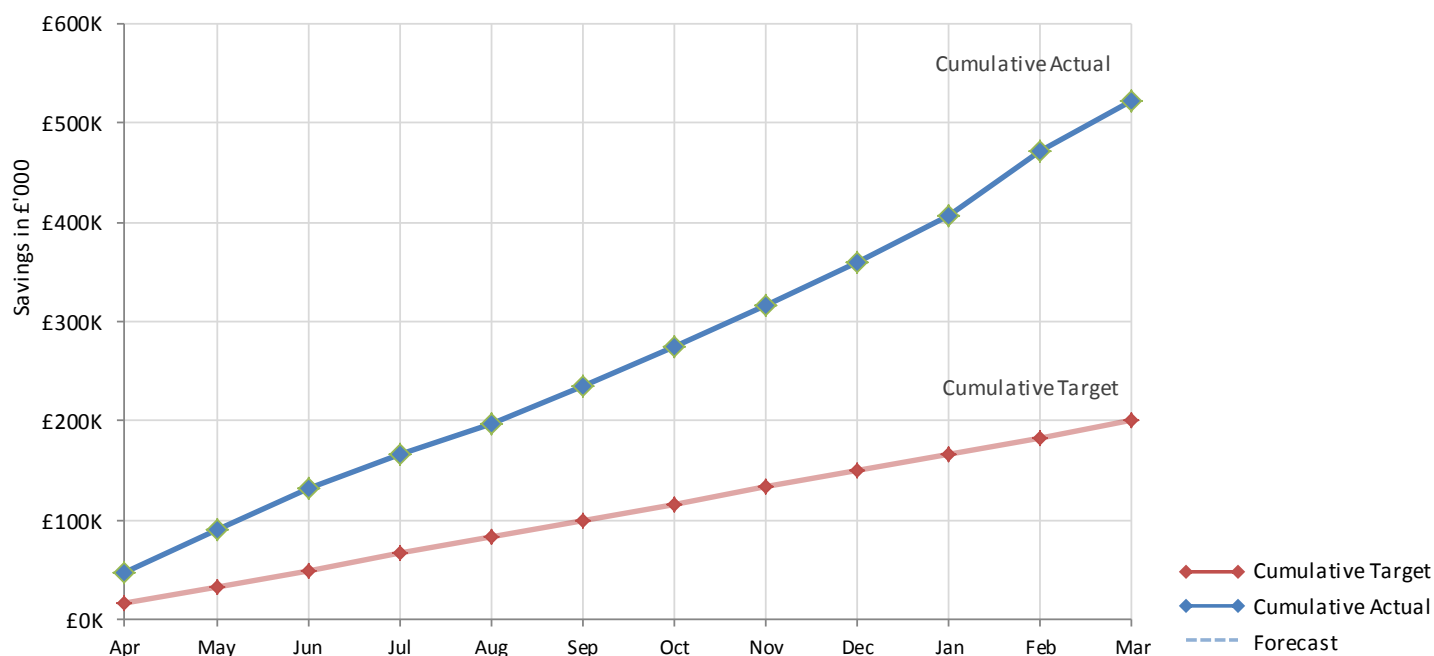


Intermediate Care Scheme Redesign

A number of schemes are being worked through to help address the pressures of non-elective admissions, including earlier identification of potential discharges, increased capacity in brokerage and additional support to self-funders and care homes. During 2015/16 a Rapid Access to Assessment and Care scheme was delivered, however the effectiveness of the scheme is currently being discussed and partners are working together to carry out a complete review and redesign of the intermediate care pathway and offer in Herefordshire (B.2.iv)(C.7.iv).

The review will be supported by analysis undertaken of the non-elective admissions and modelling this for the future demand of unplanned activity. The schemes such as the falls response service has been an effective provision in supporting unplanned activity and is identified as a scheme that will continue (C.7.iii).

Falls Response Service



Falls represent a large proportion of ambulance conveyances to Wye Valley Trust and the falls related admissions are high. The graph above illustrates the falls response measure, which is in line with the HCCG QUIPP scheme. This is in relation to the impact of service changes in reducing falls related costs. The falls first responder's scheme continues to help address the gaps in the falls pathways in Herefordshire, caring for those fallers who have not received serious injury. Due to the continuing success of this service it has been agreed to continue to invest in this service, in order to assist in reducing the number of non-elective admissions reported. (C.7.iv).

6.8 AGREEMENT ON A LOCAL ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE (DTC)

A local area action plan for DTC has been developed and is attached to this document, which demonstrates clear lines of responsibility, accountabilities and measures of assurance and monitoring (C.8.i), (C.8.vii). The aim of this plan is to reduce delayed transfers of care ensuring that people are discharged in a timely manner to the most appropriate setting to meet their needs.

A number of objectives are identified in our DTOC plan which include:

- to ensure that our local DTOC improvement plan is based on national guidance and best practice **(C.8.viii)**
- to ensure that the DTOC improvement plan is implemented within the framework of the overall System Resilience Group plan for improving patient flow and performance, with all partners engaged in and accountable for implementation **(C.8.iii)**
- to ensure a whole pathway approach, with an emphasis on prevention and admission avoidance as well as on discharge planning.
- to monitor and assure progress against key milestones and performance through the JCB and Systems Resilience Group
- to provide a framework for shared outcomes through risk pooling.

Our DTOC plan will be a key component of monitoring and reporting in both the System Resilience Group and the Joint Commissioning Board. As such it sits within the overall context of the System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge). The plan was discussed within the February SRG and will be presented formally at a future meeting. **(C.8.iii)** The adoption of a risk share agreement for DTOC has been considered and is further discussed within section 8 of this plan – financial risk sharing and contingency **(C.8.v)**.

In delivering and further developing the DTOC plan, we will continue to engage with the relevant acute and community trusts **(C.8.vi)**. We have a process of continuous engagement with our local independent and voluntary sector providers on a range of topics. A key element of the DTOC plan is the use of intermediate care and step up / step down beds as the redesign of these services is a key focus of the 2016/17 BCF the engagement with providers through our current processes will form an integral part of this. **(C.8.ix)**

The local area, including the local acute and community Trust, has developed a detailed action plan for reducing delayed transfers of care. Unify data indicates that Herefordshire, and the local acute provider is not a significant outlier in terms of acute delayed transfers, and the action plan focusses upon non-acute delayed discharges. A significant amount of work is being undertaken, following on from schemes begun in 2015/16, the plans are laid out in detail in the DTOC Action Plan. The local area target is based on the action plan delivering reductions in DTOC by the end of 2016/17, such

that there is a 7.5% reduction in DTOC per 100,000 population in Herefordshire compared to the out-turn performance for 2015/16 **(C.8.ii.)**

Reducing delayed transfers of care is an important enabler in HCCG's operational plan. Reduction in DTOCs is important to the Acute and Urgent care work streams of the CCG's operational plan, and reducing DTOCs per 100,000 population is a key target in the Urgent Care work stream. The plan reflects the importance of BCF as an enabler in the wider transformation of health and social care in Herefordshire. The importance of reducing DTOC through working with the local acute and community provider Trust is reflected in the detailed DTOC action plan. Work with the local provider reflects ECIP analysis and recommendations and also the provider is working with peer organisations to improve discharge performance. This work will promote adoption of best practice and effective interventions, as well as improving data quality **(C.8.iv.)**.

The local DTOC stretch targets have been established and developed and are detailed within section 5 of this document. **(C.8.ii.)**

7. JOINT SPENDING PLAN

Funding contributions for 2016-17 **(A.3.iii)**

Herefordshire's minimum fund contributions and indicative additional contributions from each partner are summarised below. This table also **sets out any changes from funding levels in 2015/16 (A.3.iv)**. The final budget contributions for the additional pool are based on the cost of care for current clients as at end March 2016.

Overview of Contributions 2016/17 versus 2015/16

£'000	Ref No.	Source	Funding by LA	Funding by CCG	Total 2016/17	Total 2015/16* ¹	Incr * ² (Decr)
Protection ASC	1	Minimum		4,541	4,541	4,520	21
Care Act	2	Minimum		460	460	458	2
Community Health & Social Care	3	Minimum		6,748	6,748	6,716	32
Sub Total Minimum Fund		Minimum		11,749	11,749	11,694	55
DFG (15/16 figs incl. SC capital)	4/5	Min Fund	1,558		1,558	1,356* ²	202
Care Home Market Mgmt	6	Additional	19,468	9,272	28,740	27,048	1,692
Total Indicative BCF			21,026	21,021-	42,047	40,098	1,949

*¹ The figure reported for BCF budget for 2015/16 is lower than the budget included in the approved plan. This is because at the time of submission the exact criteria for the additional pool contributions

had not been finalised, and final contributions were confirmed at a lower level as out of county placements were excluded from the final pool. Overall funding for 2016/17 is now confirmed and agreed by the partners.

*2 in 2015/16 social care capital contribution £490k, DFG £866k

*3 increase in minimum BCF provisionally allocated pro rata

The minimum fund includes the former carer's breaks and reablement funding at the same level as 2015/16 in line with the original BCF allocations and assumptions. (A1.i, A1.ii, A1.iii, A1.iv, A1.v)

Allocation of the funding for the protection of adult social care has been rebalanced in some areas to reflect financial efficiencies achieved in year through recommissioned services (carer's support) which do not result in reduced service provision & to enable the resources to be allocated to meet other service pressures such as DOL's demand. Funding also reflects the redesign of social care teams to provide better support to crisis response, facilitating hospital discharge and closer working with health teams.

The Herefordshire BCF plan maintains the schemes identified in the 2015/16 BCF submission and therefore an assessment of the impact of these changes on these services is minimal, however the impact of the key schemes is summarized below (A.3.v).

The funding for the protection of social care includes increased support to deliver DOLS in response to the increased demand seen as a result of legal rulings.

The funding currently identified for RAAC within the protection of social care will be reallocated. Partners are currently discussing the form that this new service will take. One option under consideration is an alternative service in the community to support hospital discharges, potentially through an expanded / enhanced rapid response service. This has the potential to support discharge for approximately double the number of patients as the existing scheme on a full year equivalent basis.

The increased funding for DFG in 2016/17 provides the potential to deliver additional adaptations, potentially up to 100 more in year (subject to local capacity). Based on central government estimates this may lead to the delay of residential admissions of up to 30 people (10% per CSR projections).

The investment in the falls response service has proved very successful delivering more than double the target savings in 2015/16. This scheme is jointly funded by the CCG, council and the provider.

In relation to pool 2 the partners are looking to reduce the risks by engaging providers to actively risk share and improve provision across the entire pathway. This is work in progress and may result in a reduction in the pool 2 budget in year as these arrangements are confirmed.

The risk stratification and hospital at home services has proved to be highly successful and is being rolled out county wide and will impact further in 2016/17.

The scheme summary is included within tab 4 HWB expenditure plan of the reporting template but is shown below for completeness.

Scheme Summary (Ref Tab 4)

Scheme Name	Ref No	Scheme Type	Area of Spend	Comm.	Provider	Source of Funding	Expenditure		
							2016/17 (£'000)	Budget 15/16 (£'000)	Outturn 15/16 (£'000)
Intermediate Care - reablement (Kington court)	3	Reablement services	Comm Health	CCG	NHS Community	CCG Min.	534	484	484
Integrated Community Care (community health svcs)	3	Integrated care teams	Comm Health	CCG	NHS Community	CCG Min.	3,806	3879	3879
Early Interv'n & rapid response / intermed. care -Hospital at Home	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	768	800	800
Early Interv'n & rapid response - Risk Stratification	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	768	800	800
Early interv'n & rapid response -Falls Response service	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	123	123	123
Intermediate Care - Step up / Step down community bed	3	Intermediate care services	Comm Health	CCG	Charity/Vol. Sec.	CCG Min.	240	153	153
Prevention - Short breaks / respite care for children and families	1	Ledbury Road (carers)	Comm Health	LA	NHS Acute	CCG Min.	427	427	427
Carers Support	1	Carers	Comm Health	LA	Charity/Vol. Sec.	CCG Min.	50	50	50
Support to ECIP/DTOC	1	Joint Commissioner	Comm Health	CCG		CCG Min.	32	0	0
Reablement	1	Reablement services	Social Care	LA	Charity/Vol. Sec.	CCG Min.	420	420	420
Carers Support	1	Support for carers	Social Care	LA	Private Sector	CCG Min.	460	843	718
Community Equipment / HIA	1	Pers. support/care @ home	Social Care	LA	Private Sector	CCG Min.	272	266	266
Rapid Response / OT	1	Pers. support/care @ home	Social Care	LA	Local Authority	CCG Min.	670	595	648
Kington Court	1	Intermediate care services	Social Care	LA	Private Sector	CCG Min.	366	366	366
RAAC	1	Intermediate care services	Social Care	LA	Private Sector	CCG Min.	494	494	352
Integrated Crisis and urgent care	1	Integrated care teams	Social Care	LA	Local Authority	CCG Min.	712	641	713
LD Health	1	Other	Social Care	LA	NHS MH Provider	CCG Min.	331	331	331
Other Social Care Demand	1	Other	Social Care	LA	Local Authority	CCG Min.	793	564	706
Support to ECIP/DTOC	1	Other	Other	LA	Local Authority	CCG Min.	23		
Care Act	2	Support for carers	Social Care	LA	Charity/Vol. Sec.	CCG Min.	460	458	458
Disabled Facilities Grant	4	Pers. support/care @ home	Other	LA	Private Sector	LA Min	1,558	866	866
Care Home Market Management CCG contribution	6	Other	Contin. Care	CCG	Private Sector	CCG Add'l	9,272	8685	9888
Care Home Market Management LA contribution	6	Other	Social Care	LA	Private Sector	LA Add'l	19,468	18363	18418
Social Care Capital	5	Other	Other	LA	Private Sector	LA Min	-	490	490
Total BCF							42,047	40,098	41,356

*Reference numbers to cross reference scheme details to high level summary table above

The total allocated to carers support across the CCG and council is £937k, including £477k former carers grant (**C.2.iv, A.1.iv**).

8. FINANCIAL RISK SHARING AND CONTINGENCY

A **fully populated and comprehensive risk log** is located within the appendices of this plan **(B.3.V)**. This has been developed in partnership with all key stakeholders and provides a description of how risks will be managed operationally.

The following KLOEs have been addressed within this submission of the narrative plan:

(B.5.i), (B.5.ii), (B.5.iii), (B.5.iv), (C.7.iii), (C.7.v)

The BCF plan for 2015/16 contained a risk share arrangement for pool 2 for the first year of operation. The risk share arrangement recognised that a revised arrangement would need to be negotiated for future years. The Joint Commissioning Board were to use the first year of the BCF to monitor and evaluate both performance and risks arising in year to inform the development of more sophisticated risk share arrangements for future years.

The BCF fund is fully allocated to existing schemes within Herefordshire, and no funds have been retained for contingency or payment for performance purposes.

Herefordshire took up the offer of regional support to develop a local approach to risk share arrangements for 2016/17. The support was used to consider the options for risk share arrangements in relation to non-elective admissions, DTOC and the additional aligned fund contained within the BCF plan for 2016/17. The support facilitated a workshop between both partners and to inform the discussions with best practice of risk sharing arrangements and the development and implementation of these in other areas.

Partners have worked together to consider the use of a local risk sharing agreement with respect to a number of key areas, including DTOC. Following clear consideration partners have concluded that a risk share, in relation to DTOC, NEA and schemes contained within pool 1 of this plan would not be of benefit to either party at this time. In regards to pool 1, as previously mentioned, partners are currently working together to review and redesign the Intermediate Care Scheme (previously delivered through the RAAC framework). This redesigned service offer will provide a therapeutic reablement provision within clients homes following discharge from hospital, as well as utilising existing block contracts to deliver bed-based intermediate care options in the county and will focused on unplanned activity and supporting DTOC **(C.8.v)**.

The principles of a risk and benefit sharing arrangement has been agreed for Herefordshire which is based on behavioural change and service innovation within the system aligned to the funding contained within pool 2.

The risk share arrangement for pool 2 is currently being finalised with the detailed funding split to be agreed. It will be based on a cap for risk and benefits to both partners and will be consistent with guidance.

The delivery of service innovation with the implementation of the unified contract for the residential and nursing commissioning of placements and assertive reviews for continuing healthcare provision are key deliverables for this risk and benefit share arrangement.

The following scoping of the risk sharing arrangement for pool 2 has been undertaken.

The partners are finalising that the risk share agreement will be restricted to a defined and agreed cohort of clients. This client cohort will be defined as follows:

1. Includes those clients who are not funded at the usual price*2 and who have not been reviewed in the twelve month period since 1st April 2015
2. The list of clients identified in 1 above will be jointly assessed by the council and CCG to agree which clients are likely to result in a behaviour change*3 due to the length of time since the last review or for other reasons relating to a change in the approach being taken by the commissioner.
3. The defined client list excludes any clients identified by the CCG as being part of separate arrangements with 2g for risk share.
4. The defined list will exclude non-reviewed clients who, the partners jointly agree, are unlikely to have incurred a substantive change in health and care needs in the intervening period. These clients will be classified as business as usual and excluded from the specific risk share arrangement.
5. The eligible clients list, as defined above, will include the totality of eligible clients, this is a total of 27 clients and is within appendix one of this document.
6. The expectation will be that the clients will be reviewed within the next six months and the monitoring of the reviews will be through the Better Care Fund Partnership Group, with further reporting to the Joint Commissioning Board.

*2 in this context the usual price is defined as any local authority client funded at either the old, or new usual price for older peoples residential and nursing care (£570, £523, (old / new nursing rates), £468, £457 (old/new residential & dementia rates) per week), and clients who receive FNC/FCO only support from the CCG

*3 in this context the term behaviour change means that the partners agree that due to the length of time since the last review a stepped change in level of needs is likely to be identified upon review which may result in a change of statutory partner responsibility for the individual client.

The cohort of clients that has been scoped for the risk share agreement is quantified in the table below:

Clients not reviewed since 1/4/15	Number	CCG £k	LA £k	Total £k
CHC	4	314	-	314
Joint Funded	1	34	-	34
LA non usual price clients	22	6	1,031	1,037
TOTAL	27	354	1,031	1,385
Proportion		26%	74%	

The non-financial risks associated with not meeting the BCF targets are:

- The BCF targets contribute to both partner organisation strategic objectives and this will have a negative impact on delivery of these.
- Further pressures and destabilisation will be placed on a fragile health and social care system
- The people of Herefordshire outcomes will not be improved
- Limiting our ability to meet the changing needs in the population

The principles and risk share arrangement and will be subject to the section 75 agreement. The delivery of the risk share will be monitored on a monthly basis within the BCFPG and will routinely reported to the JCB. The financial risk will be applied to the overall net cost or gain from those clients who change statutory responsibility with the balance being agreed on an annual basis.

9. DELIVERING THE PLAN

The delivery plan below details **key milestones associated with the delivery of the plan of action in 2016/17 (B.3.iv)** Please see the attached risk log for further information regarding managing risk in relation to the following delivery plan.

Delivery	By when?	Accountable partner*
HWB sign off BCF plan 2016/17 (12 th April 2016)	Q1 2016/17	Both
BCF plans 2016/17, including pooled fund arrangements commence	Q1 2016/17	Both
Agree approach to Risk share arrangements	Q1 2016/17	Both

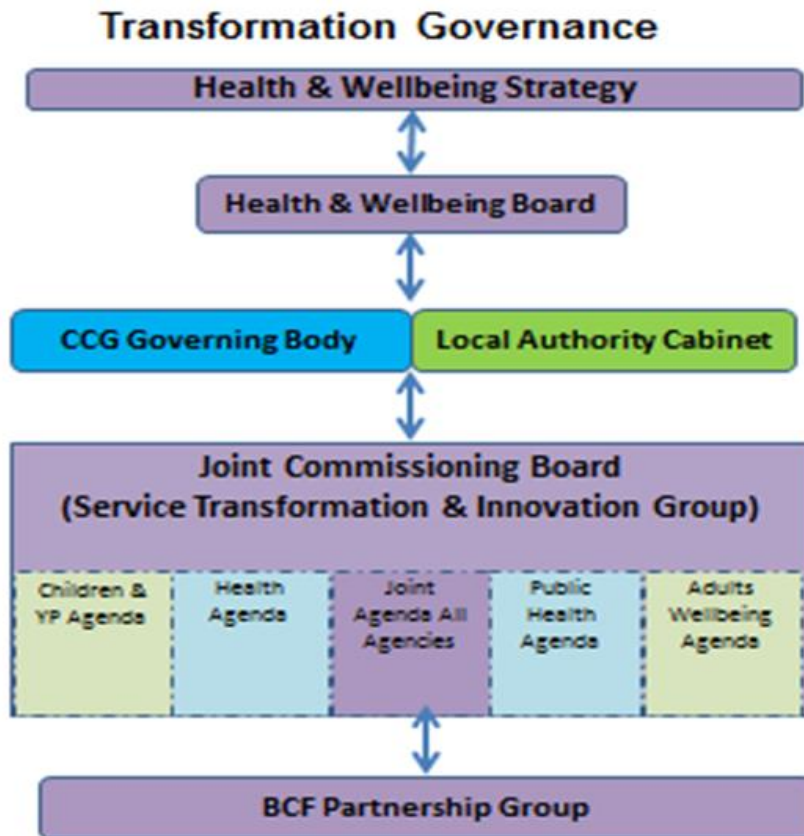
Delivery	By when?	Accountable partner*
Single S75 to be developed and agreed	Q2 2016/17	Both
Approval of unified contract	Q1 2016/17	Both
Implementation of unified contract	Q2 2016/17	Both
Implementation of redesigned social care teams into locality / complex care teams	Q4 2015/16	LA
Monitor effectiveness of redesigned social care teams via BCPG	Q2 2016/17	Both
WISH (Wellbeing Information & Signposting for Herefordshire) service launched	Q1 2016/17	LA
Enhance content of IAS	Q2 2016/17	LA
Review and reconfigure RAAC framework arrangement	Q1 2016/17	Both
Implementation of Herefordshire Carers Strategy	Q2 2016/17	Both
Develop a provider engagement plan	Q1 2016/17	Both
Care Co-ordination Centre mobilised	Q1 2016/17	Both
Submit System Transformation Plan	Q1 2016/17	Both
Agreed county-wide Estates Strategy that supports consolidation & transformation	Q3 2016/17	Both
Devolution of acute specialities to community settings	Q3 2016/17	CCG
Increased primary care capacity through development of primary care at scale	Q3 2016/17	CCG
New community Health and Wellbeing Hubs opened in x localities	TBC	CCG
Single physical and mental health community teams in place	Q1 2016/17	CCG
Re-procure advocacy service	Q1 2016/17	LA
Initial local area development of community links model	Q1 2016/17	Both
Establish working group to review DFG scheme	Q1 2016/17	Both
Procurement exercise following redesign of domiciliary care	Q2 2016/17	LA
Intermediate care redesign	Q2 2016/17	Both
Primary care and community services - Increase capacity and capability over 7 days at locality level	National announcement awaited	CCG

Delivery	By when?	Accountable partner*
Integrate NHS 111 with Herefordshire's urgent care services	Mobilisation of new contract Q4 2016/17	CCG
Complete consultation exercise regarding Minor Injuries Units and Walk-In Centre	Q1 2016/17	CCG
New model of care for community hospitals	Q1 2017/18	CCG
Integrated single gateway for urgent care	Q1 2017/18	CCG
Single health and social care record	Q1 2018/19	Both

* Accountable partners are identified as Herefordshire Council (LA), Herefordshire CCG (CCG) or both.

10. GOVERNANCE AND ACCOUNTABILITIES

The Herefordshire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports from the Joint Commissioning Board.



The BCF Partnership Group includes representation from provider organisations and is responsible for overseeing implementation of the action plan and for the continuing review and development of the fund.

Oversight and responsibility for the BCF is embedded within the Senior Leadership Team of both Adults and Wellbeing within the council and the Clinical Commissioning Group **(B.3.i)**. In both cases this is in the form of a senior leader who is able to maintain the profile of this agenda and ensure linkages to wider health and social care matters as well as connection to the corporate council agendas in the case of Adults and Wellbeing

A dedicated multi-agency group (the Better Care Fund Partnership Group) is supporting focus and progression of the Better Care Fund and acts as the key problem solving vehicle and is accountable to the Joint Commissioning Board. The JCB will receive a monthly highlight report from this group with key decisions and issues being escalated to the board for resolution as appropriate

An integrated performance report has been developed and is shared with the Joint Commissioning Board on a monthly basis. Such **arrangements are in place to support joint working (B.3.iii)** and to enable a move to increasing alignment of our commissioning arrangements, including development of joint strategies and commissioning arrangements, in particular in relation to adult community health and social care services including personal budgets, support to carers, care home market management, mental health and learning disabilities. The next stages of completion of our BCF section 75 agreement will include confirmation of the future ways of working to support delivery of our shared objectives **(B.3.ii)**.

The proposed governance structure for the wider transformation programme can be located within the One Herefordshire report, in the appendices of this document.

11. INTEGRATION PLAN

Herefordshire has developed the One Herefordshire plan which is an alliance of all the health and social care organisations working together to address the fundamental issues facing our community.

The BCF plan is a key component and integral part of this overarching plan for Herefordshire.

Herefordshire has also agreed its STP footprint and governance arrangements as part of its relationship with Worcestershire, details of which can be found in the appendices. The One Herefordshire plan, which the BCF plan supports, is the central contribution on behalf of the county to the wider STP plan.

12. APPENDICES – SUPPORTING INFORMATION

One Herefordshire Plan As per submission two	STP - Governance As per submission two
2016/17 DTOC plan As per submission three	JSNA – Evidence Base As per submission two
Risk Register As per submission two	Original BCF Plan As per submission two

**MEMORANDUM OF
UNDERSTANDING**

BETTER CARE FUND

RISK SHARE AGREEMENT

2016/17

1. AGREEMENT

Between Herefordshire Clinical Commissioning Group and Herefordshire Council, this agreement is dated 31/08/2016.

Signed on behalf of Herefordshire Clinical Commissioning Group



.....
NAME: ...Simon Hairsnape

POSITION: Chief Accountable Officer

DATE: 1/9/16

Signed on behalf of Herefordshire Council



.....
NAME : Martin Samuels

POSITION: Director Adults and Wellbeing

DATE: 31 AUG 2016

BCF Risk Share Arrangements in Herefordshire 2016/17

Agreed Principles

Overarching Principles

1. Targeted Actions and Behaviour Change

- Any risk/reward share arrangements must be supported by a targeted programme of actions that change behaviour and improve the effectiveness and efficiency in deployment of resources.

2. Measureable and Evidence Based

- Changes in behaviour and agreed actions must be measurable and evidence based.

3. Baseline Metrics and Regular Reviews

- Baseline metrics to measure impact must be jointly agreed beforehand and regularly reviewed and where necessary updated throughout the period of the agreement.

4. Limit to Financial Risk / Ownership of Financial Costs

- No risk / reward share can have an open ended financial risk / reward to either partner.
- The risk share agreement is intended to support joint working on specified areas to improve care and reduce overall system costs. It will do this by sharing the impact (both positive and negative) of in-year changes in how care is provided and commissioned. It is not intended for the risk share arrangement for 2016/17 to create a long term subsidisation by either partner in statutory funding responsibilities.
- For the longer term, financial costs should be borne by the partner who has the statutory responsibility for those costs. That is to say health costs and impacts on the system should be borne by the CCG and social care costs and impacts on the system should be borne by the council.
- For specific clients with both health and social care needs, where a joint approach is agreed, the appropriate ratio and lead commissioner arrangements will be jointly agreed and documented.
- Any increase in cost to the other partner as a result of changed behaviour relating to pool 2 , this means outside of normal day to day processes*¹ (these processes will be defined) will be managed through application of the risk sharing agreement. The partners have agreed that it is their intention to identify any likely groups of patients to which the latter arrangement would apply and agree a framework to ensure that the specific patients can be clearly identified (e.g. noting through the assessment process when the deterioration in condition actually occurred).

- When agreeing the financial implications of a risk share scheme both financial costs and potential financial benefits/rewards should be considered.

**¹ day to day processes are defined as undertaking 3 month reviews for new clients, and annual reviews for all clients.*

5. Joint Agreement

- The partners recognise and support the requirement that plans for spending the resources in the BCF should be jointly agreed by the H&WB Board and signed off by the Local Authority and the CCG governance systems. The BCF risk share agreement will also be signed off by the Local Authority and CCG governance systems.

6. Regular and Effective Monitoring

- Both partners will ensure that clear and regular monitoring is in place to ensure that the BCF partnership is able to demonstrate how the joint fund is supporting the delivery of care in Herefordshire within the agreed strategic objectives.
- Each partner will identify a lead review officer to report on progress and performance each month.
- Progress will be monitored by BCPG, with regular jointly produced financial updates provided by the partners.
- Issues / success / lack of progress will be reported by BCPG to JCB for escalation and action to resolve where necessary.

Financial Risk Share Arrangements for 2016/17

Pool 1 (Minimum Fund)

Agreement

It has been agreed by the partners that there will be no financial risk share arrangement in relation to pool 1.

Herefordshire council have agreed to fund the therapeutic and medical inputs for the redesigned RAAC scheme to the values agreed in the scheme for 2016/17 only.

The partners will agree how the RAAC scheme will be redesigned and the effective start date of the new scheme by 30th September date.

Measurement and Monitoring

The partners will monitor the delivery of the scheme through performance metrics which will be jointly agreed by the partners.

Monthly update reports will be provided to the BCPG, for consolidation into the JCB monitoring report

Pool 2 (Additional Fund)

1. Definition of the Risk Share Cohort (Risk Share 1) –“catch up cohort”

The partners have agreed that the risk share agreement will be restricted to a defined and agreed cohort of clients. This client cohort will be defined as follows:

1. Includes those clients who are not funded at the usual price*² and who have not been reviewed in the twelve month period since 1st April 2015
2. The list of clients identified in 1 above will be jointly assessed by the council and CCG to agree which clients are likely to result in a behaviour change*³ due to the length of time since the last review or for other reasons relating to a change in the approach being taken by the commissioner.
3. The defined client list excludes any clients identified by the CCG as being part of separate arrangements with 2g for risk share. (The client list for 2g as provided by Jade Brooks and matched to the BCF client list).
4. The defined list will exclude non-reviewed clients who, the partners jointly agree, are unlikely to have incurred a substantive change in health and care needs in the intervening period. These clients will be classified as business as usual and excluded from the specific risk share arrangement.
5. The eligible clients list, as defined above, will include the totality of eligible clients, this is a total of 27 clients and is within appendix one of this document.
6. The expectation will be that the clients will be reviewed within the next six months and the monitoring of the reviews will be through the Better Care Fund Partnership Group, with further reporting to the Joint Commissioning Board.

**² in this context the usual price is defined as any local authority client funded at either the old, or new usual price for older peoples residential and nursing care (£570, £523, (old / new nursing rates), £468, £457*

(old/new residential & dementia rates) per week), and clients who receive FNC/FCO only support from the CCG

^{*3} in this context the term behaviour change means that the partners agree that due to the length of time since the last review a stepped change in level of needs is likely to be identified upon review which may result in a change of statutory partner responsibility for the individual client

2. Financial Risk Share Arrangement

a. Value of the Risk Share Pool

The current annual cost of the defined client cohort is £1,384.7k. Costs within the risk share pool are split as follows:

Table 1

	No Clients	Annual Cost	Cost Ratio
Herefordshire Council	22	1,036.6	75%
Herefordshire CCG	5	348.4	25%
Total	27	1,384.7	100%

b. Calculation of the Value of the Cap

The cap will be set at an agreed percentage of the pool value. If partners subsequently agree a change in the value of the risk share pool the cash value of the cap will be varied in line with the agreed percentage.

Table 2

Cap %	Cap Value £'000
10%	135k ^{*1}
12%	166k ^{*2}
13%	180k^{*4}
14%	200k ^{*3}

^{*1} council position

^{*2} MS proposal to SH

^{*3} CCG counter proposal

^{*4} Agreed percentage

The cap has been jointly agreed at 13% of the pool value.

The total cost of any clients that transfer responsibility will be split **75:25** up to a maximum of £180,000 for each partner in 2016/17 (as specified in table 1 above) based on the agreed client cohort. Any costs over and above £180,000 for each partner will be met by the partner to whom statutory responsibility transfers.

The risk or benefit of clients whose package change but whose statutory responsibility does not change will not be factored into the risk sharing arrangement.

Packages of care which move from sole partner to joint funded will be excluded from the risk share arrangement, unless there is an agreed change of statutory responsibility.

The financial risk will be applied to the overall net cost or gain from those clients who change statutory responsibility. (See worked example 4 below)

3. Savings Targets

It is recognised that both partners have in year savings targets of £500k each. These savings are deliverable across the totality of both the in county placements included in pool 2 and out of county placements.

All savings achieved by the partners will be retained by the beneficiary partner, in so far as they are not associated with the specific clients subject to the risk share arrangements.

4. Measurement and Monitoring of Risk Share

The baseline will be the agreed cohort at the uplifted 2016/17 budget value by client.

For the agreed cohort, regular (monthly) reports to the Better Care Partnership Group (BCPG) will

- Identify the number of clients reviewed in the month, and cumulative year to date.
- Summarise the number of packages which have switched statutory responsible partner as a result of the review
- Include a summary of the number of packages which have increased / decreased / had no change in value
- Summarise the in year financial impact and full year equivalent cost impact.
- Include a cumulative summary of the risk share impact for both partners.

The BCPG will on a monthly basis provide a summary update to JCB on the risk share arrangement.

BCPG will receive and review on a monthly basis reports on the performance on the totality of pool 2 in addition to the specific risk share arrangements.

5. Joint Agreement

This agreement is only valid if this memorandum of understanding is signed by both partners.

6. Review of the scope and success of the agreement

The partners will formally review the agreement at 3 monthly intervals (September will be the first review point) and consider whether the scope of the agreement should be extended to include additional specific cohorts of individuals.

Additions to the scope of the agreement will only be considered where there is a clearly worked up proposal, including full identification of the resources required to deliver the proposal, and where the proposal has been developed jointly.

The partners will formally review the Risk Sharing agreement in January 2017.

The risk share will require formal re-ratification by both partners if to continue on the same basis in 2017/18.

7. Risk Share 2 – In Year Changes in Commissioning Behaviour - Potential Arrangement

The partners have agreed in section 6 above to regular formal reviews to determine whether any in year changes in commissioning behaviour beyond the “catch up cohort” covered by the risk share arrangement, for example a substantive change in review processes or frequency, are likely to give rise to substantive financial risks / benefits between the partners.

In the event a substantive risk being identified by either partner, the partners will work together to provide an informed estimate of the financial scope, and derive an equitable approach to managing the risk for the remainder of the financial year.

Worked Examples

1. HC transfer £100k of client costs to CCG, and no clients transfer from the CCG to council,
 - a. HC would pay 75k to CCG under risk share cap (£100k cost transfer x75% being council contribution to pool), net benefit to LA **£25k**
 - b. Net cost to CCG **£25k**
2. HC transfer £240k of client costs to CCG, no clients transfer from CCG, agreed cap at £180k.
 - a. Cost £240k x75% = 180k, cap limit is reached.
 - b. Net saving to council £240k less £180k **£60k**
 - a. Net cost to CCG £240k less risk share contribution £180k at max cap value of £180k **=£60k**
3. HC transfer value £400k and no clients transfer from the CCG to council (and cap £180k)
 - a. Cost x75% = £300k, above cap threshold therefore cap applies.
 - b. Net Saving to council £400k less cap £180k = **£220k**
 - c. Net cost to CCG £400k less risk share contribution at max cap value of £180k **=£220k**
4. HC transfer value £400k to CCG, CCG transfer value to council £100k (and cap £180k)
 - a. Net Transfer cost £400-£100k = £300k
 - b. Net Cost benefit to council £300k before cap. £300k x75% = £225k, above cap therefore cap paid in full to CCG
 - c. Net Saving to council £300k less cap £180k = **£120k**
 - d. Net cost to CCG £300k less risk share contribution at max cap value of £180k **=£120k**



Meeting:	Health and wellbeing board
Meeting date:	20 September 2016
Title of report:	Update on priority three of the health and wellbeing strategy – quality of life, social isolation, fuel poverty
Report by:	Director for adults and wellbeing

Classification

Open

Key decision

This is not an executive decision.

Wards affected

Countywide

Purpose

To review progress in delivering the third priority of the health and wellbeing strategy, covering older people, to include progress plans and challenges.

Recommendation(s)

THAT:

- (a) the approach, process, progress and barriers to success to deliver the priority be reviewed; and
- (b) additional actions or approaches to remove any barriers to success or further improve rate of progress be identified.

Alternative options

- 1 The alternative to pursuing the areas of work set out in this report would be for services to continue as they are now. This is not recommended, given the implications for demand for services resulting from demographic trends, which forecast a substantial increase in the number (absolute and proportion) of older people in the population, and the poor outcomes currently experienced by many older people.

Reasons for recommendations

- 2 The work set out in this report plays a key role in securing better outcomes for older people and contribute to Herefordshire's health and wellbeing strategy.

The recommendations enable the health and wellbeing board to meet its responsibilities to review whether the commissioning plans and arrangements for the NHS, public health and social care are in line with and have given due regard to the health and wellbeing strategy .

Key considerations

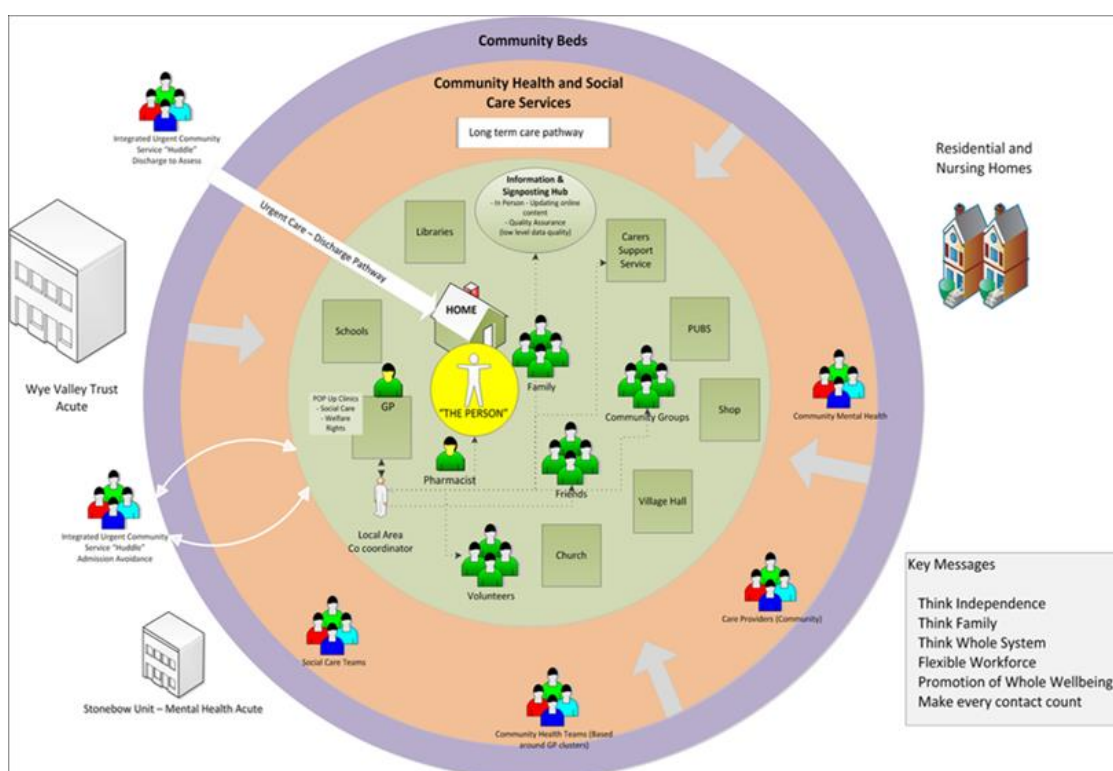
- 3 The development of these areas of work comes at a time of increased financial pressures on all agencies and organisations, including NHS, public and mental health services, as well as the council's adults' services. At the same time there is an increased pressure on resources, with higher numbers entering health and social care settings as the population ages. These significant cost pressures, with capped budgets that need to be absorbed, mean the current resourcing is not sustainable.
- 4 To make the sustainable changes that will have an impact on these numbers and incurred costs, there is a need to maximise an approach that will enable effective, early work that will not only achieve 'best value', but will facilitate and influence communities and partners to provide effective and coordinated evidenced-based help and support to older people at the earliest opportunity. It will rebalance resources across Herefordshire's multi-agency services to enable sustainable service provision that will benefit older people and their families.
- 5 The data regarding the older population of Herefordshire sets out a clear picture of need and demand:
 - 23% of residents are aged 65 years and over (compared to 17% nationally);
 - The number of 85 year olds is set to double (to 11,700) by 2031, which will mean the social care and health demand will rise;
 - The growth will continue, especially amongst the over 65 year olds, with projections of over 30% of the population by 2013;
 - Rates of dementia are increasing as the population ages and this links to the need for appropriate housing;
 - There is considerable association between people with learning disabilities (LD) and dementia, such that as people with LD increasingly live into old age, they are disproportionately likely to suffer from dementia;
 - A further 950 people aged 65+ are estimated to have LD; 150 classed as moderate or severe. Around 60 people aged 65+ receive social care support related to LD;
 - Access to services and housing conditions are the biggest issues for the county, affecting both the towns and the rural areas;
 - One in five households live in poverty; and
 - One in 20 report feeling isolated.

6 The current local circumstances give rise to the following key drivers:

- Current and future financial challenges;
- Increasing levels of demand;
- Establishing and maintaining consistent quality of service
- Acuteness, level and duration of care packages;
- The increasing complexity of care needs;
- Improving the effectiveness of the reablement function;
- Recruitment/retention difficulties in social care and the need for improved market stability and sustainability;
- Improving market capacity to meet needs in a timely manner; and
- The need for greater integration with health and local communities.

Progress plans

7 A whole systems approach to transformation is currently being taken, within which commissioning and delivery of services are the key change drivers in Herefordshire. This approach, based on the adults and wellbeing blueprint below, connects individuals with family, friends and community support networks so people can live independently and prevent or postpone the need for funded care and support services, reduce isolation and improve quality of life.



8 Our approach is to be proactive in helping and encouraging people to live healthier lifestyles and developing resources that offer more choice and control in remaining independent, therefore reducing or delaying the need for formal social care.

9 The blueprint recognises the need to empower people to feel able to find help, access it and use it to improve their health, wellbeing and general lives. Services in the community will be the first option for people, and market development is key to supporting and developing this approach.

- 10 In Herefordshire, we are building an asset based approach, linking to existing local community provision, encouraging the development of innovation and the release of additional capacity, not just of those entitled to support, but also of other individuals and organisations to provide support. The ongoing collaborative approaches undertaken with health partners and other key stakeholders supports and underpins this work.

Help to Live at Home – Redesign of home care services

- 11 Herefordshire Council's vision is to have innovative, high quality home care services that promote individual wellbeing, independence and ensure a good quality of life.
- 12 The Help to Live at Home project moves this forward by redesigning services through co-production and strengthening social capital through community development; activities that put strong and inclusive communities at the heart of Herefordshire's future health and care system.
- 13 The redesigned service will support the adults and wellbeing blueprint and aims to embed an enablement ethos to promote individuals independence, whilst utilising support from the communities. Cabinet will be asked to agree that a competitive tender process should commence at the end of October 2016.

Housing

- 14 Herefordshire Council is currently negotiating on planning gain sites with a proportion of wheelchair accessible properties. The government has removed any standards above building regulations, so any additional standards that we can achieve mean a reduction in overall affordable housing unit numbers. In addition, these negotiations have resulted on the increased availability of bungalows.
- 15 The council's housing team is also supporting extra care schemes throughout the county with mixed tenures.
- 16 On the open market we are actively encouraging developers to develop bigger two bed properties on the footprint of a three bed property. The reasoning for this is that we find older people who are downsizing, often have a lot of belongings and so storage is an issue. The bigger footprint allows for additional storage to be incorporated within the property.

Fuel Poverty

- 17 Fuel poverty is a significant public health issue. Cold-related illness, stress and excess winter deaths can all be linked to the prevalence of fuel poverty. High proportions of people unable to heat their homes adequately are of pensionable age (27%), particularly those living alone (33%). Analysis in Herefordshire Council's affordable warmth strategy suggests that, using Age UK (2012) and Herefordshire population data, it can be estimated that the cost to the NHS in Herefordshire owing to cold homes is £4,706,935 and that reducing fuel poverty would lead to consequential reductions in local health spend, GP referrals and hospital admissions. The following schemes are in development:
- Keep Herefordshire Warm actively working with partners and residents to improve awareness of fuel poverty through Warmer Marches and Big Energy Saving Network schemes, an opportunity is also being explored around targeting vulnerable residents for affordable warmth funding via a mail out.

Further information on the subject of this report is available from
Martin Samuels, director for adults and wellbeing on Tel (01432) 260339

- Warm Healthy Homes project currently targeting vulnerable fuel poor households; two replacement heating systems installed to date through this project.
- Winter awareness campaign planned for winter 2016/17, other awareness raising being developed via case studies, news releases and social media.
- Future collective energy switching scheme being investigated as off-shoot of local municipal energy supply scoping work that is currently taking place.

Public health

- 18 The healthy lifestyle trainer service (HLTS) for behaviour change supports people to achieve their goals to improve their health. During 2015/16, 28% of the clients were aged 45-59 years, a good target group to prevent the onset of long term conditions and 32% of clients were aged 60 and over, with 53% of its clients being from the most deprived quintile. It has undergone development in the last six months to add to its core service, to now offering a gateway to ActiveHERE, BP check, training for health champions including via the transport transformation fund, and preparation for delivery of Healthier You.
- 19 ActiveHERE is delivered by Brightstripe within a council-led project to get inactive adults active, funded by Sport England with public health grant contribution. In the first six months there has been engagement of 4,889 people with 348 taking part and 189 becoming more active, meeting the minimum guidelines.
- 20 Healthier You is the national diabetes prevention programme. Herefordshire Council is a partner in this Herefordshire Clinical Commissioning Group (CCG) led programme, Reed Momenta has been appointed as the provider in Herefordshire via a mini-competition. People identified by the pilot GP practices have been offered the programme and two courses have started with a further six on line for delivery in the autumn. Through connecting with the Herefordshire and Worcestershire Sport Partnership, instructors from the county are being trained to deliver balance and strength exercises in communities. This is a start to an evidence based programme of fork for falls prevention from a physical activity perspective.
- 21 Public health is influencing the wider public health workforce development to use community assets which includes any individual who is not a specialist or practitioner in public health, but has the opportunity or ability to positively impact health and wellbeing through their paid or unpaid work. The adults workforce, both health and social care, are crucial to this work as it provides the confidence and knowledge to improve quality of life and reduce social isolation.

Integration

Better Care Fund (BCF) – Residential and nursing unified contract

- 22 The largest pool within the BCF plan for Herefordshire is for the joint contracting and commissioning of residential and nursing placements. A unified contract, in relation to both council and CCG commissioned placements, has been developed during the last year, involving a detailed engagement process with the market on the contract principles and changes. The content of the unified contract was agreed during quarter one of 2016/17 and is currently available to providers via an accreditation process. The advantages of providing this unified contract are consistency in contractual arrangements across partners, a joint quality assurance framework, a movement to gross payments for the council, and a reduction in administrative support requirements.

Further information on the subject of this report is available from
Martin Samuels, director for adults and wellbeing on Tel (01432) 260339

Improvements are expected to be delivered during 2016/17.

Intermediate care and reablement – whole system approach

- 23 The intermediate care service offers short term care that supports a period of change and recovery and aims to enable the person to stay in their usual place of residence whilst rebuilding their health and confidence.
- 24 Intermediate care can be funded for up to six weeks and provides a therapeutic goal setting, progress and exit planning for individuals who need intensive support to regain their independence. Work is being taken forward to redesign intermediate care, in order to ensure that the opportunities to bring individuals back up to the highest possible level of independence are fully secured.
- 25 There will be three core areas within the revised pathway:
- Bed based care – rapid access to discharge and community beds
 - Community health – delivering healthcare and therapy at home
 - Social care enablement – maintaining and extending independence through care at home

Falls responder service

- 26 A number of schemes have been set up via the BCF to address the demand in non-elective admissions with a view to reducing these further in Herefordshire. The falls response service has been an effective provision in supporting the delivery of this and improving individuals' quality of life.
- 27 The falls response service continues to help address the gaps in the falls pathway in Herefordshire, caring for those fallers who have not received serious injury. Due to the continuing success of this service, it has been agreed to invest in this service through the BCF, in order to assist in reducing the number of non-elective admissions reported.

Community impact

- 28 The health and wellbeing strategy identifies the key priorities for the county; by reviewing the plans for achieving these priorities the board can gain assurance that resources across the health and social care system are being directed in the most appropriate way.

Equality duty

- 29 The work to support older people will pay due regard to our public sector equality duty and will ensure that we have considered and paid due regard to the need to:
- "eliminate discrimination, harassment, victimisation and any other conduct ... prohibited by or under this Act;
 - advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

Financial implications

- 30 None arising directly from this report. If the board identifies additional actions; regard must be had to the financial implications of delivery.

Legal implications

- 31 None arising from the recommendations. The Health and Social Care Act 2012 provides the primary responsibility of health and wellbeing boards to identify the current and future health and social care needs of the local community. The board is acting under this duty by reviewing the current arrangements as identified in the report.

Risk management

- 32 Each of the work areas has its own risk management arrangements in place.
- 33 The main risks to successful delivery of the desired outcomes are:
- The pressure to deliver current reactive services, such as non-elective healthcare and residential care, may absorb such a large proportion of the available resources that little is left to support preventative work, leading to a vicious cycle. This is being addressed through concerted efforts to ensure that only the necessary care is provided to eligible individuals, thereby making best use of resources and maintaining capacity for prevention.
 - The longstanding culture across the public service that encourages a focus on delivery of services, rather than on securing outcomes, may encourage staff to concentrate on intervening in the lives of residents at an earlier stage, and to a greater extent, than might be compatible with an asset-based philosophy, which focuses on the maintenance of independence, choice and control by the individual. This is being addressed through a programme of culture change and organisation development with staff across all sectors.

Consultees

- 34 Each of the work areas outlined in this report seeks to ensure that stakeholders are fully engaged at the key stages of the development and implementation of service changes.

Appendices

None

Background papers

- None identified.

